'It takes a village', but the village is gone: Women's perinatal experiences during COVID-19

by

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Abstract

This qualitative study explored women's perinatal experiences during the COVID-19 pandemic. Specifically, this study sought to not only explore this experience, but to understand if and how their mental health was impacted. Utilizing a feminist theoretical framework, eight women in Winnipeg, Manitoba were interviewed for this study. From these in-depth interviews with women, four main themes were identified: the pandemic's adverse impact on mental health, experiences of motherhood, challenges to support networks, and silver linings.

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Dedication

This thesis is dedicated to the women who participated in this study. Your enthusiasm, bravery, and honesty in sharing your stories is so appreciated. This would not have been possible without you, thank you.

Table of Contents

Chapter One: Introduction

The coronavirus (SARS-CoV-2) commonly referred to as COVID-19, was first identified in December of 2019 in Wuhan, China, spreading quickly and resulting in the pandemic being declared by the World Health Organization (WHO) on March 11, 2020 (WHO, 2020). The first case of COVID-19 identified in Manitoba was on March 12, 2020 (CTV News, 2020). The consequences of this pandemic have been far-reaching, as there is no segment of society left untouched. To mitigate the effects of the virus, governments around the world rapidly enforced a multitude of public health directives, forcing individuals and families to isolate and limit social contact as much as possible. Workplaces began mandating employees to work from home, schools and daycares closed, and those working on the front lines faced uncertainty and fear on a daily basis, causing major psychological distress for many (Racine et al., 2021). COVID-19 has placed a strain on health care systems globally, with over 6.9 million people dying from the virus, and over 766 million confirmed cases, as of May 2023 (WHO, 2023).

On May 5th, 2023, the WHO declared that the COVID-19 pandemic is no longer a public health emergency, as is now considered "an ongoing health issue" (WHO, 2023, para 3). Despite this, we continue to experience repercussions from the pandemic, and continue to manage the effects it has caused. The Canadian Medical Association (CMA, 2021) reported that the socio-economic impact of the pandemic on Canadians is even more expansive than the physical effects of the virus itself. According to the CMA (2021) among the general population, visits to hospital relating to substance misuse and self-reported mental health concerns both increased during the pandemic. Food insecurity increased during the pandemic, with food bank use in Canada increasing by 20% (Reimer, 2021), rates of intimate partner violence (IPV) increased (Lucas &

Bamber, 2021), as did calls to crisis and suicide prevention hotlines across the country. These statistics show a bleak picture of just some of the ways individuals have been affected by the pandemic, and how the pandemic has impacted our collective mental health.

Research conducted during the pandemic has shown that disparities exist among people when it comes to the health outcomes of the virus, and that women, and mothers in particular, are in a higher risk category when it comes to experiencing the effects of the pandemic (Davenport et al., 2020; O'Reilly & Green, 2021; Rice & Williams, 2021). Men are more likely to experience direct consequences such as increased rates of hospitalizations and mortality (Lucas & Bamber, 2021; Ryan & El Ayadi, 2020). The more indirect consequences of the pandemic, however, have more adverse effects on women and girls. These include economic impacts (Ryan & El Ayadi, 2020), increased risk of mental health issues (Davenport et al., 2020; Rice & Williams, 2021), increased risk of IPV (Lucas & Bamber, 2021), and food and housing instability (Ryan & El Ayadi, 2020). It should also be noted that research suggests that globally, there is not enough focus on the collection of sex disaggregated data, making it difficult to analyze the true gendered impact of the COVID-19 pandemic (Smith et al., 2021). Women take on most of the care work in society (Cummins & Brannon, 2022; O'Reilly & Green, 2021), which has only increased during the pandemic with school and daycare closures, work from home mandates, and stay at home orders. Globally, women make up "70% of the global health and social care workforce" (Ryan & El Ayadi, 2020, p.1405). This places women at a higher risk of contracting COVID-19, particularly in many countries where access to personal protective equipment (PPE) has been limited. Women who were pregnant during this time faced barriers to their prenatal care due to closures and changes to health care delivery, and women who had recently given birth faced isolation and limited resources while at home caring for their new

baby (Davenport et al., 2020). Access to contraception and abortion services were limited, and the increase of telehealth support created barriers for women trying to access all types of routine health care, as those without appropriate internet access or technological equipment necessary faced further barriers. Increased barriers to routine sexual and reproductive health care also resulted in increased rates of sexually transmitted infections and unplanned pregnancy globally (Ryan & El Ayadi, 2020). Rates of IPV have increased during the pandemic, an issue which disproportionately affects women (Lucas & Bamber, 2021). The economic impact of the pandemic has also particularly impacted women, as women are more likely to be living in poverty and hold precarious employment (Ryan & El Ayadi, 2020).

Statement of the Problem

During the pandemic, early research from Canadian (Davenport et al., 2020) and international studies (Basu et al., 2021; Durankus & Aksu, 2020; Mayopoulos et al., 2021) suggested that women experience high rates of anxiety and depression, both clinically significant and self-reported, at all stages of the perinatal period (Basu et al., 2021; Davenport et al., 2020; Durankus & Aksu, 2020; Mayopoulos et al., 2021), and that mental health related challenges among those who had given birth during the pandemic are acute (Rice & Williams, 2021). The perinatal period is a time of complex change and major transition, and women in the perinatal period are faced with numerous challenges. According to Lebel et al. (2020) there is a global push to understand the mental health impact of the COVID-19 pandemic, which contributes to our understanding of the current effects but also prepares us to prevent and mitigate the after affects. As O'Reilly & Green (2021) state, mothers in particular "are overwhelmingly responsible for the care work of their homes and communities – childcare, elder care and domestic labour" (p. 41), which have all increased during the pandemic. O'Reilly & Green

(2021) go on to state, "mothers are most affected because it is mothers who perform the necessary care work and are responsible for social reproduction to sustain their families and communities through and after this pandemic" (p. 42). The COVID-19 pandemic only exacerbated the situation for women and mothers, attempting to manage the increase in care work, while simultaneously managing all other responsibilities and changing pandemic mandates. Therefore, it is no surprise that the COVID-19 pandemic placed further strain on the already complex reality of women in the perinatal period. As not only the expectations in the private sphere were changed, so too was the health care and mental health care landscape (Cummins & Brannon, 2022).

Since the beginning of the pandemic, research has rapidly emerged, and it has been established that compared to prior to the pandemic, women in the perinatal period have experienced significantly increased rates of emotional distress, anxiety disorders, and depressive symptoms (Berthelot et al., 2021; Davenport et al., 2020; Kinser et al., 2022; Shuman et al., 2022). However, despite this evidence to suggest that women's mental health at all stages of the perinatal period has been affected, there remains limited understanding of the *experiences* of women during this time (Atmuri et al., 2023) and answers as to *why* their mental health has been impacted remain limited (McKinlay et al., 2022).

Purpose of the Study

The purpose of this study was to explore women's perinatal experiences during the COVID-19 pandemic, and to identify if and how this has impacted their mental health. The purpose of this study was not to compare women's mental health symptoms or experiences with diagnostic criteria, or to list mental health symptoms, but rather to explore their mental health in

general to capture an overall understanding of the mental health impacts, regardless of an official diagnosis. The decision not to utilize a formal clinical rating system or utilize specific diagnostic criteria was made as I wanted to acknowledge the importance of using women's voices to describe and explain their mental health without the use of a dominant medical framework or screening tool. This decision is also in line with the feminist theoretical framework (discussed later in Chapter 3).

Our understanding of perinatal mental illness comes from the dominant bio-medical models, influenced by a patriarchal society. Bio-medical models also often ignore social and cultural factors which impact our mental health (Cosgrove, 2000). What we know about perinatal experience and maternal mental health is largely constructed from the male dominated biomedical model, often framing this knowledge as superior to that of women's own knowledge and experience (Cahill, 2001). Cosgrove (2000) notes that when researching and exploring women's mental health, we must understand the historically gendered representation of mental health and emotional distress, and the ways these experiences have largely been ignored. While this is not meant to outright reject modern screening tools or clinical guidelines, I wanted the data collected for this study to come from women's voices and experiences, in their own words.

Women were asked to identify a specific phase of the perinatal period that they felt was most impacted by the pandemic, and to share this experience. I asked women to describe how they experienced this time while also managing with the consequences and changes during the pandemic, and what this impact was. This included an exploration of what it was like to care for a baby and be a mother during this time. Many of the studies conducted to date relating to the perinatal period and the pandemic focus on one phase of the perinatal period, such as pregnancy (Groulx et al., 2021; Lebel et al., 2020; Racine et al., 2021) or postpartum only (Gribble et al.,

2020; Vigod et al., 2021). While these studies are all of critical importance to understanding the experience as a whole, I sought to give women the choice in which phase they felt was most impactful, and expand on why they felt this way, to provide a more holistic understanding of this experience.

Secondly, I sought to understand and explore if and how their mental health was impacted. Women were asked to describe, in their own words, what their mental health was like during the perinatal experience. This included an exploration of potential protective factors that assisted in their coping during this time, as well as the risk factors and how these impacted them. This study asked women to explore their thoughts and feelings during this time, and to understand if they sought any kind of support or treatment for any of their mental health concerns, and if there are ways they could have been better supported. Much of the existing literature relating to perinatal mental health focuses on improvement or treatment at the individual level, viewing women "as the main agent for change" (Howard & Khalifeh, 2020, p. 320). Gendered risk factors, such as poverty, economic status, IPV, and food and housing instability, are often not the focus of potential useful interventions (Howard & Khalifeh, 2020). Consistent with a feminist informed theoretical framework, I wanted to ensure that the focus was not just on women's individual feelings and responses, but rather, to be able to make the connection to the larger societal structures and dominant discourses which impact women, their experiences, the services and supports they receive, and the ways their mental health is ultimately affected.

This study came to be from personal experience and had a personal objective to understand women's experiences and enable these stories to be told as I experienced a lack of opportunity to do so for myself. As a first-time mother who gave birth six months prior to the

beginning of the pandemic, I found the impact of the pandemic to be significant to my own mental health. As a large period of my postpartum phase occurred during the beginning of the pandemic, I experienced long periods of isolation and lack of supports due to social distancing and isolation measures, while learning to care for a new baby and navigating the new experience of motherhood. It was not until later that I learned through informal discussions with other new mothers, social media, and news articles, that this experience was shared by many women, and that the impacts on women's mental health during this time were emerging as a major issue.

Historically, health crises, natural disasters and previous pandemics and epidemics have disproportionately affected women (Ryan & El Ayadi, 2020; Smith et al., 2021), but it is also important to note that in Canada and internationally, the inclusion of a gendered lens or analysis in government responses to COVID-19 is lacking. This includes the ways in which governments and health care systems, including mental health systems and supports, have responded to the needs of women in the perinatal period during the pandemic. Thus, exploring women's experiences becomes increasingly important. This study acknowledges the gendered aspect of this pandemic, and how women, and in this case mothers, have been particularly affected in a multitude of ways.

Significance of the Study

This study contributes to the existing literature relating to maternal mental health, the perinatal period, and the COVID-19 pandemic, and to the overall body of literature about the societal impacts of the pandemic. This study is significant as it focuses on women's experiences during this time and focuses on women as the experts. As mentioned, much of the emerging literature relating to women's perinatal experiences during the pandemic gathered data through survey or questionnaire, or by comparing pre-pandemic rates of mental health symptoms to

current or post-pandemic data (Cameron et al., 2021; Durankus & Asku, 2020; Lebel et al., 2020; Racine et al., 2021). This study did not gather data in this manner and enabled the mothers share their experience in their own words. This study provided women an opportunity to discuss their own experiences and provide insight on this experience, contributing to our emerging understanding of the pandemic and mental health. While there is still much to be discovered about the experience of the perinatal experience during the pandemic, what we do know is that perinatal mental health declined during this period, and that women's satisfaction with their birth experience and all aspects of perinatal care was significantly impacted (Rice & Williams, 2022). O'Reilly and Green (2021) state that "publishing the experiences of mothers within the first year of the pandemic is crucial, as it captures and documents some of the ways in which the COVID-19 pandemic has drastically changed the way of life for mothers, children, and other family members" (p. 24). Documenting women's experiences in this study is also significant to clinicians, social workers, health care professionals, and policy makers as it hopes to be able to highlight protective and risk factors for women during this time, which can help us to improve maternal health care and mental health supports in the perinatal period. As previously discussed, the COVID-19 pandemic has impacted men and women in different ways. Research on the gendered aspects of the pandemic exists and continues to emerge but understanding the pandemic through a gendered lens has not been included in the policy responses from governments, the health care system, or the mental health system.

Definitions and Use of Language

This study is focused on women in the perinatal period and their mental health and, therefore both terms are used throughout. To clarify, the perinatal period includes the time of pregnancy to approximately one year postpartum (Winnipeg Regional Health Authority, 2014).

Exact definitions for 'mental health' can vary, and often mental health and mental well-being are used interchangeably. For the purposes of this study, a definition of mental health will be taken from the WHO (2022), which defines mental health as:

> A state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in… [mental health] exists on a complex continuum which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes (WHO, 2022, paras 1-4).

Chapter Two: Literature Review

This section begins with an overview of the existing literature regarding the overall impact of the COVID-19 pandemic on maternal health. Following this is an overview of maternal mental health overall, and then a review of the impact of COVID-19 and the perinatal period. This provides a review of what we currently know about maternal health, maternal mental health, and how COVID-19 pandemic has changed this. Following this is a brief overview of what we know about the impacts of public health emergencies and natural disaster on mental health. Finally, an overview of the discourses of motherhood and mothering are discussed. As this study involves women who are mothers, it is imperative to understand these constructions, and how they impact mothers during the perinatal period, and beyond.

Pandemic Impact on Maternal Health

It has been established that the mortality rate associated with COVID-19 is higher in males than females (Lucas & Bamber, 2021); however, research suggests that the indirect effects have more adverse effects on women's health. The broader maternal health consequences, such as changes to maternal health care service delivery, appear to present much deeper consequences than individual infection for maternal health (Lucas & Bamber, 2021). Changes to maternal health have included changes to policies on partners present during birth, place of birth options, and changes to in-person service provision including mental health and breastfeeding supports. The pandemic has meant a complete reorganization and at times constantly changing maternal health care delivery system in Winnipeg, and globally and health care responses to the pandemic have meant limits to interpersonal contact across all stages of the perinatal period. According to Rice and Williams (2022) the impact of pandemic related perinatal health care policies and practice have yet to be explored in Canada, and around the world. Changes to care provision

evolved rapidly during the pandemic and varied widely across sites. In Canada, access to doulas and allowing support persons to remain with women during childbirth were significantly reduced, if not eliminated completely as a means of reducing the spread of the virus (Rice & Williams, 2022). Research has established that women who have a partner or support person present during childbirth improves obstetric and psychological outcomes for women in labour but also for their babies (Hermann et al., 2020). Continuous support during childbirth has also been shown to reduce the duration of labour, increase women's satisfaction with their birth experience, and results in higher rates of vaginal childbirth (Rice & Williams, 2022). These outcomes are also improved with the presence of a birth professional, such as a midwife. During the pandemic, many hospitals mandated that women birth alone, or choose only one person to be present, often meaning that women had to forgo their planned birthing support system. For example, in the United Kingdom, the option of home birth was largely reduced, and almost eliminated, during the initial phases of the pandemic, due to changing health mandates (Bridle et al., 2022). While some evidence of an increase in at home births during the pandemic in Canada exists (Association of Ontario Midwives, 2022), there remains little data on this topic. Emerging European and Canadian studies are also showing that during the COVID-19 pandemic, medical interventions in childbirth increased (Jago et al., 2020; Rice & Williams, 2022). This includes an increase in caesarian section rates, and the encouragement of epidurals in many hospital settings (Rice & Williams, 2022), which according to the WHO (2018), contributes to the over medicalization of childbirth, resulting in major psychological impacts for women around the world.

Maternal Mental Health

In Canada, it is estimated that 20% of mothers suffer from perinatal mental illness (Canadian Perinatal Mental Health Collaborative, 2021). Perinatal mood and anxiety disorders (PMADs) refer to a range of mental health disorders, which "can affect an individual from conception to 12 months after birth" (CPMHC, 2021, p.6). PMADs include prenatal and postpartum depression, post-traumatic stress disorder, anxiety, obsessive compulsive disorder, panic disorder, bipolar disorder, and psychosis (CPMHC, 2021). These disorders can have a range of adverse outcomes for women and their families. The CPMHC states that prior to the pandemic, the prevalence of PMADs among mothers in Canada was 1 in 4 (CPMHC, 2021). The CPMHC (2021) reports that Canada "has no comprehensive national strategy, mandate or directive" (p. 6) to lead health care practitioners in the assessment, diagnosis, or treatment to women living with PMADs. The CPMHC (2021) reports that while there is existing research to suggest the prevalence of PMADs in Canada, gaps remain in these statistics and research due to the non-existence of a comprehensive national strategy, and reports that many of these disorders may go undiagnosed. Mental health during the perinatal period is also associated with gender-based risk factors (Raghavan et al., 2022). These risk factors include poor social support, low levels of income and education, and younger age (Raghavan et al., 2022). For women in low- and middle-income countries in particular, factors such as family power dynamics, lower autonomy, and lack of control over resources, increase perinatal mental health symptoms (Raghavan et al., 2022). For women who belong to groups who have experienced "historical and current marginalization and stigmatization" (Hicks et al., 2022, p. 2), the risk of experiencing PMAD's is higher.

According to the CPMHC (2021), rates of perinatal mental illness doubled in Canada during the pandemic. The CPMHC reports that the COVID-19 pandemic has placed a spotlight on the already inadequate services for women who are experiencing PMADs in Canada. In a Canadian study conducted through an online survey by Davenport et al. (2020), women reported an increase in self-reported levels of depression and anxiety from before to after the pandemic. Rice and Williams (2021) note that while women report several issues that have impacted their mental health during the pandemic, overall, the policies impacting them were largely related to policies limiting support persons during childbirth and limiting interpersonal contact at all stages. The existing research surrounding perinatal mental health during the pandemic has mostly relied on surveys, usually with the purpose of assessing change in mental health (Rice & Williams, 2021). While this information is valuable, the experiences that influence or impact mental health struggles during the pandemic remain largely uninvestigated. Racine et al. (2021) reported that many studies published since the pandemic began relating to mothers' anxiety and depression, but are limited in their ability to assess change over time, due to the lack of data relating to mothers' pre-pandemic mental health. Racine et al. (2021) also noted that it is difficult to measure pandemic mental health struggles in mothers against pre-pandemic mental health outcomes, as there remains a gap in this literature.

COVID-19 and the Perinatal Period

As compared to Canadian mothers prior to the pandemic, in their online survey of mothers (n=267) during the pandemic, Cameron et al. (2020) found an increase in maternal depression of 10 % to 32 %, for women with children aged 0-18 months. An online poll conducted by the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Use and Addiction (CCSA) of over 4,000 Canadians found that during the pandemic,

"parents with children under 12 were more likely to report moderate to severe symptoms of anxiety" (MHCC, 2021, p. 3) as compared to the general population**.** Racine et al., (2021) found that difficulties in obtaining childcare, home schooling, and working from home were associated with increases in maternal depression and anxiety, based on data collected from a COVID-19 impact survey, conducted from May 2020 to July 2020 with over 1,300 Canadian women. These authors also reported mothers who experienced family loss of employment or income due to the pandemic had an increase in mental health symptoms, compared with those who did not (Racine et al., 2021). While this may not be a surprising finding, it is important to note the ways in which the overall economic impact of the pandemic can affect maternal mental health in particular. All of the effects of the COVID-19 pandemic on women are not only associated with enduring mental health issues among mothers but have also been reported to have potential long term consequences for child development, including disruptions to child attachment (Cameron et al., 2020; Davenport et al., 2020; Mayopoulos et al., 2021).

Available literature relating to pregnancy, childbirth, and postpartum during the pandemic has made it clear that women's access to services and supports at all stages of the perinatal period were deeply affected (Rice & Wiliams, 2021). This period is one of significant change, involving major transitions for women and their families (WRHA, 2014; Lebel et al., 2020) and can result in major psychological changes (Ahmad & Vismara, 2021). The perinatal period is "associated with increased risk for onset and relapse of mental health conditions for women – higher than at most other times in a woman's life" (CPMHC, 2021, p.13). The leading cause of death among women during the perinatal period is suicide, accounting for approximately 5-20% of maternal deaths (CPMHC, 2021). Women in the perinatal period during the pandemic are coping with the existing stressors of becoming a mother, and are now doing so

coupled with the effects of the pandemic (Mayopoulos et al., 2021). Research has shown the importance of social support during this time as social support and interaction have been shown to improve perinatal mental health outcomes (Basu et al., 2021).

Psychological distress during the prenatal period is associated with negative outcomes for women and their babies, including poor psychosocial functioning (Berthelot et al., 2020); parenting difficulties, including difficulty with attachment and bonding (Berthelot et al., 2020; Davenport et al., 2020); and negative perceptions of the birth experience (Groulx et al., 2021). Other risks include an increased risk of miscarriage (Lebel et al., 2020), preterm birth (Davenport et al., 2020; Lebel et al., 2020), low infant birthweight (Berthelot et al., 2020; Lebel et al., 2020), and lower Apgar scores[1] at birth (Lebel et al., 2020). Low birth weight, preterm birth, and risk of miscarriage are also associated with inadequate prenatal care (Groulx et al., 2021). Although prenatal stress may be considered common, considerable stressors such as natural disasters and health crisis only contribute to an increase in psychological distress, ultimately exacerbating potential effects (Berthelot et al., 2020). Sustained symptoms of depression and anxiety during this period increase a woman's risk of postpartum depression (Lebel et al., 2020) and prenatal anxiety and depression can contribute to changes to sleep, nutrition, and physical activity, which can have effects on maternal mood and fetus development (Davenport et al., 2020; Lebel et al., 2020). Social support has been shown to improve the effects of prenatal stress and assists in lowering impacts of anxiety and depressive symptoms on maternal stress response systems (Basu et al., 2021; Lebel et al., 2020).

[1] The Apgar score is a scoring system used to assess a newborn's physiological well-being by monitoring five vital signs: appearance, pulse, reflex, muscle tone, and breathing. *Manitoba Centre for Health Policy, 2004.*

Specific factors that have been found to cause these elevated symptoms are concerns about social isolation measures (Lebel, et al., 2020), concerns for their own mortality (Lebel et al., 2020), risk of negative neonatal outcomes (Basu et al., 2021), and concern about the uncertainty of contracting COVID-19 during pregnancy (Basu et al., 2021). With rapidly changing policies relating to support persons during prenatal appointments, limited number of prenatal appointments and changes from in-person to virtual meetings, pregnant women were faced with increased stress and uncertainty as it related to prenatal care (Groulx et al., 2021). In their study of Canadian women (n= 4,604) who were pregnant during the initial stages of the COVID-19 pandemic, April 5 to June 1, 2020, Groulx et al., (2021) found clinically significant increases to depression and anxiety related symptoms directly associated with changes or disruptions to routine prenatal care.

Pregnancy is a time of increased risk for women to experience IPV (Wadsworth et al., 2018). Research emerging from the pandemic has shown that IPV has increased globally (Lucas & Bamber, 2021). During pregnancy, women who are experiencing IPV are more likely to experience poor mental health symptoms such as increased thoughts and feelings of depression, anxiety, post-traumatic stress disorder, and suicidal ideation (Stewart et al., 2017; Wadsworth et al., 2018), and are also more likely to delay access to routine perinatal health care (Wadsworth et al., 2018). Experiencing IPV during the perinatal period also presents women with more challenges to leaving their abusive partner, a challenge which has only become more difficult during the pandemic. An increase in remote or virtual appointments for women in the perinatal period has also been identified by a variety of health care professionals as a potential risk factor for women experiencing IPV as they no longer can disclose or discuss potential violence without their partner present (Lucas & Bamber, 2021). Stay at home orders and isolation directives also

placed women experiencing IPV in a situation in which reaching out for support through crisis lines or emergency shelters was more difficult (Evans et al., 2020).

Childbirth can be described as a major life event, which is complex, multi-dimensional, and highly subjective (Goodman et al., 2004; Larkin et al., 2009; MacDougall, 2020). Along with the physical aspects, childbirth encompasses emotional and psychological facets for women, resulting in long lasting effects to women's health and well-being. The research on childbirth experience generally places these experiences within two categories: positive or negative, the latter at times referred to as traumatic birth. While other researchers argue that birth experience exists along a spectrum (Larkin et al., 2009; Simelela, 2018) regardless of how childbirth is experienced for women, research tells us that it will have lasting impacts, not just from the brief period of labour and subsequent birth of the child but can expand into the postpartum period and into the rest of the woman's life (Baker et al., 2005; Goodman et al., 2004; Henriksen et al., 2017; Smarandache et al., 2016).

Women who report negative childbirth experiences are at risk of short and long-term impacts to their wellbeing, and the wellbeing and relationship they have with their child (Henriksen et al., 2017). In addition to the issues noted previously, research also reports that negative childbirth and perinatal experiences increase risk of postpartum depression and anxiety (Larkin et al., 2009; Smarandache et al., 2016), lower quality of life (Smarandache et al., 2016), create issues with breastfeeding (Henriksen et al., 2017; Mayopoulos et al., 2021), and difficulty with attachment and bonding (Bossano et al., 2017; Nystedt & Hildingsson, 2018). Research has also found negative birth experiences can largely impact future reproduction and subsequent

childbirth (Henriksen et al., 2017; Smarandache et al., 2016) and cause disruption to family relationships (Reed et al., 2017).

Women who have reported having a positive childbirth experience have been shown to have increased ability to bond with their child (Larkin et al., 2009), positive attitudes towards motherhood (Goodman et al., 2004), increased self-esteem (Goodman et al., 2004; Larkin et al., 2009), and lower risk of postpartum depression and anxiety (Goodman et al., 2004; Larkin et al., 2009).

Early research on childbirth during the COVID-19 pandemic has shown that women experienced a higher stress response to childbirth during the pandemic (Mayopoulos et al., 2021), and that this experience was also associated with increased symptoms of post-traumatic stress (Mayopoulos et al., 2021). As health care facilities and hospitals rapidly adjusted care provision to urgent needs only, this meant that women giving birth were one of the preeminent groups receiving care in hospital during the pandemic. Thus, women were among the few being admitted to and treated in hospitals and health care facilities while healthy and not being treated for COVID-19, all while major changes occurred to hospital policies (Mayopoulos et al., 2021).

In a Canadian cross-sectional study using linked health databases in Ontario, Vigod et al., (2021) found an increase in clinical visits for postpartum mental health issues during the first nine months of the pandemic. Many women identified the lack of in-person support to be a major issue during the postpartum period during the pandemic, whether it be at home due to social isolation restrictions, or in hospital (Rice & Williams, 2021). In their Canadian study with women in the postpartum period, Rice and Williams (2021) found that while women reported social isolation mandates stressful, when they did seek help it often caused further stress, as it went against public health directives. The difficulty in managing without access to home visits

from public health, support groups, or in-person programming is particularly difficult for those in the postpartum period (Vigod et al., 2021). Issues relating to breastfeeding in the postpartum period have also been noted in multiple studies (Gribble et al., 2020; Mayopoulos et al., 2021; Rice & Wiliams, 2021), with women reporting in one Canadian study that they ended breastfeeding sooner than they wanted due to lack of in person supports (Rice & Wiliams, 2021). This same study noted that the women who required breastfeeding support during the postpartum period reported that online or virtual breastfeeding supports were not useful (Rice & Williams, 2021). Concern about infant safety during the pandemic has been found to be a major stressor (Basu et al., 2021) and alcohol use increased among women with young children (Vigod et al., 2021).

In a Canadian study with women who experienced the perinatal period during the COVID-19 pandemic (n=57), Rice and Williams (2021) noted that women reported experiencing mistreatment and undignified care, leading to a negative experience and potentially negative consequences on their mental health. As Rice and Williams (2021) crucially point out, the issues emerging from the postpartum period during the pandemic mirror those of Indigenous and racialized women in Canada. Literature is well established on the increased risk of poor mental health outcomes for Indigenous women in Canada due to policies restricting support persons when they are transported from remote communities to give birth (Rice & Williams, 2021), isolated from their family and communities. Indigenous women are also at an increased risk of mistreatment and racism during childbirth and in the immediate postpartum period, leading to negative mental health outcomes (Rice & Williams, 2021).

Mental Health During Public Health Emergencies and Natural Disaster

Existing literature relating to natural disasters, epidemics, and public health emergencies can offer insight into the effects on individuals and families. Research into the effects of quarantine during times of public health emergencies and crisis found that symptoms of post-traumatic stress, depression, and anxiety were all common outcomes (Brooks et al., 2020). A Canadian study conducted by Hawryluck et al., (2004) during the SARS outbreak found that the longer period individuals engaged in isolation and quarantine, the more elevated their symptoms of depression and post-traumatic stress disorder became. Lebel et al. (2020) state that research related to infectious disease outbreaks increase the anxiety and depression symptoms in the general population. Research also suggests that self-isolation during infectious disease outbreaks is associated with "anger and anxiety symptoms several months post quarantine" (Cameron et al., 2020, p. 766) and "four times the risk of post-traumatic stress symptoms in parents and their children" (Cameron et al., 2020, p.766).

Discourses of Mothering

As this study involves women who are mothers, a discussion on the discourses and construction of motherhood is imperative. The dominant discourse which prevails in North America is that of intensive mothering. Intensive mothering refers to mothering that is "exclusive, wholly child centered, emotionally involving, and time consuming" (Arendell, 2000, p. 1194). The ideal mother within this discourse is always devoted to the care of others, self-sacrificing, and always placing the needs of her children before her own (Arendell, 2000; Meeussen & Van Laar, 2018). This discourse also enforces the idea that women are innately equipped to be mothers and should be the ones to solely care for their children (Arendell, 2000).

Within these discourses, motherhood and femininity are entangled, and the concepts of womanhood, and motherhood are seen as one and the same (Arendell, 2000).

As women become mothers and feel they cannot uphold the (often impossible and unrealistic) standards of motherhood, it can lead to internalized conflict and feelings of distress and are linked to adverse mental health outcomes including anxiety and depression (Batram-Zantvoort et al., 2022; Choi et al., 2005). Research has shown that discourses of 'good mothers' or 'happy mothers' contribute to postpartum depression and anxiety and increased stress during the perinatal period (Law et al., 2021). Fear of being judged as a "bad" mother, fear of social penalty, or of feeling that they have failed to uphold this norm of intensive mothering, also contributes to women not disclosing symptoms of poor mental health or of reaching out for supports (Law at al., 2021; Meeussen & Van Laar, 2018). Intensive motherhood is also closely connected to neoliberal ideology, in that the care work and domestic labour performed by individuals, mainly women, is devalued as it is seen as private work, and "outside the scope of market valuation" (Cummins & Brannon, 2022, p. 126). When women's experiences of motherhood, pregnancy, birth or postpartum, do not align with what society expects or deems as normal, they are stigmatized and often fear reaching out for support (Law et al., 2021). Another way that women's experiences of mental health are minimized within the discourse of intensive motherhood is in the ways we emphasize the potential effects of their mental health symptoms to their baby, minimizing their own experiences and feelings. An example of this is how women are often instructed to minimize their stress during pregnancy to protect their baby from potential negative outcomes (Law et al., 2021). Research has shown that even women who actively reject these dominant discourses of motherhood still feel the negative psychological impact, including increased stress and feelings of guilt (Henderson et al., 2016; Meeussen & Van Laar, 2018).

These discourses are engrained in our society, and often we use these discourses of motherhood to measure ourselves, and others, in relation to the standard of motherhood. These constructions also mean that it is difficult for women to discuss the negative feelings or experiences associated with motherhood, out of the fear that we will be labelled as 'bad' or will fail to conform to the standard (Choi et al., 2005). These discourses of motherhood also lead to the monitoring and controlling of mothers through various techniques of surveillance, ensuring they are living up to the standards of the 'good' mother (Cosgrove & Vaswani, 2020).

Research Questions

This study sought to explore mothers' experiences of the perinatal period during the COVID-19 pandemic and the impact on their mental health. The research questions that guided this study were, what are the perinatal experiences of women during the COVID-19 pandemic, and if and how this has impacted their mental health?

Chapter Three: Theoretical Framework

As this study involves women, I thought it appropriate to utilize a feminist theoretical framework. While there are many strands of feminist thought, they all have in common the central concern to improve women's status, and to challenge and transform the patriarchal structure of society, including challenging and exposing issues of power (Thorpe, 2018). As presented in the review of the literature, we know that the pandemic has placed women, and mothers, in a vulnerable position, and that they have been uniquely impacted in several ways by the effects of the pandemic. This study also acknowledges the situation of women during the perinatal period as potentially vulnerable and acknowledges the patriarchal influence on perinatal health, mental health, and motherhood. Using a feminist informed theoretical framework allows a gendered analysis of women's experiences during the pandemic, of their mental health, and the overall consequences of the pandemic on women. Traditionally, research, including all kinds of health research, has ignored women's experiences. A focus on women's experiences serves to inform us of the ways women's voices are silenced and can uncover the ways women of various groups, such as from varying cultures and ethnicities, and differing socio-economic status, have experienced injustice and discrimination (Ackerly & True, 2010).

Feminist research is grounded in women's experiences and emphasizes women's voices, ensuring they are heard and valued, providing an opportunity to challenge and question patriarchal assumptions. At its core, feminist research asserts that "conventional science functions within a male-dominated paradigm and produces an androcentric bias in science" (Gringeri et al., p. 392). Feminist research utilizes a diversity of research methods, generally utilizing qualitative methods. While there is no one feminist research method, to conduct feminist research, we can bring together a variety of feminist ideas and principles to the process

(Gringeri et al., 2010). Gray et al. (2015) summarize three key elements of feminist research, common among most strands of thought. First, feminist research is about women's experiences, and understanding them (Gray et al., 2015). Secondly, feminist research has as an underlying objective, the improvement of women's lives; and third, "feminist researchers are concerned with equalising or reducing power imbalances in the researcher-respondent relationship" (Gray et al., 2015, p. 759).

During the pandemic, research has largely ignored the voices of women and their diverse experiences, and as O'Reilly and Green (2021) discuss, there is a scarcity of research emerging relating explicitly to mothers and the pandemic. Researchers have also discussed the overall lack of a gendered lens by governments and policy makers when planning for disasters or disease outbreaks (Smith et al., 2021). This study utilized semi-structured interviews with women as the method of data collection, which served to highlight women's experiences and voices, while acknowledging them as the experts and a source of valid knowledge and sought the voices of women from a particular standpoint.

As discussed by Harding (2014), a feminist standpoint is one which acknowledges that often, the voices of those in the most marginalized or oppressed groups are not recognized as valid or are not seen as the starting point from which research should begin. Feminist standpoint theory suggests that research begin within the lives of those who have experienced marginalization and discrimination, and recognizes that knowledge is socially situated (Harding, 2014). This study utilized feminist standpoint theory as a guide, as it provides a framework for acknowledging women's unequal status in society, and how this has impacted women in the perinatal period, by ultimately recognizing their stories and experience as valid knowledge. It also provides a framework for then analyzing these experiences, highlighting issues of power,

and challenging the dominant discourses which have been privileged in society. Thus, to truly understand the experiences of women in the perinatal period during the pandemic, we must place them at the centre of the research and consider them the experts of this experience. In their study of perinatal mental health, Law et al., (2021) discuss how oftentimes the dominant discourses surrounding motherhood and mother's mental health "can be sources of shame, guilt and suffering" (p. 1377), but also emphasize that through the further exploration of perinatal mental health highlighting women's voices and diverse experiences, we can also ensure these narratives are a source of recovery, healing, and change.

Chapter Four: Design and Methods

The following chapter contains a description of the design and methods utilized in this study, providing an overview of qualitative research design, and data collection and analysis procedures. Eligibility criteria, ethical guidelines and considerations, and method of participant recruitment are also discussed. Finally, this chapter will provide a discussion of quality and verification techniques used in this study, as well as a researcher reflexivity.

Qualitative Design

This study utilized a qualitative, exploratory methodology. As the purpose of this study was to gain insight into the experiences of women, the chosen methodology needed to be one which could fit this purpose. I also wanted to ensure that the chosen design would fit with the feminist theoretical framework and would be one which would allow an in-depth exploration of women's experiences. Qualitative research provides us with rich and in-depth insights into the experiences of participants (Braun & Clarke, 2014), and generic qualitative studies focus on understanding an event or an experience, without the constraints of an established methodology (Caelli et al., 2003). The objective of qualitative studies is to gather a rich description of the experience or phenomenon being studied (Kahlke, 2014), and those engaging in qualitative research "are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences" (Merriam & Tisdell, 2016, p. 6). As previously discussed, while literature relating to the perinatal experience has rapidly emerged since the onset of the pandemic, there remains a gap in qualitative research allowing for the exploration of women's experiences of the perinatal period and their mental health during the pandemic. For this reason, exploratory research is appropriate to add to the existing literature and explore the topic further.

As this study is exploratory and qualitative in its design, I utilized semi-structured interviews as the method of data collection, which ensured the collection of in-depth, rich data. This was intentional as I wanted to explore and understand the experience of the perinatal period during the pandemic, and the mental health impact by acknowledging that women are the experts of their own experience, and not simply gather quantitative data or compare clinically significant symptoms to diagnostic criteria. Using this type of research design ensured I was able to explore the questions with women, in depth, and ensure women were able to share their experience in their own words. Qualitative research also supports the feminist perspective, which guided this study.

Eligibility Criteria

The eligibility criteria for this study included biological mothers who had experienced any phase of the perinatal period between March 15, 2020, and March 31, 2021, in Winnipeg, Manitoba. This period of eligibility was chosen for several reasons. First, as the pandemic was officially declared on March 15th, 2020, this period would capture women's experiences from the outset of the pandemic. Secondly, it was chosen as within the first year of the pandemic there was unprecedented change and reflects a period of which women's experiences were unique. This period during the pandemic was also a time of heightened uncertainty as it related to healthcare mandates, including restrictions on perinatal and mental health services and supports. This period of eligibility was also chosen as it fits with the research question, which focuses on the experience of the perinatal period during the COVID-19 pandemic and looks specifically at the correlation between mental health and the pandemic.

The decision to exclude women who gave birth to multiples, or whose baby needed serious medical attention at the time of birth was made as these experiences are likely to have

added additional factors and stressors to a woman's perinatal experience. While these experiences are important, they may divert the analysis away from the focus of the pandemic impact on women, and their mental health.

This study invited women to participate regardless of current mental health diagnosis or pre-existing mental health diagnosis prior to the perinatal period. This decision was made as it enabled women to define what mental health meant for them, and not focus on mental health as determined by diagnostic criteria or specific symptoms. As I wanted to understand the potential mental health impact from women in their own words and based on their own experiences, it was important for women to participate in the study regardless of their mental health history.

Ethics

Prior to beginning recruitment for this study, I obtained ethics approval through the University of Manitoba Fort Garry Research Ethics Board 1. Participation in the study was voluntary, and women were advised of the confidential nature of their participation as soon as they reached out and expressed interest in participating. At the beginning of each interview the consent form was reviewed and signed, and I ensured women were provided the opportunity to ask any questions regarding their participation in the study prior to beginning the interview (see Appendix A). All data collected for this study has been stored in accordance with protocols outlined by the research ethics board.

Participant Recruitment

Women were recruited for this study through specific Facebook groups which were aimed at supporting women and mothers in the Winnipeg area; "Parents of Winnipeg and surrounding areas" and "Winnipeg Moms." I posted an electronic copy of the recruitment poster, which provided all contact information necessary (see Appendix B), in these Facebook groups. The poster was electronically posted by me, and as these are all public groups, they were

viewable by all who may follow these two Facebook pages. The recruitment poster included my University of Manitoba email address, and my personal cell phone number and asked that women reach out through either of these methods if they were interested. The recruitment poster also included the research protocol number, and contact information for my thesis advisor. Once women contacted me and expressed their interest in participating, I went over the eligibility questions to ensure they met the criteria for the study (See Appendix C). Once it was determined that they were eligible, women were provided with more details for the study, and a date, time, and location for the in-person interviews were discussed and confirmed.

Women were provided the option of meeting at their closest Winnipeg Public Library in a private meeting space or were invited to suggest a location that would be comfortable for them to meet for the in-person interview. Of the eight women who participated, four women chose to have private rooms booked at the closest Winnipeg Public Library to them, two women invited me to their homes to conduct the interview, one woman chose a public space (small coffee shop) to meet, and one woman requested to meet in her private office at her place of work. Women were provided with a cash honorarium of $40.00 for their participation. Women were also provided a list of free community resources/supports at the time of the interview and were encouraged to access them should they feel they need more support after the interviews. (See Appendix D).

Data Collection

In order to gain in-depth and rich data from women for this study, in person, semi-structured interviews were chosen as the method for this study and were the sole source of data collection. Qualitative interviews are particularly useful when the goal of the research is to gain insight about a person's thoughts, feelings, experiences, and behaviours (Tutty et al., 1996). Semi-structured interviews, also known as guided interviews, provide predetermined questions

that are posed in an open-ended way. Asking questions in this manner provides an opportunity to elicit a variety of responses and answers that reflect participants' experiences (Tutty et al., 1996). This type of interview provides structure, while also maintaining flexibility. The types of questions asked, and ensuring these questions seek an understanding of the lives of the women involved in the study are markers of feminist interviewing (Hesse-Biber, 2007). This method is also compatible with the feminist theoretical framework as it places women's experiences at the centre of the research. Feminist researchers engaging in interviews are also engaging in research, which promotes social change and social justice and are engaging in a process of reflexivity. Using this method allowed me to ask open-ended questions, ensuring I was able to explore the topic in depth with women. (See Appendix E). While the interview guide provided structure and focus for the interviews, it is important to note that as I began conducting the interviews, I found that they mostly took the form of a conversation, allowing women to freely share their story, resulting in the discussion moving back and forth between certain topic areas and issues which the women wanted to discuss. This meant that ultimately, themes and topics discussed remained consistent, but there was space for unintended responses, and ultimately made way for an interview style more consistent with the feminist theoretical framework.

All interviews were conducted in person, and ranged in duration from 46 minutes, to one hour and eight minutes. Prior to the interviews beginning, women were asked to complete a demographic questionnaire (see Appendix F). All the women who participated completed the questionnaire in full. This questionnaire asked questions relating to their age, relationship status, and supports during their perinatal period such as a midwife or doula. This data assisted me in the data analysis phase, as it provided further context to each woman's experience.

Data Analysis

The semi-structured interview data in this study was analyzed using thematic analysis. Thematic analysis can be used as a flexible research tool, that has the possibility of yielding "a rich and detailed, yet complex, account of data" (Braun & Clarke, 2006, p. 78). Thematic analysis is a method used to identify, analyze and report themes, or patterns, within data in qualitative research (Braun & Clarke, 2006). The approach to thematic analysis set out by Braun & Clarke (2014) was chosen for its theoretically flexible approach, and for the rigorous framework it provides for coding qualitative data, and then identifying patterns and themes relating to the research question.

There are six phases of thematic analysis as described by Braun and Clarke (2006). They are: familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and finally producing the report (Braun & Clarke, 2006). This process was also chosen as it provides clear and concise direction and steps to follow. As a novice researcher this was my first experience analyzing a data set and the descriptive and step by step outline provided by Braun and Clarke (2006) assisted me in organizing and analyzing the data, and ultimately producing the final study results.

All of the interviews with women were conducted by me while being digitally recorded. After the interviews, I transcribed them all verbatim. Once the transcripts were completed, I read through them while once again listening to the audio recording to ensure accuracy. After ensuring the transcript was accurate, I then read through them to get an initial sense of the overall data and noted emerging items of interest. I then compared these transcripts and the notes, with the field notes that I recorded after each interview. This assisted me in the iterative process of analyzing the data.

The next phase involved re-reading each transcript through several times and beginning to code the data. First, I read through each transcript line by line, and wrote down names for the ideas which were presented, which then formed the initial codes for the data. Then, I compiled these codes together, and again went through the transcripts to see how some of these codes could come together, grouping similar ideas and concepts together. The codes were also grouped together to identify latent codes and semantic codes (Braun & Clarke, 2006), which later assisted in bringing the codes together into meaningful groupings (i.e., preliminary themes). Coding was organized and managed by me, without the use of qualitative software. This was done by a using Microsoft Word document, also created by me, and updated and organized as the data was analyzed.

Once the coding process was complete, I began sorting the list of codes into themes. In this phase, I began to consider the ways in which each code could combine, to ultimately form an overall theme (Braun & Clarke, 2006). Following this process, I was left with a list of potential themes, which I then began to refine further by re-reading through the data. At the end of this phase, I had an overall sense of the four main themes and their corresponding sub-themes that emerged from the data.

Finally, each theme must be named and further defined. I did this by defining what each theme captured and what each theme was ultimately about. Braun and Clarke (2006) caution that in this phase one is not simply paraphrasing what the data from each theme is about, but rather identifying what and why is of interest within the themes selected. This resulted in a thematic map, which contained the list of themes, and sub themes, along with the codes and data extracts from which they were formed (See Appendix G).

Quality and Verification

In conducting this research, I ensured reliability and trustworthiness in several ways. According to Lincoln and Guba (1985), trustworthiness criteria involve establishing credibility, transferability, dependability, and confirmability. I established credibility through the transcription of the interviews, which were done myself, to remain closer to the data and ensure I remained as familiar as possible with the data collected. After I had initially transcribed each interview, I then listened to the audio recording again to check for accuracy. Credibility can also be established by including representative quotes from participants to demonstrate the various themes, which were included in the presentation of the findings of this study. My own expertise in conducting this research also led to further the credibility of this study. According to Forero et al. (2018), credibility can be further established through the researchers or investigator authority, particularly through the "familiarity with the phenomenon and research context" (Forero et al., 2018, p. 5). This study came about through my own personal experience, as I too experienced the perinatal period during the COVID-19 pandemic, and experienced my mental health being impacted. I also have professional experience in the field of mental health, and in conducting interviews.

Ensuring and enhancing the transferability of a study includes detailed descriptions of the settings, participants, and contexts so that the reader of the study "can evaluate the potential for applying the results to other contexts or participants" (Braun & Clarke, 2014, p. 287). This includes not just a description of the participants and the setting, but also the methods, and process of data analysis. The women who participated in the study, as well as the settings, the methods, and the process of analysis were all thoroughly detailed throughout this thesis, which I believe can assist others in determining if the results can be applied to different settings.

Dependability was established through the interview process, as all women in the study were asked the same set of questions. While the interviews were semi-structured, the questions posed were utilized as a guide and therefore did change slightly throughout each interview. However, the intent and general content of the questions remained consistent through each individual interview. I also established dependability through the process of debriefing with my thesis advisor. Once several interviews were completed, we met to discuss the progress and provide an opportunity to debrief and go over any questions that had arisen for myself during the initial stages. Once the interviews were complete and the process of transcription had begun, I met again with my thesis advisor to discuss the progress and receive additional feedback and support. Lincoln and Guba (1985) discuss the process of an audit trail, which consists of a written record of how the research study is conducted. Throughout the course of data collection and analysis, I kept a detailed research journal, which was used to record the decisions I made along the way, including initial thoughts and observations which came up after each interview. During the process of data analysis, my research journal helped me to ensure that I was engaging in all steps of the analysis process in a consistent and thorough manner, through the analysis of each interview.

Reflexivity and Role of the Researcher

According to Creswell and Creswell (2018) reflexivity requires the researcher to comment on two areas in particular: past experiences and how these experiences "shape interpretations" (p. 184). I acknowledge that my social location and experience impacted not only the design of this study, but the ways in which participants interacted with me and responded to questions. My experience as a new mother during the pandemic and my experience with perinatal mental health shaped my interest in the topic area, the design of the study, and

ultimately the analysis of the results. Many of the women in the study were within the same age range, and stages of motherhood as me. This may have influenced the ways in which they answered the questions and engaged with me during the interviews. This also may have encouraged women to discuss certain experiences in more detail or depth, or provide insight they may not have felt comfortable sharing with others.

I also ensured that I was controlling researcher bias by engaging in continued reflexivity throughout the study. During the interviews, I ensured that I briefly documented any thoughts or observations that I found to be relevant for review after the interviews. I also documented further thoughts, observations, and questions that emerged from the interviews immediately afterwards. As previously mentioned, this study came about through personal experience. Throughout the study, I also ensured that I documented my own personal thoughts and feelings about this topic area, as it is admittedly an emotional and personal topic. This ensured that I was able to focus my attention on listening to how women answered the questions, and that I followed their cues and paid close attention to their responses, without having my own experience interfere with their interview. While I engaged in this process to ensure that the women in the study were the focus, it is important for me to note that because of this personal experience, it likely did impact the ways I interacted with the women in the study, and the ways I posed the questions.

Chapter Five: Study Results

The following chapter outlines the results of this study, by first providing an overview of the participant demographics, followed by a brief introduction to each of the women who participated. The four main themes from this study: pandemic's adverse impact on mental health, expectations of motherhood, challenges to support networks, and silver linings, are then discussed along with the corresponding sub-themes in depth.

Study Participants

As reported when discussing eligibility criteria, all women in this study had experienced the perinatal period from March 15, 2020, to March 21st, 2021. In total, 14 women reached out and expressed interest in participating in the study. All women contacted me by email, with two women reaching out through email and following up with a phone call. Two women were not deemed eligible as they lived outside of Winnipeg. One woman was not eligible as she requested a virtual meeting, which due to my ethics application I was unable to accommodate at the time. I reached out to interested participants based on who contacted me first. Five women then agreed to be placed on a waitlist, and agreed to be contacted should I require more interested participants. I then contacted the first six women who contacted me, and all were agreeable to setting up interviews. Once the interviews began, in discussion with my thesis advisor, it was determined that an additional two women would be contacted from those who had agreed to be placed on a waitlist, to provide further depth to the data collection. After conducting eight interviews, it was then that I had determined that data saturation had been reached (Saunders et al., 2018), as enough data had been collected that I observed some of the same patterns and themes, with no new information emerging. It was then determined I would not conduct any further interviews. Prior to conducting the interviews, a possible sample size of eight had been

discussed with my thesis advisor. As I began to experience saturation of the responses, this number became relevant. In total, eight women who met the eligibility criteria were invited to participate.

All participants were invited to choose a pseudonym at the outset of their interview. Seven of the women who participated chose pseudonyms at the outset of the interview. One woman chose not to use a pseudonym. I offered to choose a pseudonym for her; however, she reported that she wanted her real name used in the study. Five of the women reported being between the ages of 25-34, with two women reporting their age range from 35-44. All women who participated reported being in relationships, with four identifying common law relationships and four identifying as being married. Seven women in the study identified as Caucasian, with one participant identifying as East Asian.

For six of the women who participated, their first child was born during the COVID-19 pandemic. Two of the women reported having more than one child at the time of their interviews. Of the two women who had more than one child, one had reported that her first child was born during the pandemic, thus, seven women in the study were first time mothers during the COVID-19 pandemic.

All eight women in the study gave birth in hospital. Two of the women reported having the support of a midwife during the perinatal period, and one woman reported having the support of a doula (see Appendix H).

Katie

I met with Katie at her place of work, in her private office. Katie was friendly and upbeat and reported she was looking forward to talking about her experience, as she felt she had few opportunities to do so. Katie had her first baby during the pandemic, and as we began to speak, tears welled in her eyes. Katie talked at length about her feelings of loss and grief during the

perinatal period, and about how much she felt her mental health was affected, particularly during the postpartum phase. Despite this, Katie also talked about how hopeful she feels that we can make changes to better support women in the perinatal period.

Kayla

Kayla and I met at a public library close to her home. Kayla arrived reporting she was looking forward to discussing her experience, and how important she felt this topic area was. Kayla had her first baby during the pandemic and experienced almost all of her pregnancy during strict lockdown measures. Kayla talked about many of the challenges she faced, but also wanted to talk about the positives, and the things she felt grateful for. Kayla also spoke eloquently about the larger issues to our health care and mental health care system, and the ways she feels society can improve the ways we support mothers.

Gillian

Gillian was one of the first women who reached out to participate and was the first interview I conducted. Gillian arrived for the interview at the library excited and enthusiastic to share her experience. Gillian is a mother of three, and reported to me she was wanted to participate so that others could learn from her experience. Gillian spoke at length about her experience as a mother, and how she felt it prepared her for having her third child during the pandemic. Gillian was the only woman who participated who stated that she did not feel her mental health was affected by the pandemic but spoke in depth about how she feels women carried a heavy load during the pandemic, and about the burnout she experiences as a mother.

Chien

Chien was also one of the first women to reach out and express interest in participating and requested to meet at a public library. Chien told me about being a newcomer to Canada and spoke a lot about her isolation and anxiety during the pandemic. Chien had her first baby during

the pandemic and spoke with sadness about not being able to have her family come visit her new baby right away due to travel restrictions.

Monica

Monica invited me into her home to conduct our interview. Monica had her first baby during the pandemic and had since had her second baby. While we spoke, Monica fed and rocked her newest baby, while commenting frequently on how different her current perinatal experience differed from her first during the pandemic. Monica spoke about her mental health challenges and the multiple stressors she experienced when she had her first baby. Monica spoke of how eager she was to be able to talk about this experience, and how important she felt it was for there to not only be research in this area, but also to provide women a chance to talk about how they experienced the pandemic.

Dawn

I met with Dawn at a public library near her home. Dawn had her first baby during the pandemic. Dawn spoke at length about the difficulties in finding supports when she was struggling, and of the ways she felt stigma and pressure relating to the experience of motherhood and of mental health. Dawn talked about the excitement she felt when she knew she could participate in the study, as she felt she did not get enough opportunities to talk about the impact the pandemic had on her perinatal experience.

Joy

I met with Joy at a small local coffee shop, at her suggestion, to conduct our interview. Joy had her first baby during the pandemic and began our interview by commenting that she has not shared much about her experience with others as she felt nobody wanted to hear how difficult it truly was. Joy talked extensively about the feelings of anxiety she experienced during the

pandemic, and how overall, her experience was largely impacted, and is something she still regularly thinks about.

Sam

Sam and I met at her home to conduct our interview. Sam was friendly, and weaved humour into our lengthy discussion. Sam had her first baby during the pandemic and reported to me it was the most challenging thing she had ever done. Sam spoke a lot about the mental health impact she felt from the constant isolation. As we spoke, Sam also mentioned throughout that despite the enormous challenges, many of her feelings and thoughts about the experience have never been shared with anyone.

The interview data in this study resulted in four main themes: (1) Pandemic's adverse impact on mental health, (2) Expectations of motherhood, (3) Challenges to support networks, and (4) Silver linings. These four main themes and sub-themes are discussed below.

Table 1. Study Results

Theme	**Sub-themes**
1.Pandemic's adverse impact on mental health	(a). Alone and isolated (b). Grief and loss over missed experiences (c). Increased stress during prenatal appointments (d). Fear and Uncertainty
2.Expectations of motherhood	
3.Challenges to support networks	(a). Formal support in the first six weeks (b). 'It takes a village' but the village is gone (c). Strain on relationships (d). Technology
4.Silver linings	(a). Time together (b). Improved communication (c). Less pressure

Theme One: Pandemic's adverse impact on mental health

All women in the study identified that in some way, experiencing the perinatal period during the pandemic impacted their mental health. Seven of the women who participated reported that their mental health was most impacted during the postpartum period, with one woman reporting that her mental health stayed relatively unchanged from her prenatal (pregnancy) through to her postpartum. One woman reported that while she did feel the pandemic added stress during the perinatal period, the most significant mental health impact was related to the burnout she experiences from motherhood and identified that the pandemic exacerbated this feeling.

Anxiety, sadness, worry, feeling overwhelmed, anger and frustration, suffering, loneliness, trauma, and heightened stress, were all words used by the women when asked to describe their mental health during this time. When asked to describe how the pandemic impacted her mental health, Chien stated "I feel it's huge. [A] huge impact (…) because I was suffering." Chien went on to elaborate how she felt that at every turn the pandemic created a new challenge, which impacted her coping and overall mental health. Chien described this feeling of suffering as an increase in sadness, feeling overwhelmed, and anxiety.

Several women described their mental health as being impacted by the "waves" or "rollercoaster" of emotions that was a constant issue during the pandemic. Monica recalled: "the feelings of overwhelmed or whatever negative feelings would come but they always would go quickly. Quick. So, it was a rollercoaster." Recalling similar feelings of emotional waves from changing restrictions and the postpartum period, Dawn stated:

> It was definitely waves of happiness and sadness… happiness and sadness…. And it just was… it was confusing also like I have a healthy baby, I should be so happy but it's just

> the confusion of being a new mom, and then the pandemic going on with all the restrictions being new ones… and then… they take them away… and then just all the, every day was definitely just an emotional roller coaster.

Two women in the study reported receiving a formal diagnosis during this time, with one woman being diagnosed with postpartum depression, and another postpartum anxiety. Four of the women who participated identified that given time to reflect on their perinatal period during the pandemic now that pandemic restrictions have changed, they likely should have sought more support than they did. When asked to describe her mental health during this time, Monica stated "Now, looking back… terrible." When asked if she could elaborate on this statement, Monica sat in silence for a moment, then recalled that she struggled with her mental health in so many ways, and experienced a range of adverse effects, such as increased anxiety, stress, and sadness, that she was unsure how to capture this experience in one word or statement. Sam echoed this feeling, and stated "In hindsight, worse than I thought." Sam also elaborated on this, stating that until she sat down to speak with me about her experience, she had never fully reflected on just how bad the impact was to her mental health. The women who identified that in hindsight, they should have sought more support, reported that they did not due to lack of outlets during the pandemic. They also reported that due to the constantly changing nature of the pandemic and the fear and uncertainty (to be discussed later), they were unable to properly process the state of their mental health.

(a). Alone and isolated

All women in the study spoke about the challenges that isolation during the pandemic caused, and how it contributed to poor mental health. Six of the women spoke about how the isolation and restrictions during the postpartum period was the most challenging thing they had

to endure, and feeling alone was spoken about frequently. Katie stated, "to be isolated, alone, a new mom with a newborn as well. So yeah, it was… the postpartum part of the pandemic was the hardest." She continued, "it was the most challenging, isolating thing I've ever felt. And I almost thought it would break me." Joy echoed these feelings, "postpartum was probably the hardest. Because I was very alone. At home." Dawn talked about the impact of no in-person contact during the postpartum period when she felt she needed support the most:

> It was scary …. And, if the pandemic didn't happen, I knew I could just call on my girlfriend and she would have just come over and I would have had that reassurance that it would be ok and I was going to be able to get through it.

Not only was it difficult for the women in the study to not have in-person contact, women also discussed having restrictions on where they could go as compounding the sense of isolation and being alone. For Sam, who had her baby at the height of the pandemic and lockdown restrictions, she stated:

> You start to go sort of crazy right? You get like cabin fever. So… I lived in a three story walk up, and had just had an emergency c section…. So, when we got home, we went upstairs, and I was in that apartment for I think like eight weeks. I think it was eight weeks before I finally was like, able to leave. That's a long time. And you start to lose it.

Sam expanded on this feeling of starting to 'lose it', as the beginning of her major struggles with her mental health during the postpartum period, due to the ongoing isolation and loneliness, and feeling as though she had little to no ways to cope with how she was feeling.

Chien also talked about the sense of loneliness she felt after giving birth, "After giving birth, the first three months was really difficult because it was still pandemic… Yeah that was really difficult because I basically had nobody I can see in person." She went on to discuss her

experience as a newcomer to Canada, and how these challenges were woven with the experience of being alone:

> Um, I felt isolated. And I didn't know who can I look for… um, help, or because I don't have comparison, like people who was pregnant during not [a] pandemic, like what resources I can have, I didn't know … So, I felt really lonely, and like alone. Yeah…. Also, I'm a newcomer, my parents couldn't come here. Um, I have no one and then this is the first birth, so doula couldn't come with me, and I just felt I'm all alone, and then really scared.

(b).Grief and loss over missed experiences

A subtheme which emerged from almost all the interviews, were women's sense of grief and loss over missed experiences during the perinatal period due to the pandemic. Women spoke of experiencing feelings of grief during their postpartum period as they navigated what their experience would look like, compared to what they may have expected. When asked about her postpartum experience, with her eyes welling with tears, Katie stated, "Yeah, so when I talk about my mat [maternity] leave, I just say that I grieved. Like the entire mat leave. It wasn't the mat leave that I felt that I had envisioned or that I had planned." Katie goes on to talk about how during her prenatal period, she was told by numerous professionals, including her physician and a birth class instructor, not to have a birth plan to avoid being disappointed, and that women who have strict or detailed birth plans are often left disappointed when they do not turn out how they want. Katie:

> Well, I had this plan for my postpartum! And not being able to experience any of that really made me really sad. And really like almost depressed. Like I definitely

> had the baby blues post [partum]. Yeah, it was just really hard, yeah, really sad. It was just really sad. Just a sad time.

Sam also spoke a lot about the feeling of grief that she experienced, and continues to think about even now:

> There's loss. I lost the first three months of my child's life with his grandma. You know? That… he didn't get to have that. And I didn't get to have that with my mom. You know? And, it's not because she wasn't there... it's that she couldn't be there. And so, you… you grieve, like you lose things. You go through all the steps like… you grieve those losses.

Six of the women spoke about the ways in which they experienced loss as it related to experiences they missed having, due to the pandemic. As Monica pointed out, this included the loss of special traditions she had hoped to have for her daughter, and how this impacted her mood during that time:

> Me and my girlfriends have all kinds of traditions when a new baby is born, and the things we do. Like, we would always have… when there's a new baby, we would all get together and line up all the kids on the couch! And take a picture. And like, [my daughter] doesn't have a couch picture… and it's just… all those things, like you said, that you imagined, are not happening. And I can't even pinpoint one thing. It's just like all so terrible from start to finish.

When asked how it made her feel to think about these experiences she lost, Monica stated "Ugh! So much … so much bitterness."

Women also spoke about the ways they felt they lost out on experiences when talking about life events which others may not think about as significant, but greatly impacted their mental health. In speaking of these events Katie said: "even like, little things you don't think

about get impacted. All those life experiences that kind of got washed away… for that year or so." Several women used the term "taken away" when discussing the experiences they had expected to have that were lost. In talking more about her feelings of loss, Katie said:

> I used to say to my friends, you know when you have a baby, and then your friends come over so you can like eat or shower or take a nap … all of that was taken away. Nobody came over. I couldn't have a break to eat. I couldn't have a break to shower. I couldn't have a break to sleep because I was pumping when she was sleeping, so I was like there was none of that "oh I will come over" and your friend will look after baby and you can sit for half an hour and like, enjoy a meal. There was none of that.

Joy and Dawn spoke about how they felt loss over the fact that family and friends could not meet their baby right away as they had envisioned. In speaking of loss during the pandemic, Joy stated "no one could see, or visit at the hospital, or see her and we were there five days. So, no one got to meet her, none of our friends got to meet her for ages." Dawn reported the difficulty of this missed experience, "my friends could only see him virtually and not actually hold my son. So… that was hard just because I've seen my friends' kids like a couple weeks after they were born so that was definitely hard for me."

The experience of having a baby shower, decorating your nursery and looking at baby items, travelling with their baby, and even having to cancel plans for maternity photo shoots, were all experiences women reflected on through the lens of grief and loss. From Joy: "we had had all these plans to do maternity photo shoots, and baby shopping, like… we couldn't do any of that with COVID." In reflecting further on the way the loss of certain experiences contributed to her mental health, Katie stated:

> (…) not being able to have any of those experiences, I really grieved that experience not being able to have the postpartum that I felt I deserved, and that everybody else got to have. I didn't get to have a baby shower, I didn't get to have like any of those things. And it was really, really difficult mentally.

The women who spoke of these feelings of grief and loss reported their mental health was impacted in a negative way. The women also discussed how even now, they look back on these missed experiences with sadness, and these memories often still evoking negative feelings and emotions.

(c). Increased stress during prenatal appointments

A major stressor identified by all the women was the fact that their partners were unable to accompany them to their routine prenatal appointments. The women in the study reported that this increased their stress and anxiety during pregnancy, particularly during ultrasounds, where they were hopeful to see images of their baby and share this experience with their partners. About this experience, Chien said: "My partner couldn't go with me. That was a little bit sad." Joy echoed this feeling, stating: "My partner wasn't allowed to go to any of my appointments. She had to miss all the ultrasounds which was really, really hard." Sam recalled being alone without her husband during these times:

> I was alone for all of my scans. You know? That's another thing… like my husband [and I] did not get to see our baby at the same time. Right? That didn't happen. And I had to be at these scans alone.

Women also went further to discuss how they were fortunate not to have "bad news" at any of their appointments, but that they had prepared for that, and thought about how this would have affected them. This required discussion and preplanning for the worst-case scenario with

their partners while they were pregnant, again adding stress and increased feelings of anxiety to the experience. Chien discusses how due to her age, she was considered high risk and, therefore, already experiencing heightened anxiety about her pregnancy:

> (…) I felt afraid because I,…I don't know what can I see from the ultrasound, or what kind of news I will get from the appointment, of course we hope it's good news but because I'm over 35, like higher age, so sometimes we worried. So if he could come with me, I will feel more settled. (…) I remember one of the appointments I had to go back a second time (…) so I had to go back and that got me really nervous for the next time. (…) so, if my partner could go in hospital with me, like for the appointments, I [would] feel more safe and less worried.

Joy spoke of her heightened fears that she may lose the baby, as her path to conception was fraught with some challenges, and how not being able to have her partner with her heightened her anxiety:

> It was really hard going because I have a lot of, I have medical anxiety to begin with. So having to go to ultrasounds and things by myself was hard. Um, and baby, baby was conceived through artificial insemination so we had to do a lot of fertility treatments, so those are a lot… and then um, I was very afraid of losing the baby. So, having to go to every ultrasound and not having someone there to hold my hand was rough.

Joy was the only participant who reported difficulties with conception, and with conceiving her baby through invitro fertilization. While Joy reported that this caused heightened stress and anxiety, and likely would have despite the pandemic, she stated that she felt not having her partner present seriously exacerbated these feelings, and that this was a catalyst for the beginnings of struggles with coping with her anxiety.

(d). Fear and Uncertainty

Seven of the women in this study became first time mothers during the pandemic. All of these women talked about how having a baby and being at home with a newborn was already an experience which caused some levels of fear, but the added factors of the pandemic exacerbated this sense of fear of the unknown. Dawn shared, "(…) when you're pregnant too you deal with the stress of being pregnant but just on top of now… all the worries because of an unknown virus." Kayla expressed similar feelings during her pregnancy, stating "[the pandemic] added like this level of like anxiety that you know, no one in the world has experienced before, certainly when you're a pregnant person and there's just so much more vulnerability there in so many different ways." There were also unknowns as it related to what birthing during the pandemic may look like, Monica stated: "there were stories out of New York, of husbands not being allowed in the delivery room. So… [it was] so scary to think about (…) I was terrified that he [my husband] wouldn't be in the delivery room." Reflecting on the time leading up to her delivery, Kayla recalled:

> We weren't sure what the hospitals were going to look like. Definitely leading up to my due date we weren't sure if we should be like, you know, sort of [be] isolating ourselves before we prepared to go to the hospital. There was definitely a concern about my partner being with me through… during labour.

Joy talked about her last ultrasound before her baby was born, and how scared she was. A situation that would be concerning for anyone, being alone only made things worse:

> It was hard. (…) the worst one was the ultrasound right before she was born because they (…) the ultrasound tech got that look on their face that you know something is,

> something is not right. And then she hooked me up to a machine and she left for 20 minutes. So, I was… I was freaking out and I was texting like my partner and I called her, and just… waiting. And not having anybody there. Um, yeah because baby wasn't moving anymore. And that was… that was… I was really scared. And not… it would have been good to have somebody there. That was the worst one.

Women identified the fear of the unknown as even more difficult once their baby had arrived, and they had to make decisions about what their lives would look like. Monica reflected on trying to decide what her "rules" might be during this time: "we just were *so*… unsure. You're so unsure anyways. But then it was like, you know, who can we see? how tight should our rules be?" Women also discussed how there was so much uncertainty around COVID-19, meaning when they had questions or were concerned, there was limited information, which led to further fears and stress. Chien recalled: "I worried more, "what if this happens, what if my baby gets COVID, what if, I, myself gets COVID, can I still breastfeed?" I had lots of questions, but nobody can tell me, or certainly [sic] answer… (…) it was difficult." In talking about how much uncertainty there was during the pandemic, Gillian stated "I think I can say it was very surreal. Nobody knew what was going on and nobody knew how to handle it. It was just a lot of guesswork."

As previously discussed, women identified the difficulty in experiencing isolation and being alone and wanting more in person support and connection. At the same time, women did state that when they had opportunities to have in-person contact, it compounded their existing fear and uncertainty. This contributed to heightened emotional conflict for many of the women in the study. Dawn reflected on the feeling of not wanting to be alone, but being scared:

> I definitely was scared of everything even more. Not just the simple common cold… I was just scared of like, the symptoms... the virus I was just scared of… I wanted people to come over but at the same time with the pandemic going on I didn't want anybody to come over.

In talking about how parenting already comes with fears and uncertainty, Sam recalled:

> [the pandemic is an] addition onto it of this is already a hard scary thing to do as a parent, let's make it worse by like adding a virus that we don't know what it actually is going to do… we don't know what it's going to do long term, we don't really know how bad it's going to be on little ones. It sucked. It's never good. You know, and it's just… it took all these things that are already really hard and scary, and made it harder and scarier.

Monica and Kayla spoke about the times during the pandemic when they made decisions to see others, and the fear and conflicting feelings and emotions this caused after the fact. Monica recalled:

> We were constantly questioning ourselves, are we too tight? are we too loose? We would do things like… we would loosen up, we would see someone in the backyard (…) And then the next week they would be positive for COVID and we would be like oh my god! Do we have COVID? What have we done? We are never doing that again! So scary! The whole thing was just…. Terrible.

In recalling a time when she and her husband decided it would be okay to take their baby to a small gathering, Kayla stated:

> I distinctly remember afterwards back home and like a sense of oh my god what did I just expose her too? What did I expose all of us to? I had these waves of anxiety about, what

> did we just do? Um, ultimately you know nothing came of it, we never had COVID through that or anything, and nobody got sick.

This again speaks to the conflicting feelings that almost all women in the study reported, when trying to make decisions about their family's safety and health, often resulting in heightened and constantly changing emotions.

Not surprisingly, women also spoke of the fear that their baby would get sick. This was compounded during the pandemic, due to the uncertainty of the effects of COVID-19 on babies and infants. According to Katie, "there was such a fear that your child would get sick." Dawn reported similar feelings, stating:

> (…) even just leaving… I lived in an apartment (…) and I was just even scared, I was scared going for a simple walk with him in case I ran into somebody. And it made me fear everything. It's like I'm scared to take my child out in the hallway just because I don't want to interact with something… let's say I catch something and I pass it on to my son.

Theme Two: Expectations of motherhood

The women in this study were asked if they felt that the ways they experienced motherhood, or the ways they engaged in mothering was impacted by the pandemic. Most women did not outright state that they felt the way they experienced motherhood or the way they mothered their children was affected or different than they expected. Interestingly, statements connecting to the larger concept of dominant mothering discourses were found throughout our conversations.

Women spoke about the negative discourses, which they felt impacted them in their roles as women and mothers, and how these expectations of motherhood interacted with the

constraints of the pandemic. Women reported that while the pandemic placed additional stressors on the experience of new motherhood, that there was little acknowledgment that these compounding factors were making things worse. Women spoke about how the messaging they received such as, women are strong and can get through this, that they must 'be there' for their baby and protect them from the virus while all supports were gone due to ongoing pandemic restrictions, made them feel that their own mental health and well-being was no longer important. Dawn spoke about how when she was really struggling with her mental health, she felt overwhelmed by the messaging she received, telling her that her son needed to be put first, and that her maternal instinct would help her through her difficulties:

> The message is like once I have my kid ok, he's number one but in reality, you have to be number one (…) it's the stigma of just, I think that is put on new mothers that you should be able to figure it out. [They say] "you had 9-10 months to actually read all these books, or figure it out" (…) "It's a maternal instinct, you should just know" I'm like it just kicked in! Give me a year!

This speaks to the ongoing messaging mothers, particularly new mothers, receive about needing to put their children first and not acknowledging when they are struggling. All of the women in the study spoke about how their feelings were often minimized, and they were often told by family, friends, and even medical professionals to be grateful for their healthy baby. Joy spoke about how she attempted to speak with others about how her birth trauma had impacted her and how she was feeling postpartum, but felt that she should not discuss it. Joy also noted how she felt that she received the message that since her baby was healthy, she needed to move on:

> I had been trying to do the whole "I'm a mom, I'm superwoman! I'm fine, I'm fine everything is fine." Um, because it was (…) when she was first born, I had mentioned it [birth trauma] to a few people and I had gotten a lot of "oh she's healthy, she's fine there's no problems." Like… so the whole fact that the whole birth was very traumatic didn't matter because the baby…was good. The trauma doesn't mean anything. So, I was trying very hard to be like "I'm fine. Everything is fine."

According to Joy, this feeling of needing to push through how she was feeling was compounded by the mental health struggles she felt due to the pandemic, which caused her to delay seeking help. The feeling that the way she felt was minimized or ignored was similarly felt by others in the study as well. Many of the women who identified feeling minimized in how they felt also stated that they felt this is how mothers are often forced to feel, as there is an expectation that it is hard.

Monica reflected on the feeling that once you become a mother, you are expected to be that and nothing else, at times leading to negative feelings and emotions. While Monica reported that regardless of the pandemic, new motherhood can be a struggle, she felt that there was little understanding from others regarding the ways the pandemic made this experience so much harder, and that the usual supports or outlets that are in place to help mothers during this transition, were gone. She stated:

> I love my kids, but for me motherhood is… pretty terrible. Just, you're just… you're just only a mother. Like on mat [maternity] leave. You're really nothing else anymore. And as somebody who really loves my career, and my friends, and socializing ... going out, and all of those things are taken away from you. So that was… I think that part is you know, there whether its pandemic time or not.

While Gillian was the only woman in the study to state she felt that the pandemic did not have a major impact on her mental health, she did talk in depth about feeling burnt out, frustrated, and at times overwhelmed with the load of motherhood, exacerbated by the pandemic. When asked about if she felt there needs to be more focus on maternal mental health, she stated, "yeah like there definitely needs to be a lot more focus on mom burnout, pregnancy burnout… because its 100% there." She then elaborated on how she got through the pandemic with a large sigh, followed by, "I was just pushing myself. Like … I didn't let a lot stop me." When asked to expand on how burnout contributed to her mental health, or if she ever feels that the load of motherhood can be too much, Gillian stated:

> No, I just basically looked at it as more, not dip into that side [becoming overwhelmed, depressed, etc.]. Because I had to take care of two little kids. It just, it can't happen. You can't. Like, that was my bubble. Was… I'm still Mom. Life still has to happen.

None of the women in the study spoke of their expectations of their perinatal phase being without challenges or difficulty. All of the women acknowledged that this was expected to be a difficult time, from pregnancy to childbirth and ultimately postpartum, and that the experience of motherhood was not expected to be easy. They did discuss, however, that they felt the pandemic added significant amounts of stress, making things more difficult to manage and cope with, and adding to the already complex and at times confusing period of new motherhood. This can be seen in Sam's statement about her expecting things to be hard, and not wanting to change anything, but acknowledging the added impact of the pandemic:

> So, I guess looking back like, it at like… I can't say I would change anything. I would have had my son right then and there because that's who I have, you know, so I can't say

> I would change anything but it was hard. And harder than it would have been right? Like the pandemic just made it harder.

When asked to elaborate on how it made the experience of new motherhood harder, Sam reported that she felt that while the messaging to mothers remained the same, she felt little acknowledgement that many of the usual ways to cope or receive support were taken away.

Katie also recalled how the added stressors made her feel during her postpartum period:

> Yeah, it was just, it was incredibly … compounding. Like one thing on top of another. I'm going to break, like I'm going to have a nervous breakdown. Because I can't do this. How am I supposed to do this? And, yeah, those restrictions they didn't help anything at all, and they just made it harder and they just made it worse, by not being able to just get a break.

In discussing how the pandemic compounded the difficulties of the postpartum phase, Monica stated:

> There were just more. More things to stress about, more things to worry about. So, I think just the overwhelming-ness of it all was so much more than it would have been. And having no outlets, there may have been things that wouldn't have affected us so much, if we were able to you know, do other things. Be other places.

Theme Three: Challenges to support networks

Women in this study discussed their experiences with formal and informal supports, and how they felt this impacted their perinatal experience and their mental health. All of the women spoke specifically of their experiences with supports in the first six weeks after giving birth, and of the strain the pandemic placed on their relationships and support networks.

(a). Formal support in the first six weeks

All of the women in the study discussed their experiences interacting with a public health nurse once they were discharged from the hospital. While women discussed the importance of this role, six of the women spoke of feeling unsupported by their public health nurse, and believed the support offered to women in the first six weeks postpartum could be improved. Kayla recalled having one phone call check-in with her public health nurse once she was home. She identified this as being enough at the time, as she did not feel that additional support was needed. Later in the interview, when discussing how we can better support mothers, Kayla reflected on this experience:

> You know, a phone call does feel a lot different than someone coming into your home and spending a little bit of time with you (…) that can be a really powerful moment for, you know, new parents (…) people who are becoming parents again… to have somebody come and sit with them and spend a little bit of time with them and like really checking in on the mother, and also the father.

Gillian reflected on being an experienced mother (having her third during the pandemic), and telling the public health nurse she did not need the home visit, or any additional supports. Gillian then stated, "but it kind of worried me that maybe some people get lost in the shuffle of it… because they didn't hound me."

The other six women in the study made statements about the lack of support they experienced during their postpartum period, and their belief that postpartum care, particularly mental health care, not only needs to improve but needs to last beyond the six-week mark. Joy remarked:

> (…) the public health nurse and the midwife asked right at the beginning and then I'm like "everything is fine, I'm fine I'm fine, everything is great." And then those people go

> away. And I feel like those people maybe need… they need to stay longer. Because those first three months you're so focused on figuring out the mom thing. That you don't feel like you have time to process anything, and then kind of get a grip on the mom thing, and then I don't know… I crashed and burned pretty hard at that point. And then I really didn't feel like there was anyone to talk to anymore. Because everyone was… you know… yeah. They checked off and they're gone.

Sam spoke of her experience with her public health nurse:

> (…) our public health nurse, I heard from once. She called to check in, um, but they weren't going into people's homes, right? I assume they are now but I have no idea. So, I just got a phone call, and she's like here's my phone number if you need anything but that felt, that felt very um, un-supportive.

The women who discussed wanting more or improved supports during the first six weeks did acknowledge that while it was not about the specific public health nurse or an unwillingness to support them, they did talk about how they believe the current system needs to be strengthened and new ways of offering support should be explored.

In talking about her experience with her public health nurse, Chien felt that the check-in was not enough, and that she wished it was not optional. Because of her poor mental health, she declined to see them in-person. She stated: "I hope (...) public health nurse could insist to visit me… during that time. If she [could] insist to come, probably, I'd feel much better. And then, feel, more taken care of."

Katie could not recall exactly what her interactions were, if any, with a public health nurse, and noted that she was not sure if she received any check-ins from a formal support during her first six weeks postpartum. She recalled:

> There was (sic) just no supports for mom until the six-week check-up. So, I just felt like I was on my own until six weeks. And at six weeks it was very much like "ok you're physically ready to exercise now if you want", like ok you get a clean bill of health and you're done. (…) no public health nurse came and said, how are you coping? I remember a friend asking me how are you coping maybe two weeks in and I was like I think maybe that's the first time someone has asked. And I [said] I'm actually having a really hard time.

Three of the women reported reaching out to find their own therapy supports during their perinatal periods, and the challenges they encountered trying to access supports. They also identified challenges with the virtual nature of services. Joy recalls her experience trying to find support when she felt her anxiety became unmanageable:

> I couldn't get a therapist to save my life during COVID. [I] did look at some online options, but that didn't feel comfortable to me. And they were really expensive. Trying to get any kind of, free, or subsidized mental health care over the pandemic… yeah forget it.

Dawn reported that she was able to find some services, but that they were all virtual, which made things harder for her, as she felt it was unhelpful. When Chien did seek help, she was ultimately referred to a therapist she could see through her ACCESS Centre[2]. Chien identified this as a positive support; however, she spoke about how her file was closed and her sessions ended right at 12 months postpartum, despite still feeling she needed help. With no referral to other supports, Chien felt like she was once again let down, stating "I'm just… threw (sic) out of the system, and then good luck. Kind of like that."

[2] ACCESS Centres in Manitoba provide health and social services and are unique to each community or area in which they are located. They provide a range of services, such as physicians, nurse practitioners, and midwives, mental health supports, counselling and employment supports. *Winnipeg Regional Health Authority, 2021*

Katie and Monica spoke about their struggles with breastfeeding, and not being able to find appropriate supports, placing strain on their mental and physical health. Katie stated "There were no lactation consultants available at the time. And we, her (sic) and I really struggled. And so, I turned to exclusive pumping but there was no resources for that. And so, it was like trial by fire." Monica recalled a very similar experience, reporting "I was having such trouble breastfeeding and all of the typical supports were not in place... you can't go to the support groups."

An important note here too, is that while all the women thought that support for women at all periods of the perinatal period should be improved, all of them acknowledged that during the pandemic, those working in health care and social services were also experiencing great stress, change, and uncertainty. None of the women felt that any one individual was to blame for the lack of supports or services, but did acknowledge that the systems in place need to be strengthened. While women did not have specific suggestions for how this may be improved, several women reported that there should be more focus on support beyond the first six weeks, and that once this time period has passed, women are often left to find their own supports or services with little information.

(b). 'It takes a village' but the village is gone

All mothers spoke about the "village" or a community of "moms" that they assumed they would have after they had their baby. We all know the common phrase "it takes a village to raise a baby" but many of the women spoke about this being taken away due to the pandemic, and the struggles and distress it caused. Monica had her first baby during the early stages of the pandemic, and has since had her second, after restrictions were largely removed and just prior to the pandemic being changed to a public health emergency. Monica spoke often of the

comparisons between the two experiences, particularly of the lack of community she felt during her first postpartum phase:

> Um, the… motherhood community was robbed from me completely. I think that, now with second baby I'm realizing how much it means to have that community. To lean on, and that … I had my girlfriends who were mothers, but none of them had a baby at the same time as me. We really are just … dying for connection. Like somebody who is going through the same things at the same time as you… so that, that was gone.

Katie and Sam spoke about how they felt that if they had more supports around them, such as their own mothers, or family and friends who are mothers, that they would have learned things faster, or that some things would not have been such a struggle, as they would have had more moments to learn from others. Katie:

> But by also not having any outside sources I felt that I probably would have learned faster if I had people around me like, saying, oh that's probably this or probably that, or you know maybe they're gassy. So I think it took me a little bit longer to figure out those basics that I maybe I would have figured out faster had I had those maternal supports around us. My mom my sister my mother-in-law those types of things.

Later, Katie went on to say: "there's that lived experience that other people that have that's just so invaluable – that's just – you can't put a price on it; you can't find it online."

Sam echoed this experience by stating, "so, I didn't have another mom. You know, I didn't have my mom, I didn't have a friend mom, a sister, I didn't have any other moms to just be like 'it's ok'". She then spoke more about not having other mothers to learn from who were available in-person:

> I had you know people that I would talk to about things, but it's completely different than when someone is there and can see like "oh, like adjust what you're doing slightly" and it changes everything and they know because they've done it, right? So, you're learning how to be a parent, completely independently which is… unique.

Dawn also felt that not having in-person connections with other mothers, even to do 'simple' activities was difficult, and impacted her mood:

> That just definitely made me depressed not being able to have the in-person connection or be able to have a mom [over to my] home for coffee or a simple playdate, or simply go for a walk… just simple things that some people take for granted.

Joy and Gillian also spoke about the difficulties they had in finding other mothers they could talk to during the pandemic, and while they ended up accessing online supports, felt that the in-person connection offers more than online. For Kayla, she acknowledged that she believes support is necessary for women in the perinatal period, but at the same time acknowledged that regardless of the pandemic, the "village" concept no longer exists in our culture:

> Our society is so different than it used to be, moms and parents are just doing it on their own, in their homes. For a lot of families, it used to be these community, larger family experiences, community experiences when a new baby arrived. Now it's really like, you know, a parent or parents in the home trying to figure it out for themselves. So that's certainly not probably helpful to a lot of families, [for] mental health and wellbeing… just sort of the way our world looks now.

In discussing how she thought her motherhood experience was impacted by the lack of other mothers being present and available, Sam stated:

> I think just by virtue of not having other moms. That it, it wasn't so much a learning from other people… I think there's this beautiful thing that happens with … people who have babies, and are moms that is so often shared you know? I expected to share that birth process with my mom because who else? You know. And all those little things after, that you have this community of moms, that you share together just wasn't there. So, you're really, *really* learning every single thing on your own.

Monica spoke about not having many supports available when she struggled with breastfeeding, and about how she felt due to the pandemic it became all-consuming, as she believed that if she were able to see people and have others around, she wouldn't have felt so stressed. "I think I would have had an easier time letting go if I would have had been able to like, access more people's experiences and support and things like that. But I just destroyed myself."

Monica, Sam, and Katie all spoke of their struggles with breastfeeding during their perinatal period. While all three women did not think that their struggles to breastfeed were the result of the pandemic, all three reported that the pandemic severely impacted their ability to receive breastfeeding supports, ultimately making the experience more difficult.

(c). Strain on relationships

While all the women in the study identified their partners, friends, and family as often being a source of support and happiness, a sub-theme which emerged was how the pandemic placed strain on these relationships, ultimately resulting in negative feelings and increased stress. Monica discusses how this impacted her relationship with her husband:

> It's so stressful anyways. And then to layer that on top as an issue… where we would disagree about how loose we would have to be at certain times, and then that's causing conflict. And then… yeah. So, then it's hard on your relationship.

Kayla also acknowledged that since she and her partner did not always agree on how to navigate the pandemic while being parents, it placed some additional strain on the relationship: "yeah some, like I said, conflict with my partner just around like how we were going to navigate this and just being in different places there."

Monica and Joy spoke specifically about the strain the pandemic placed on many of their relationships with friends and family. They spoke about how having to discuss their safety preferences, or checking in about who others had been in contact with prior to seeing their baby caused stressful and at times upsetting conversations with those informal supports they wanted to utilize as a source of support. Joy stated: "Yeah, just discussing our safety preferences and not having people take them seriously or undermining them. Was very hard." She continued on to state "lots and lots of family drama. Lots of first-time grandparents not liking being told that they couldn't come [visit]."

Monica spoke about making plans with others in order for them to see their baby, and discussing their safety preferences ahead of time, only to be met with differing opinions, and feeling like she was not being respected, or that time with their baby was not really valued:

> (…) we'd make plans, and then it'd be like, ok understood we'd talk about … ok you're going to tighten up before you come see the baby or you can visit outside. And then they'd call the day before … "ok well we were at this outdoor gathering and a couple people there tested positive for COVID. We feel ok, but how do you guys feel about us still coming over?" And it's like, fuck you. Just say you can't come over. Don't put it on us to make the decision now, and be the bad guys (…) Just say you're not coming. So, we felt angry about always having to be the ones saying no. Especially to his [my partner's]

> parents… who would do the same kind of thing. His brother would do the same kind of thing. So, that was a big feeling.

(d). Technology

Interestingly, the use of technology in a variety of forms was simultaneously brought up by women as helpful and unhelpful in almost all of the interviews. All women talked about the ability to call, text and FaceTime with their loved ones, and the importance of being able to do so. Katie and Sam both commented on their use of text and Facetime to communicate regularly throughout the pandemic. Katie stated, "well obviously we could text and stuff so like Facetiming was really supportive (…) being able to communicate with my mom and sister." Sam also reported that the use of technology to communicate was helpful, particularly when it came to communication with her mother:

> having the technology (…) we [mother and I] talk all the time, she Facetimes my son every night at bath time to the point when she's here, he just knows her (…) those kinds of supports made it so that I'm not looking back and feeling just bad. You know, even though I was alone, I still had a support network.

Many women also found support through online groups on social media sites, such as Facebook and Reddit. Joy spoke about the positive support she received through Reddit:

> I had quite a few people on there that were really helpful, and actually the whole Reddit community was helpful. It made me feel like I had a community of mothers. And most of them were very supportive… we were all going through the same thing. We could all talk to each other.

Gillian spoke about the positive support she received through several Facebook groups she joined during the pandemic, and Katie also spoke of a support group she found through

Facebook for women who were not able to breastfeed. Dawn spoke about finding an App through social media, which helped her meet other mothers she could connect with. She stated "there is a mom app and I was able to connect with a mom and me and her have been connecting. So, I'm very grateful for social media. That was great to meet moms."

Kayla spoke about resuming her university classes during the pandemic when her baby was four months old. Kayla reported that the ability to continue her education was a positive mental health support, made easier by the adaptability of online classes, as she stated that needing to attend classes in person would have likely not been possible:

> I started taking classes again. Also, the classes were still online, so it ended up being a really convenient thing for me. So rather than having to pack up and leave to go to the university to go to class and be gone from her for much longer periods of time, it was like my mom came by, I went down to the basement to go to class for a couple hours.

Chien discussed the ways in which technology was simultaneously helpful, but also hindered how she felt at times. Chien reported that while the use of technology was a major factor in staying connected to her family and friends in her home country, she also felt it made her feel worse as it reminded her of their physical distance and inability to support her in person. Chien said at first she spent hours talking to friends via text message, but began reflecting on how this began to make her feel more alone and disconnected and at times impacting her sleep:

> I talked to my friends back home … because of the different time zones, so even when I'm awake at nighttime but my friends [are awake] … I can talk to them or text them. But after a while … [it] didn't work that well because I need to sleep. Also, the text… through the phone still couldn't replace the in person talking. So, that was what I really

> needed. I thought it was good … but I look back now … at that time I thought oh ok that's good I can talk to my friends, I'm not alone, but I still felt alone.

Joy and Dawn also reported that at times the use of technology was not always helpful, and left them experiencing further stress due to the type of support the online communities offered. While both identified that they accessed online support groups, they also spoke of needing to be cautious when sifting through the advice and at times mis-information that was being discussed, compounded with the difficulty of in person connection online. Joy referred to some of these groups as "toxic."

Theme Four: Silver Linings

While the women spoke at length about the difficulty they experienced during the perinatal period in the pandemic, they also spoke about positive aspects, or "silver linings". Importantly, despite the enormous difficulty and challenges they spoke about, the women noted moments of happiness and joy in their perinatal experiences and in becoming mothers, including benefits to their relationships and the time they spent with their baby.

(a). Time together

As previously presented here, women experienced some strain on their relationships with their partners. At the same time, women discussed having their partners around more due to restrictions and work from home mandates as being a positive in many ways. Sam recalls how this was helpful as it provided time with her partner at times when she needed support the most:

> (…) having my husband home because of the pandemic, meant that I wasn't alone. Even if I didn't have my broader support network, I had my immediate person for everything. For every moment. And it feels weird to think of the pandemic of having given us something but it gave us my pregnancy home with my husband. You know? It gave us

> time together that we wouldn't have had. I was never alone. Those days when it's just, you're losing it because, nothing's working … your baby is crying, and my husband was just there and would just be, "I will take him, go have a bath or something".

Despite the pandemic causing some financial strain and at times job insecurity, Joy recalled:

> My partner was home basically for six months because of layoffs and COVID. That was amazing. Yeah. That was amazing. It would have been a very different story if she had been at work that time… it would have felt more alone.

Monica spoke about how helpful it was to have her husband's schedule become more flexible during the pandemic, and how this improved his connection with their baby, assisting them to create a routine for their baby.

> He got to connect with her and build that bond in a way that other parents wouldn't have. We were able to build a routine for her, because we weren't out and about, we weren't doing things, so in terms of sleep, she was sleeping 12 hours through the night by the time she was five months old. And just because we stuck to routine… everything was so consistent all the time.

Having more time with their baby without some of the routine busyness of everyday life due to the restrictions was also discussed by Dawn and Katie as a positive for them, in reflecting on the kind of bond they feel with their baby. Dawn stated "it definitely made me treasure the time, just being able to have that one-on-one connection with him [her son]" Katie stated:

> I think we spent all the time together. So, we do have an incredibly strong bond. So, in that sense it was just the two of us all the time. So, I became very in tune with her all the time very early on. Because there were no interruptions from anybody else, no visiting, no nothing like that. So, in that sense it gave me kind of … there was a positive in that.

(b). Improved Communication

Women discussed how the pandemic forced them to have difficult conversations with their partners, mostly due to uncertainty and varying levels of comfort when it came to seeing others, or making decisions about their baby's health and well-being. While identified as difficult, women also spoke about how having to have these discussions improved their communication with their partner, and at times strengthened the relationship. Dawn stated:

> So, I guess that is one positive, it just made us more aware of conversations we need to have that affect us, our small family, but then also our immediate family. Just for the simple things because, the pandemic… is gone, but COVID isn't so we're still having those conversations so that is one positive thing it just made us more comfortable having the hard conversations that wouldn't really happen if we didn't go through the pandemic.

Kayla recalled that while she and her husband were at times not necessarily on the same page when it came to their feelings about the pandemic but identified it as a positive that they were forced to communicate about it.

> Yeah, my partner and I were definitely, had moments of… he was even just more laid back throughout this whole pandemic, has just had a more laid-back approach to it, where I've been a little more um, probably anxious around it so having to navigate those conversations with him, and him being like you're too worried about this. And I'm like you're not worried enough about this! (Laughing)

(c). Less pressure

Women spoke about the pandemic giving them the ability to not feel obligated to have others around when they did not want it, or engage in social expectations, which can often make

women feel pressured. Kayla spent almost all her pregnancy during periods of strict lockdowns, and spoke about not having to share her pregnancy news too early as a positive:

> You know, I was pretty satisfied to hold onto the news for a little bit myself too. Um, so yeah, that sort of worked in my favour (…) being a first-time parent there was some like nerves in the beginning or just some uncertainty about, umm, maintaining the pregnancy, getting past that first trimester 12 week mark.

Joy recalled not wanting to have many visitors:

> Some ways it's just nice… you don't have to have a lot of visitors (…) I had a lot of anxiety about other people holding her, or feeding her (…) So not having to share her with a lot of other people, because other people holding her (…) besides my partner, I would get very stressed out about it. So, getting to have her, and not have to deal with other people was kind of nice.

Katie spoke about her vision for her delivery and being in the hospital after giving birth as having no visitors, and wanting to spend that time just with her and her partner, despite some family requests to have others be around. Katie remarked through laughter:

> (…) the pandemic was kind of a blessing in disguise because not being able to have people there was kind of what I had always wanted, and so now the pandemic as an excuse to not have people visit me in the hospital.

Eight women participated in this study, which resulted in four main themes: pandemic's adverse impact on mental health, expectations of motherhood, challenges to support networks and silver linings. Women overwhelmingly reported that their mental health was impacted during the perinatal period as a result of the pandemic, causing a multitude of feelings, thoughts, emotions, and ultimately negative mental health symptoms. Women in this study also reflected

on the expectations of motherhood, and how these constructions have impacted their mental health, and ultimately how they sought support and talked about how they felt during the pandemic. Women expressed that these expectations felt heightened and further compounded by the restrictions during the pandemic. The challenges to both informal and formal support networks were discussed at length by the women in the study, with difficulty accessing appropriate supports and the feeling that formal supports offered did not feel adequate to address their needs. The challenges posed to their informal supports, such as relationships with friends, family and their partners was also discussed. Finally, some of the positive aspects, or silver linings, of the pandemic, including increased time and bond with their baby, and feeling less societal pressures were reported. These findings highlight the significant impact the pandemic had on women in the perinatal period, and the ways in which they felt their mental health was impacted.

Chapter Six: Discussion

The purpose of this research study was to explore women's perinatal experiences during the COVID-19 pandemic, and to understand if and how their mental health was impacted. Four main themes were identified: pandemic's adverse impact on mental health, expectations of motherhood, challenges to support networks, and silver linings. These four themes are discussed below, integrated with a presentation of relevant literature.

Theme One: Pandemic's adverse impact on mental health

All women in this study reported that in some way, the pandemic had a negative impact on their mental health and reported struggles with a multitude of negative symptoms and feelings, such as increased stress, sadness, worry, isolation, anxiety, and fear. Seven of the women who participated reported that their mental health was most impacted during the postpartum period, with only one woman reporting that her mental health remained relatively unchanged from her prenatal period, through to her postpartum. These findings are consistent with the existing literature conducted during the pandemic, regarding maternal mental health in the perinatal period (Berthelot et al., 2021; Davenport et al., 2020; Durankus & Asku, 2020; Groulx et al., 2021; Kinser et al., 2022; Shuman et al., 2022; Vigod et al., 2021).

In particular, high levels of stress, anxiety and increased symptoms of depression have been documented among perinatal women during the pandemic (Basu et al., 2021; Farewell et al., 2021; Kinser et al., 2021). International research conducted since the outset of the pandemic has also focused on the overall mental health impacts to mothers, outside of the perinatal period (Babore et al., 2023; Cameron et al., 2020), specifically reporting increased stress and anxiety. Studies have also been conducted among parents of children of all ages during the pandemic, similarly, reporting increases to anxiety, depression, and parental burnout (Brown et al., 2020;

Dawes et al., 2021; Kerr et al., 2022). These findings are not only consistent with the literature relating to perinatal mental health during the COVID-19 pandemic but are also consistent with the existing literature on the impact of previous outbreaks, natural disasters, and epidemics around the world (Brooks et al., 2020; Lebel et al., 2020; Shorey & Chan, 2020).

All of the women in the study spoke about the challenges they faced during the pandemic due to living in isolation. Being alone and expressing feelings of loneliness during these times were identified by six of the women as being particularly difficult. While isolation and quarantine measures during the pandemic meant that women had little choice in being isolated or alone with little support, social withdrawal is an indicator of an increase in depressive symptoms (Perzow et al., 2021). Existing research suggests that individuals in quarantine may experience increased levels of anxiety, fear, depression and even guilt (Zanardo et al., 2021), and links between quarantine and mental health have been established (Brooks et al., 2020; Cameron et al., 2020).

In their cross-sectional study of women in the perinatal period in the United Kingdom (n=24), Jackson et al. (2022) reported similar findings. Women in their study reported that the postpartum period was the hardest to manage during periods of isolation. This led to increased feelings of sadness and loneliness and often disappointment (Jackson et al., 2022). Loneliness and difficulty coping with being alone during strict isolation periods are being reported by women in numerous qualitative studies emerging from the pandemic (Farewell et al., 2020; Perzow et al., 2021).

While there is much research relating to the overall links between isolation, loneliness, lack of social interaction and mental health overall, little research exists on the impact among mothers, in particular new mothers, and those in the perinatal period (Lee et al., 2019).

Loneliness is established in the literature as an important social problem, however often associated with older populations (Lee et al., 2019). Loneliness poses a major threat to well-being and is connected to adverse physical and psychological outcomes (Lee et al., 2019).

According to Farewell et al., (2020), "social distancing and isolation during disasters, coupled with lack of access to health care professionals, can lead to heightened intimate partner violence" (p. 5). Research has established that rates of IPV have increased during the pandemic (Lucas & Bamber, 2021). Stay at home orders and isolation directives also place women experiencing IPV in a situation in which reaching out for support through crisis lines or emergency shelters is more difficult (Evans et al., 2020). Isolation and quarantine have meant greater difficulty for women attempting to leave abusive partners. While women in this study did not report experiencing IPV, nor were they asked as it was not the topic of study, it warrants further attention and consideration for future research, including policy formulation and health care planning in times of global healthcare crisis and future pandemics.

Women in this study cited an increase in fear and uncertainty during all phases of the perinatal period. Seven women in this study became first-time mothers during the pandemic and reported that while the experience of new motherhood already brings with it a certain amount of fear and uncertainty, the pandemic exacerbated these feelings. Women spoke about the fear of exposure to and infection of COVID-19 to their baby as being a main fear during this time. This finding is consistent with studies among women in various stages of the perinatal period during the pandemic, citing fears of them, their partners, or their baby contracting the virus, and the ultimate uncertainty surrounding potential impacts of this (Anderson et al., 2022; Farewell et al., 2020; Kinser et al., 2022; Mari et al., 2023). Women in this study also reported fears and uncertainty surrounding birth planning decisions, reporting that as the information surrounding

the pandemic and subsequent health care rules and restrictions, meant there was constant uncertainty, often right up until they went into labour. These feelings are also consistently reported among recent studies conducted among women in the perinatal period in the United States and Australia (Atmuri et al., 2022; Mari et al., 2023). In their mixed methods study involving perinatal women during the pandemic in the United States, Farewell et al. (2021) found that women reported heightened levels of fear relating to birth planning, and uncertainty that their partner may not be around for the birth of their baby. In their study involving Italian women (n=21) who gave birth during the pandemic, Mari et al. (2023) also found that women cited the uncertainty about what it meant to be a mother and experience motherhood in a pandemic as a major factor contributing to increased negative mental health symptoms.

Whether it be the physical loss of a loved one due to COVID-19 infection itself, dealing with unemployment or financial strain, or even forgoing traditions or special events, "grief appears to be a primary outcome of COVID-19" (Bertuccio & Runion, 2020, p. 87). Grief is a human reaction to situations in which there is a loss, and while there is extensive literature relating to the psychology of grief and how it may manifest itself and interact with mental health outcomes, literature regarding grief during the pandemic is limited, but warrants further attention (Bertuccio & Runion, 2020; Kinser et al., 2022). Feelings of grief and a major sense of loss over missed experiences during the perinatal period was a surprising sub-theme that emerged from almost all of the interviews in this study. Women expressed feelings of grief and loss during their postpartum period, as they had to come to terms with the loss of what they anticipated their life in this new stage to look like. Feelings of grief as it related to the loss of social support from family and friends during the pandemic was noted as a major outcome of a study conducted by Kinser et al. (2021). The feeling of grief and loss was expressed over missed experiences such as

baby showers, friends and family meeting their baby, and milestone events not shared with others as they had expected is a common emerging finding from studies conducted among women in the perinatal period (Kinser et al., 2021; McKinlay et al., 2022). The inability to participate in rituals or involve family and friends in milestone events was also identified in the study by Jackson et al., (2021), where women identified this further created feelings of guilt and sadness. These findings are consistent with the current study, where women spoke of specific rituals or events they considered to be milestones, which were taken away due to the pandemic, causing major feelings of loss. Many of the women who identified these feelings in the current study reported that this grief still impacts them, and they still think often about what they missed out on.

Also reported by some women in the study were the missed opportunities to have friends and family meet and bond with their babies shortly after they were born, a finding which was also reported by Jackson et al. (2021). They found that women identified grief over not sharing in the experience of parenthood and found that it caused sadness to not have the opportunity to share their baby and have others bond with their baby as they had imagined.

Grief and loss were also expressed by participants in another study by Kinser et al. (2022); however, in this study women expressed these feelings of grief and loss not related to milestone events, but rather to the activities and supports, such as in-person "baby and me" classes, play groups, and expanded into grieving the vision they had for their postpartum experience. This is reflected in the current study, in the experience as described by Katie, who spoke of needing to grieve the vision she had for her entire postpartum experience. Atmuri et al. (2022) reported that in their Australian study (n=15) of women pregnant during the pandemic,

grief and loss were identified as major issues for the women, but also for the women's partners, as they could not participate in prenatal activities as they had expected.

While women in this study talked about their vision, or what they had imagined for their postpartum period being different than it was, it is important to discuss this as it relates to how motherhood is constructed, and how women are bombarded with images and messages about what their experience should be, ultimately impacting what our "vision" may entail. Motherhood constructions include how we should feel as mothers, and includes how we should act and provide for our children, by engaging in certain rituals. As this is framed as normal and required, when these things do not occur, mental health can be greatly impacted. According to Henderson et al. (2016), the ideology of the perfect mother is inescapable. Regardless of whether or not mothers accept or actively attempt to resist these messages, there are ever present and often result in negative implications for mental health (Henderson et al., 2016). Collins (2021) argues that maternal guilt "is a type of internalized oppression" (p. 23), as intensive motherhood ideologies reproduce mothers' feelings of inadequacy. This can be said for the rituals that the women in this study discussed missing out on, which in turn created feelings of guilt or sadness, that they were not able to be fulfilled. This is also demonstrated in the ways women internalized feeling that it was their baby that missed out, again reproducing ideals that women must always strive to do more, and be better, for their children (Collins, 2021).

Women in this study reported that uncertainty and changes surrounding prenatal healthcare were present during their pregnancies. Women also reported feeling afraid, which should not come as a surprise for women who endured their birth planning and prenatal health care during a pandemic, as we know that during the best of times, the prenatal period can cause stress and worry. All women in the study reported that due to restrictions in place, their partners

were unable to accompany them to their routine prenatal appointments, meaning they had to attend all prenatal appointments alone, which ultimately increased their levels of stress and anxiety. This finding is consistent with emerging research conducted during the pandemic with women during their prenatal period (Jackson et al., 2021; McKinlay et al., 2022). Jackson et al. (2021) reported that women identified lack of partner support during prenatal visits as negatively impacting their mental health and increased their stress. McKinlay et al. (2022) found that women also reported not having their partner share the experience of prenatal visits as they had anticipated was stressful. In their study of women's experiences of pregnancy and birth during the pandemic in Ireland (n=14), Keating et al. (2022) noted that the impact of not having their partner present was stressful for women, particularly when they required additional testing. Keating et al. (2022) also reported that while their partners were not restricted during labour, that needing to attend prenatal care alone only increased worry and anxiety over the uncertainty of having to labour alone and created a new constant worry. This is consistent with findings in the current study, where women were increasingly anxious, and fearful about their birth planning, and discussed the need to plan for the 'worst case scenario' of potentially having to be alone during labour, or be alone should something go wrong or they receive bad news during a routine prenatal visit.

Keating et al. (2022) also found that women reported that those who had experienced previous miscarriage, or high-risk pregnancies found it especially difficult to be alone, compounding existing stress, consistent again with findings from this study. Interestingly, Keating et al., (2022) also found that this also led to women feeling they could not, or had difficulty, advocating for themselves with health care staff without their partners present.

Suggestions for further research

An area in need of further research may be in the experiences of women with histories of miscarriage, stillbirth, or infertility during the pandemic, and how they managed or experienced the additional stressors created by the pandemic. All of the women in this study reported being in relationships during their perinatal period. With increased stress reported by partnered women without their partners present, an area worthy of future research is not only how did single women experience prenatal care during the pandemic? This also includes women with little to no social supports, managing prenatal care alone. According to Jackson et al. (2020), "allowing mothers to be accompanied by a support person throughout all perinatal healthcare appointments, not just during active labour, is an auspicious opportunity to improve maternal emotional wellbeing and satisfaction with healthcare professional support" (p. 517).

It should also be noted that none of the women in the current study had to experience labour or delivery alone. While reports of this occurring in the United States are documented, little to no information is available regarding the incidents, if any, of women who gave birth alone during the pandemic in Canada. Further research in this area may be warranted, due to the research that is emerging suggesting that attending prenatal care appointments alone increased stress and anxiety in pregnant women.

Theme two: Expectations of motherhood

Women in the study expressed feeling that the ways they are expected to feel about motherhood - happy, joyful, grateful, were often at odds with how they actually felt during the perinatal period. Women reported they felt as though when they did want to talk about the negative feelings they had associated with the experience, often compounded from the pandemic,

they felt stigmatized or minimized for feeling this way. These experiences are consistent with the literature on social expectations of mothering and motherhood. The literature shows that this experience is often framed as being joyful and perfect, and a natural phenomenon (Arendell, 2000; Choi et al., 2015; Cosgrove, 2000). Intertwined with these feelings of pressure and uncertainty as it related to new motherhood, was the sense that the pandemic simply further complicated this.

This leads to an understanding of not only how women are impacted by these discourses and constructions, but how these constructions affect their mental health? Research indicates that these pressures are intertwined with the stigma related to motherhood and mental health. Research shows that being concerned about being labelled as unfit, crazy, or weak impacts women's willingness to seek help or support. We also know through available research that women will often minimize or under report symptoms in order to avoid these social labels of being a "bad mother". We know that stigma exists for those living with mental illness. Maternal mental illness depicts a much more complex picture, as mothers who struggle with mental illness are dealing with the psychological and emotional symptoms along with the societal pressures of motherhood. As has been discussed, motherhood and mothering are social constructs, with dominant discourses of "good mothering", and what it means to be a woman and a mother, deeply embedded in society (Halsa, 2018; Scharp & Thomas, 2017; Woollett & Boyle, 2000), which includes the idealization of new motherhood.

Established research relating to intensive motherhood has shown that behaviours associated with intensive mothering through dominant constructions, increase levels of poor mental health, specifically symptoms of anxiety and stress (Budds, 2021; Rizzo et al., 2012). Feelings of guilt and shame are also reported to increase among women with children under five

years of age, when they feel they cannot live up to the expectations of motherhood they experience from their community and support networks (Budds, 2021). This is likely due to the messaging women receive with younger children and babies, that they must be the sole care provider and mothering must be an all-encompassing, child centered experience. It is also a time when new mothers are learning to navigate a new role (Liss et al., 2013).

This experience of having the pandemic compound the already stressful and difficult time of new motherhood is mirrored in the results of a study conducted by Kinser et al. (2022). This study found that women expected motherhood to be difficult, and the added uncertainty and constantly changing nature of the pandemic made this experience all the more confusing and stressful. Jackson et al. (2021) state that women in their study reported that when they did feel that they needed support, whether it be medical or mental health related, they avoided seeking it out of fear. They report that this fear was in relation to the worry that their mental health was not essential, that they would be viewed as simply inexperienced and that they would be judged in their role as a mother.

Underlying the discussion relating to the outcomes of the pandemic was the understanding and feeling, by women in this study that motherhood just is and will always be, hard. Women spoke of the overwhelming workload for mothers, and the exceptional difficulty that new mothers in particular face. Scharp and Thomas (2017) report that mothers diagnosed with depression, for example, often describe and define themselves as inadequate, and report feelings of guilt over not meeting the idealized role of a mother. Women diagnosed with a mental health related disorder during the perinatal period also experience a heightened level of stigma, as it is again often framed as a time that should be happy and joyful (Scharp & Thomas, 2017). Scharp and Thomas (2017) also discuss the ways in which the ways our society and

community understands perinatal mental health can shape how mothers experience their mental health. Halsa (2018) discusses the ways in which mothers who are struggling with their mental health often experience "two-fold stigma" (p. 403) as women experience the stigma of motherhood, but also of failing to meet the idealized standard of motherhood.

While not all women in the study made the connection between their mental health and expectations or discourses of motherhood, it is clear in the way they spoke about being mothers that it is an understood norm that it is hard to be a mother, there are little supports, and we must simply "get through it." This speaks to the nature and power of these constructions, which are so deeply embedded in our society. These constructions became a type of reality for the women in this study, one which they felt they could not escape, and which only made things worse for them during the pandemic. While cultural and social changes have meant that women have made numerous advances in the public sphere, as childbearing and the raising of children are often looked at as private issues, women are often left with little choice in this area (Henderson et al., 2016).

However, as Cummins and Brannon (2022) discuss, if we can acknowledge that these expectations are in fact, constructed, this means they are not natural and can therefore be challenged. In order to challenge intensive motherhood discourses, we can begin by "creating resistant narratives, small fissures in the façade of the discourse that can grow and spread" (Cummins & Brannon, 2022, p. 135). We can look outside of what has been set as the optimal view of motherhood, and look for alternatives. This includes continuing to focus on the exploration of women's experiences of motherhood, particularly more diverse experiences, and centering this knowledge. And while this also poses challenges to women, as often intensive motherhood ideals are so strong and all encompassing that mothers, "lack the energy to push for

public solutions" (Green, 2015, p. 200), beginning conversations and allowing women the opportunity to share their stories and experience, are imperative to dismantling these discourses, and beginning to look for ways forward.

Theme three: Challenges to support networks

When asked to discuss their experiences and feelings related to formal supports they received, all of the women spoke specifically about the support they received within the first six weeks, and how support provided to women during this period can be improved.

Jackson et al (2022) found that women in their study reported feeling abandoned by their health care supports, and when they were able to gain access either in person or though digital means, they felt they were rushed through due to the caseloads carried by their supports. In their study, women also reported that when discussing their experience or well-being with health care providers, it was perceived as a "check box exercise" (p. 517). This was also reflected in the findings of the current study, as women thought that the support they received in the first six weeks was very focused on their and their baby's physical health, and that they were often not asked about their mental health. When they were asked about their mental health, women reported that when they talked about how they felt, their feelings were minimized and at times ignored by formal supports.

While women identified that formal supports could be improved, particularly during the first six weeks, we also know that women may choose not to reach out for support for fear of being judged, or viewed as being inadequate mothers. Research has established that constructions of motherhood not only impact the experience, but the ways in which women seek help and support (Law et al., 2021). The stigma associated with being perceived as a 'bad' mother, or inadequate, discourages women from talking about how they truly feel, and ultimately

shapes if and how they seek support. In their cross-sectional survey of Canadian perinatal mental health providers (n=435), Hicks et al., (2022) reported that providers identified "internalized stigma about mental illness" (p. 3) to be a barrier to accessing perinatal mental health treatment or supports. Women also spoke about turning away supports when they were offered, stating they were fine and did not need anything. This is an important finding, as while it could certainly be true that at the time they felt they did not need support, women in this study also overwhelmingly discussed feeling their mental health was impacted, and that in hindsight, should have accepted more support. Constructions of motherhood, as previously mentioned, frame the experience as not only always positive and joyful, but also emphasize that it is natural, and that a mother's instinct will always kick in, further stigmatizing women when they feel they need further support (Henderson et al., 2016).

The CPMHC (2021) reports that Canada "has no comprehensive national strategy, mandate or directive" (p. 6) to lead health care practitioners in the assessment, diagnosis, or treatment to women living with PMADs. Access to perinatal mental health care varies widely among provinces and territories in Canada, with each province and territory utilizing its own approach to perinatal mental health screening and support (DeRoche et al., 2023). In the absence of routine standardized screening in Canada, according to recent research by DeRoche et al. (2023), "three-quarters of women meeting Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria for depressive and anxiety disorders are not identified" (p. 1), and only approximately 10% of women who do require mental health care and supports in the perinatal period, receive it. Another issue in Canada is the long wait times, and often high costs as women must turn to private services to gain timely access, ultimately creating additional barriers to accessing care (DeRoche et al., 2023). This is reflected in the current study, as Joy and Dawn

specifically discussed the difficulty they experienced in attempting to find support, particularly in a timely manner. Joy spoke about when she was ready to seek support, was often met with wait lists from six to twelve months long. Chien also spoke of her difficulty in accessing supports, and when she was finally able to, felt that once she reached a certain number of sessions, she was simply cut off.

According to the Canadian Perinatal Mental Health Collaborative (CPMHC), not only does Canada not have a comprehensive plan to screen and support, data is not being consistently gathered, particularly when it comes to maternal deaths. Current research suggests the need for improved screening and treatment guidelines across Canada, including more accessible services (Hicks et al., 2022). Maternal health experts in Canada report that there are "no consistent or reliable systems here to collect and share information on maternal deaths and close calls" (Gomez & Carman, 2022, para. 9). They also report that these deaths, as well as nearly fatal critical incidents are preventable, and provide learning opportunities and strategies for new research. The Society of Obstetricians and Gynecologists of Canada report that they predict the number of pregnancy related deaths in Canada are significantly higher than what is reported to Statistics Canada (Gomez & Carman, 2022). According to experts, there are a variety of reasons for this. These include the responsibility of health being relegated to the provinces, which means that each province and territory in Canada tracks, monitors, and records differently, even using different definitions for what constitutes maternal death (Gomez & Carman, 2022). This creates challenges to implementing national surveillance strategies, and even information sharing among different hospitals, which can provide learning opportunities for physicians and other health care providers (Gomez & Carman, 2022).

Hicks et al., (2022) also report that there is a lack of culturally appropriate or gender diverse perinatal mental health care services and supports in Canada. Further pointing to the inadequate system of service provision, and reporting and tracking of perinatal mental health care needs. Given these findings in combination with women in this study, and others, reporting that the services available felt inadequate, and what we know about the increase of PMADs during the COVID-19 pandemic, there is an urgent need to improve perinatal health care, and mental health care, in Canada and internationally.

In their study of perinatal women in the United Kingdom, Jackson et al. (2021) discuss how women discussed that their needs were not viewed as essential, or important enough, as changes to the routine six week check-ups meant they were skipped or changed to virtual, leaving them with unanswered questions, and having to turn elsewhere for support. Their study also found that after the six to eight weeks cut off, they were simply left with no supports or services.

Women in this study spoke about their social supports, and that they had perceived before having their baby that this support network would be there. Jackson et al., (2021) found that women identified not having the support network they had expected to be incredibly difficult, often leading to increased sadness. There is extensive literature on the impact of social support in the perinatal period (Almeida et al., 2020; Ollivier et al., 2021; Sufredini et al., 2022) and is a key protective factor during the perinatal period (Almeida et al., 2020). Lack of quality social support from immediate support networks during the perinatal period is associated with a higher risk of anxiety and depression, and women who perceive their social supports to be strong are less likely to experience perinatal mood and anxiety disorders (Ollivier et al., 2021; Sufredini et al., 2022).

Given our understanding of the importance of social supports during the perinatal period, when analyzing the experiences of the women in this study, we can see the vital importance of social support during times of crisis. While we know that the pandemic was a time of unprecedented change, with governments and health care system rapidly changing due to the multitude of unknowns, it is important that we understand the importance of social support to potentially mitigate future effects. Sufredini et al. (2022) also point out that there is a unique opportunity to examine social supports during the perinatal period, as they are often easily modified, such as the mode of delivery and, therefore, can be utilized to decrease risk of mental health risk factors more effectively than other factors.

While women in this study identified their informal relationships as major sources of support and happiness, a sub-theme which emerged was the ways in which these informal supports also simultaneously caused negative feelings and strain due to the pandemic. Strain on family and friend relationships were reported in the study by Kinser et al. (2021) when values or comfort level associated with the pandemic were not in line with their social supports. In this study, Kinser et al. (2021) report that differences with comfort levels during the pandemic relating to in person contact and activities which may increase risk of contracting the COVID-19 virus, often led to feelings of guilt, particularly when it meant they had to make difficult decisions or cut off social supports or relationships. Shuman et al. (2022) found that women reported increased emotional distress when making decisions regarding visitors, placing strain on these relationships. Gray and Barnett (2022) reported that in their study of women in the perinatal period in the United Kingdom reported an increase in anxiety when having to make decisions about who could see their baby, and that they felt pressured to make these decisions,

such as when and how to have social contact, amidst mounting uncertainty and constantly changing health mandates and restrictions.

Gendered perspectives of the role of mothers often constructs them as the ones primarily responsible for managing the health of the family (Gray & Barnett, 2022). The mother as responsible for the risk management in a family is then often used as another means to distinguish 'good' mothers, from 'bad' ones (Gray & Barnett, 2022). Risk management may refer to decisions regarding the family's health and well-being, and overall safety. In the context of the pandemic, this often meant that women were the ones managing the risks of potential social interaction, and the organization of if, when and how it may occur. This is seen in the ways women in this study described the strain placed on relationships when they had to make decisions about the family safety, and ultimately express their comfort level when it came to visiting or engaging in social activities.

The use of technology in a variety of forms, such as being able to call, text, and Facetime friends and family, were reported by all the women in the study as a helpful and beneficial coping strategy they were able to use during the pandemic. The support of technology appeared to be a protective factor for many women in times of isolation and lockdown measures. This finding is consistent with a finding reported by Kinser et al (2021). In this study, the authors note that social media, when used to connect with family and friends, was a helpful protective factor for their mental health and well-being. Interestingly, they found that in contrast, women reported that their use of technology to access news and information increased their stress and feelings of fear during the pandemic, ultimately having a negative impact on their mental health. This is also consistent with some of the comments made by women in this study, as they reported despite being a useful technological advancement, at times social media and the constant news available

to them relating to the pandemic was unhelpful in their coping. According to Chien, the constant use of social media to connect with her friends and family in her home country was initially helpful but became increasingly stressful as it was a constant reminder that they were not physically with her, and were unable to travel due to the pandemic. Studies conducted during the COVID-19 pandemic have found that an increase in social media use is correlated to higher rates of anxiety and depression (Kinser et al., 2022).

Joy, Katie, Dawn, and Gillian spoke of the helpfulness of social media groups, such as Facebook and Reddit, as it provided a way to connect with other women and mothers during the pandemic. Joy and Dawn noted specifically however, that at times it could create a "toxic" or unhelpful environment, where they felt they had to further filter through misinformation, or at times unhelpful advice and comments from others, ultimately complicating this form of support. They both noted that they found this to be the case particularly when they were seeking advice or support, as they were unable to reach out to their regular support networks in person.

The use of the Internet to seek health information is increasing, and the research available regarding the use of the internet by new mothers is an area of emerging research (Madge & O'Connor, 2006). The research on the implications of increasing internet use by new mothers has yielded mixed results in terms of the benefits which it may provide (McDaniel et al., 2012). While some research depicts the internet and online communities as potential sites of empowerment, where women can seek support on a variety of topics (Madge & O'Connor, 2006), some research points to the negative effects, particularly on women's mental health, which result from these online spaces (McDaniel et al., 2012). Use of social networking or internet sites relating specifically to mothers, can increase feelings of isolation and anxiety, but are also reported as a convenient and useful way of connecting with others while never leaving

your home (McDaniel et al., 2012). In their study involving new mothers and their use of an internet support website, Madge and O'Connor (2006) found that the online support provided women with support, which assisted in empowering them in their new motherhood experience. However, the authors noted that it also simultaneously promoted gendered stereotypes of gender roles and motherhood (Madge & O'Connor, 2006).

The use of technology and the role that the Internet plays in our lives raises important questions, particularly as it relates to new mothers and their mental health. As Internet usage during the pandemic increased, so did the increase and spread of misinformation relating to the pandemic, and the potential outcomes of COVID-19 (Gray & Barnett, 2022). As technologies advance, and more and more supports and services utilize the internet to provide supports and services, technology becomes an increasingly important issue to understand and analyze. While all of the women reported use of technology in this study, it was assumed that they all had access. The experiences of women in rural settings, or more isolated communities where internet access is not as reliable are not known and warrant further investigation.

Theme four: Silver Linings

While women in this study reported some relationship strains caused by the pandemic, one of the positives reported by many of the women was the increased time they were able to spend with their partners, and their baby. Sam, Joy, and Monica all spoke specifically about how work from home mandates and COVID-19 related changes to work schedules meant that their partners were able to be home more, providing increased support and quality time. Katie and Dawn spoke about how they felt that their bond with their baby was strengthened, and how much they appreciated being able to 'slow down' and just focus on time at home with baby. Monica also reported that this increased time at home meant a better routine for herself and baby,

resulting in more sleep and a positive impact on her well-being. Increase in quality time with partners and babies has been reported by women as a positive outcome of the pandemic in several recent studies (Anderson et al., 2022; Gray & Barnett, 2022; Kinser et al., 2021; Shuman et al., 2022). Gray and Barnett (2022) found that women reported they could spend more time with their baby, and more time with their partner was helpful, both positive for their mental health. McKinlay et al. (2022) also found that women reported times of lockdown and isolation meant that partner relationships were strengthened, which they reported improved their mental health.

Kerr et al. (2021), in their study of parents in the United States during the pandemic (n=1,009), found that parents identified a strengthened bond and relationship with their children during the pandemic. This finding is highlighted by the authors as significant, as research suggests that the quality of the parent-child relationship has a mitigating effect on the effects of stress and negative experiences of the family (Kerr et al., 2021). The benefits of improved time together are an area of limited research as it relates to the pandemic, but likely warrants further attention.

Women also spoke about feeling that seeing fewer people meant that some of the social pressures they felt related to motherhood were minimized. Women reported that pandemic related restrictions meant that they had more time alone in the hospital, and in the first few days after childbirth, when they wanted to be with their partner and baby and avoid many social and family pressures to have visitors and be social. These findings mirror the results reported by McKinlay et al. (2022) in their study of women pregnant during the pandemic (n=23) in the United Kingdom. Women in this study reportedly felt less social pressure due to isolation, and were able to avoid the "unwanted gaze, touch, or commentary of other people" (p. 7). This

finding mirrors what Joy had reported in her interview, remarking that she felt that one positive aspect of parenting during strict isolation meant that she could avoid the commentary of others as it related to her parenting decisions. While this finding is very much intertwined with the negative and restrictive consequences of intensive mothering and the surveillance of mothers (discussed earlier in this thesis), it is important to understand the perceived benefits women experienced, in this study and elsewhere in the literature, of being able to mother their children without the gaze of others. Often, the new motherhood experience "can be threatened by societal disapproval and scrutiny if contemporary constructions of the 'good mother' are breached" (Gray & Barnett, 2022, p. 535). Gray and Barnett (2022) note that the COVID-19 pandemic meant a decrease in social exposure, which may have benefited many new mothers as they were then able to avoid the scrutiny, commentary, or evaluations from others, and ultimately avoiding the potentially negative feelings and emotions associated.

In summary, the findings of this study are consistent with much of the literature conducted during the pandemic. Despite it still being limited, qualitative studies regarding women's experiences during the COVID-19 pandemic have emerged rapidly, and continue to become available. However, many gaps in our understanding of this experience remain. We know that women's mental health was impacted, and have begun to uncover the ways in which this impacted women, and how they attempted to cope. Women in this study talked about feelings of sadness, anxiety, frustration and overwhelm, coupled with the constantly changing public health mandates and restrictions. Women also spoke at length about the feelings of grief and loss which they experienced, causing major adverse impacts on their mental health and wellbeing. We also know that the ways women navigated the use of formal and informal supports were challenged, causing numerous issues and emotional struggle. Women in this

study, and others, have also reported the ways in which they believed they benefited from the pandemic, including increased time with their babies, and less social contact and reduced social pressures. Underlying all of these findings, are the constructions of mothering and motherhood, and the ways in which these negatively affect women. These constructions are so deeply embedded, that women are affected in ways which they do not even recognize, and continue to suffer from the consequences without adequate supports, or acknowledgment of the impact of these constructions.

Chapter Seven: Recommendations and Conclusion

This study sought to explore the experiences of women in the perinatal period during the COVID-19 pandemic, and to understand if and how their mental health was impacted. Four themes were identified and provide valuable insight into this experience and how women in this study were impacted. The following is a discussion of the implications of this research, including suggestions for future research, as well as the relevance to social work practice. This chapter will also discuss the limitations of this study, and the implications of these on the study results.

Recommendations for future research

The present study contributes to the emerging literature relating to the experiences of women in the perinatal period during the pandemic and the subsequent mental health impact. However, gaps remain in research in this area, and our understanding of this experience still requires further attention. First, it has been established that in Canada, more work needs to be done to establish a national screening and support protocol for women in the perinatal period, for early detection of mental health issues and to improve supports and services. As Canada has no national strategy, women are often receiving minimal support, and are left to seek out their own support often amidst limited services and potential cost barriers among private services. All women in this study identified the pandemic had an adverse effect on their mental health during the perinatal period. This is particularly significant when we understand the lack of overall mental health care strategy for women in the perinatal period in Canada.

Women in this study identified that the support for women in the perinatal period is often focused on the first six weeks' and recommended that this be changed to better support women throughout the varying stages of the perinatal period. Women stated that the formal supports they were most aware of, mainly their public health nurse, were not necessarily helpful during a time

when they were already struggling and had difficulty identifying what kind of support they may need. Women also identified that they were generally offered one check in, and that in hindsight, they turned away needed support too early. This finding, in combination with what we already know about the lack of a national strategy for women in the perinatal period for health care practitioners, and that there is an overall lack of available and timely supports for women during this time, is important for those in health care and in health and social policy to consider.

Women in this study were asked to reflect on the potential impact the pandemic had on the way they engaged in mothering or their motherhood experience. All women in this study spoke of the ways in which they believed they are impacted by mothering discourses, and how the pandemic compounded these challenges. While extensive literature does exist on mothering ideologies and the impact this has on women, continued analysis and exploration of this topic using women's own voices warrants continued attention. The ways in which dominant discourses on mothering and motherhood, and how they changed during the pandemic is also an area that warrants further attention and can provide us with more insight into the ways in which women are impacted by mothering ideologies in times of crisis or rapid social and economic change, such as the pandemic. As discussed earlier, while women took on the majority of care work in society prior to the COVID-19 pandemic, this has only increased. This increase, along with what we know about the messaging we receive about mothers being relegated to caring for children, while maintaining all other obligations, has meant that the situation of mothers has become increasingly complex. As O'Reilly (2016) states, "motherhood discourses are rewritten in response to, and as a result of, significant cultural and economic change" (p. 124, as cited in Cummins and Brannon, 2022).

All women in this study reported being in a relationship during the perinatal period, and reported that despite their broader informal supports being limited, the support they received from their partner was invaluable to their coping. While all women reported the pandemic impacted their relationship in some way, both positive and at times negative, it is important to note that the experiences of women who were single or had no supports during the pandemic is limited in the available literature. The importance of social support during the perinatal period is established in the literature, and therefore we are aware of the adverse effects little to no support can have. Understanding how limited social support affects women, particularly their mental health, is important to strengthen health and social program delivery for women, and can also assist in improving potential screening tools and protocols for women in the perinatal period. It is also important to understand how supports changed during the pandemic, to assist in mitigating the potential harm or negative effects in the case of future pandemics, or crisis.

As briefly discussed previously, women in some countries did experience childbirth alone during the pandemic, but limited research is available regarding the incidents of this, and the potential outcomes. There is also no available research regarding the experiences of women who may have had to travel to a larger city or community to give birth, and the ways this was impacted by the pandemic.

Not only is there a lack of research relating to Indigenous women's perinatal experiences in Canada overall, but there is also little available research relating to their experiences during the pandemic. There too, is little information available on the experiences of women in of varying cultural backgrounds in Canada, during the pandemic. This is an area that warrants attention, as the voices of these women are not reflected in our current understanding of not just

perinatal mental health and how the pandemic may have impacted this, but also of the overall perinatal experience for women in these groups.

Implications for social work practice

We know that social workers practice in diverse areas, including both micro and macro levels of practice, and that there are few areas in which social workers will not encounter women and their diverse experiences (Alzate, 2009). While they may not be actively involved in the process of childbirth, or provide care specific to the perinatal period, many social workers in a variety of roles could work with women who have given birth or who are in varying stages of the perinatal period. This makes social workers a direct part of care provision for women throughout the perinatal period. Understanding the experience of the perinatal period and of mothering is essential to improve the health of women, and to advocate for social justice effectively (Alzate, 2009). As the experience of pregnancy, childbirth, postpartum and motherhood vary, social workers are well positioned to explore how these experiences can shape women's lives and result in a variety of after-effects which will shape the type of care they need (MacDougall, 2020). The Canadian Association of Social Workers (CASW) outlines the Code of Ethics for social workers in Canada (2005). Core value #2 of the social work profession is the "pursuit of social justice" (CASW, 2005, p.4). Social workers have the obligation to promote equity, work to reduce barriers, and ensure all individuals receive equal treatment and have choice (CASW, 2005). Social workers also play a large role in advocating for individuals' opportunity to receive public services and benefits, which are fair and equitable (CASW, 2005). Core value #1 of the social work profession is "respect for the inherent dignity and worth of persons" (CASW, 2005, p. 4). This study had the potential to expose potential inequities and barriers for women in the perinatal period during the COVID-19 pandemic and explore the protective and risk factors

relating to their mental health during this time, thus providing valuable information relevant to social workers. This study also has the potential to provide social workers with information relating to the positive aspects of women's perinatal experiences, including positive interactions and interventions relating to their mental health, which also strengthen social workers' ability to practice in an ethical and equitable way. The core social work value #6, "competence in professional practice" (CASW, 2005, p.4) is also relevant to the study of women and the perinatal period as social workers must seek to "analyze the nature of social needs" (CASW, 2005, p. 8), and both contribute to and encourage new strategies and ways of practice to meet these needs. Social workers must also contribute to the knowledge base of social work, through an understanding of current research and by participating in research activities (CASW, 2005). This ensures that social work interventions and practice skills reflect current knowledge. As previously stated, social workers may not be actively involved with women in the perinatal period but have the opportunity to support those who do, such as midwives and nurses, through social work research (Macdougall, 2020). This allows social workers the opportunity to advocate for policies and practices which will improve maternal health services, and supports (Macdougall, 2020).

Study Limitations

As with any research study, this one is not without its limitations. One limitation is relating to the recruitment strategy. Recruiting through social media means that I may have missed some women who are not members of any social media groups, or those who do not utilize social media. The voices of women who do not speak English, or have the resources to spend an hour participating in an interview free of distractions are also not represented in this study. I also acknowledge the potentially sensitive nature of this research topic and know that

some women may have wanted to participate, but thought they would be unable to participate in the discussion out of concern it may have exacerbated how they felt, or impacted any current mental health challenges they may be experiencing.

The inclusion criteria for this study included women who gave birth and experienced the perinatal period in Winnipeg, Manitoba. This choice was made as it narrowed the criteria to one governing health authority, the Winnipeg Regional Health Authority. It should be noted that this is a limitation, as the experiences of women outside Winnipeg and in rural areas of Manitoba are not represented. Despite the study's focus on Winnipeg, this study still has broader relevance. With the global impacts of the COVID-19 pandemic, mothers around the world were impacted, and the known implications have been documented. Therefore, the results of this study could be relevant outside of Winnipeg, in communities within Canada, as well as internationally.

While there was no requirement for women to be partnered to participate in this study, only those who identified as in a relationship responded to the recruitment poster. As a result, single mothers' voices were not represented in this study. As discussed, women in this study all reported being in relationships during the perinatal period and yet overwhelmingly still reported the lack of support they felt, and the ways in which the pandemic placed strain on these relationships, making it more difficult to cope and receive support. How single mothers, and women with little to no support experienced the pandemic, is then an area worthy of more attention, as the ways they experienced the pandemic, as well as the potential impact on their mental health is important and can provide insight into an experience that is not reflected in this study.

While there was no intention to exclude Indigenous women, or those from varying cultural backgrounds in this study, no woman who identified as Indigenous, person of colour, or

other diverse identities responded to the call for participants. As noted previously, one woman in this study did identify as East Asian. Seven of the eight women who participated identified as Caucasian. This means that there is little diversity represented in this study. This has implications as it does not include voices of women in more marginalized groups. As previously mentioned, service providers in Canada are recognizing that limited access to culturally appropriate supports and services for women in the perinatal period are lacking. How these women then experience the perinatal period, including access to mental health care and supports, is vital to improving these systems. This also is important as diverse groups of women also provide insights into the constructions of motherhood within a variety of cultures. How these women experienced these constructions within the constraints of the pandemic serves to deepen our understanding of the effects, and how we may go about making change. Highlighting that these perspectives are imperative to continue developing policy and best practices which recognize and respect women of diverse cultural backgrounds to improve overall perinatal health and mental health outcomes.

Conclusion

This study explored the perinatal experiences of women during the COVID-19 pandemic, and the mental health impact. Through in-depth interviews with eight new mothers, four main themes emerged: pandemic's adverse impact on mental health, expectations of motherhood, challenges to support networks, and silver linings. This study demonstrates a clear impact on the mental health of women who experienced the perinatal period during the COVID-19 pandemic. This study also uncovered the multitude of ways in which the perinatal experience was impacted by the pandemic. While there were numerous adverse impacts, with the pandemic often compounding existing difficulties for new mothers, there were also positive outcomes identified which assisted women during this time. It is my hope that this study contributes to the existing literature on the perinatal experience during the pandemic, and has highlighted areas where

future research is warranted. It is also my hope that I have highlighted women's voices in this study and represented the importance of valuing and acknowledging women's voices and experiences.

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Appendices

Appendix A – Informed Consent

University of Manitoba | Faculty of Social Work

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Research Project Title: COVID-19 and the Perinatal Period: Exploring women's experiences and mental health impact

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This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

1. **Description of the research:** The purpose of this research study is to explore the experiences of women in the perinatal period during the COVID-19 pandemic, and to explore the mental health impact during that period.
2. **Your participation in this study:** Your participation in this study consists of a one-time, one-on-one interview, in person. This interview is expected to last approximately sixty to ninety minutes in length. These interviews will be audio recorded, using a recording device. These recordings will then be transcribed verbatim by the researcher. I will also ask you to complete a demographic questionnaire as part of your participation in this study. This questionnaire consists of eight (8) questions.
3. **Confidentiality:** All aspects of this study are strictly voluntary. Your information will be kept confidential, and all data collected in this study, such as this consent form, the demographic questionnaire, and the audio recordings, are stored securely. I also wish to inform you that I am required, by law, to report any allegations of abuse or maltreatment against children or persons in care to the appropriate authorities.
4. **Benefits and potential risk:** Your participation in this study is not intended to pose a risk of harm. However, I do acknowledge that the subject matter may be difficult, emotional, and at times potentially distressing to you. At any time, you may stop the interview. You may also request a break at any time. A copy of resources will be provided to you in case you feel after the interview you are in need of further support. I believe participation in this study may benefit you, as it provides an opportunity to share your experience and contribute to this research area.

5. **Data collection:** The interview transcripts from your interview will be coded and will contain no personal identifiers. I will ask you to choose a pseudonym at the beginning of the interview. This pseudonym will be connected to your interview transcript. Select quotes will be extracted from the individual interview transcripts and shared in the final thesis document, as well as potentially shared in journal articles and/or presentations related to this study. If any quotes are used from your interview transcript, you will be identified by your pseudonym only, not your real name. All data will be stored on a password protected computer, accessible only to myself as the researcher, and my thesis advisor.
6. **Honorarium:** An honorarium of $40 CAD will be provided to you, in the form of cash, at the beginning of the interview to thank you for your time and participation in this study.
7. **Withdrawal from the research:** Your participation in this study is voluntary, and you may withdraw at any time, without any consequence. If you wish to terminate the interview at any time, please just let the researcher know and it will be stopped immediately. Should you choose to withdraw prior to the data analysis phase, your consent form, and any audio recordings, will be destroyed. Individual quotations cannot be removed after the data analysis phase has begun. Should you wish to withdraw after the interview has been completed, please contact the researcher no later than 12/22 to inform me of your withdrawal.
8. **Debriefing:** Immediately following the interview, the researcher will provide time for you to debrief.
9. **Dissemination of results:** Research results will be disseminated to the thesis advisory committee. This is required as part of the MSW program requirements and will be publicly presented at a thesis defense presentation. A copy of the published thesis will be made available online, through the University of Manitoba's institutional repository, MSpace. The results of this study may also be shared in journal articles and/or presentations.
10. **Summary of results:** Once the research is completed, the researcher can provide you with a brief research results summary. This summary should be available to you within 6 months of your participation in the study, by approximately 03/23. If you wish to receive a copy of the research results summary, please provide me with your contact information below, and indicate how you wish to be contacted.
11. **Destruction of data:** Any confidential data collected for this study will be kept until 11/23, at which point it will be destroyed, as per REB guidelines.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.
The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. **If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or** HumanEthics@umanitoba.ca. **A copy of this consent form has been given to you to keep for your records and reference.**
---------- Provide for Signatures as Required: ----------

I consent to being audio recorded during my interview for the purposes of this study (Please circle): Yes No

I confirm that I have received the $40.00 cash honorarium (Please Initial): _____

Participant's Signature: _____ Date: _____

Researcher and/or Delegate's Signature: _____ Date: _____

I wish to receive a copy of the research results summary (Please circle): Yes No
How would you like to receive it? (Please Circle): Email Mail

Please provide your email or mailing address:

Appendix B - Recruitment Poster

University of Manitoba | Faculty of Social Work

173 Dafoe Road
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7050
F: 204 474 7594
Social_Work@umanitoba.ca

Seeking participants for a research study: The impact of the COVID-19 pandemic on the perinatal experience, and impact on mothers' mental health

What is this study about?

This study is looking to explore women's perinatal experiences during the COVID-19 pandemic, and to understand the mental health impact it may have had.

Who can participate?

You may be eligible for participation in this study if you:

- Are over the age of 18, and living in Winnipeg, Manitoba **and** Experienced pregnancy, childbirth, or the postpartum period during the COVID-19 pandemic (from March 15, 2020 to March 31, 2021)

What can you expect?

Your participation includes a 60-90 minute interview, in person, with the researcher, which will be audio recorded. Your identity will be kept confidential, and you will receive an honorarium ($40) in appreciation of your time.

To participate, or for more information, please contact:
Laura McDonald by email mcdona54@myumanitoba.ca or by phone XXX-XXX-XXXX
Research Advisor: Dr. Tracey Bone, Tracey.Bone@umanitoba.ca
This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus
Protocol # HE2002-0259

Appendix C – Eligibility Criteria

1. Did you experience the perinatal period, and currently residing in, Winnipeg, Manitoba?
2. Are you over the age of 18 and English speaking?
3. Do you have the ability to provide informed consent, which includes agreeing to have their interviews audio recorded?
4. Are you the biological mother of your baby, born during the eligibility period?

Appendix D – Community Resources

Listed below are a number of community supports available to you. All of the listed services are available at no cost.

Crisis Lines

1. WRHA Mobile Crisis Service (24 hours/7 days a week) 204-940-1781
2. Manitoba Suicide Line 1-877-435-7170 (24 hours/7 days a week)
3. Postpartum Warm Line 204-391-5983 (9am-9pm 7 days a week)

In Person services

1. WRHA Crisis Response Centre at 817 Bannatyne Ave (24 hours/7 days a week) Walk in crisis services
2. Postpartum Support Group, Mood Disorders Association of Manitoba 204-250-3079

Appendix E – Interview Guide

1. Can you tell me when during the pandemic, from March 15, 2020 to March 31, 2021 you gave birth to your baby? Which stages of the perinatal period did you experienced during the pandemic?
    - Prompt: If they experienced multiple stages: Can you tell me about one stage which stands out for you? This may have been the time of pregnancy or childbirth during the pandemic, or the postpartum stage.

2. What was it like to experience the perinatal period during the pandemic? Can you tell me how you feel that the pandemic impacted your experience during this time?

    - Prompt: What was it like to be a mother during the pandemic? If this was not your first child, do you think the way you mothered/experienced motherhood this time was different?

3. Can you tell me about your mental health during this period? How would you describe your mental health during this time?

    - Prompt: Can you identify anything which may have positively/negatively affected your mental health?
    - Prompt: Things which may have affected mental health; relationships (family, marital/partner), COVID-19, informal or formal supports, etc.

4. Can you tell me about any coping strategies you used during this time?

    - Prompt: Did you find any of these were helpful? How do you feel about these strategies? Were they positive/negative? How did you develop these strategies?

5. Did you seek or receive any treatment for mental health issues/concerns?

    - Prompt: If yes, what made you decide to seek support. If no, is there anything that stopped you, or prevented you from getting support?

6. What would you like professionals (health care workers, social workers, policy makers) to know about your experiences of the perinatal period during the pandemic? What about your mental health experience during the pandemic?

7. Is there anything else you would like to share?

Appendix F – Demographic Questionnaire

University of Manitoba | Faculty of Social Work

173 Dafoe Road
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7050
F: 204 474 7594
Social_Work@umanitoba.ca

Demographic Questionnaire

1. Pseudonym _____

2. Age (Please check which applies)

   18-24 _____
   25-34 _____
   35-44 _____
   45-64 _____
   Over 65 _____

3. Marital/Relationship status (Please check which applies)

   Married _____
   Single _____
   Divorced ____
   Common law _____
   Separated ____

4. Which racial and ethnic groups do you identify with? (Please check all which may apply)

African
European/Caucasian _
First Nations, Inuit, Metis ___(Please specify) ____
East Asian (Chinese, Korean, Japanese, Vietnamese) _____
South Asian (Afghani, Pakistani, Sri Lankan) _____
South East Asian (Filipino, Indonesian, Malaysian, East Indian) _____
Latin American (Central and South American) ____
Other (Please Specify) _____

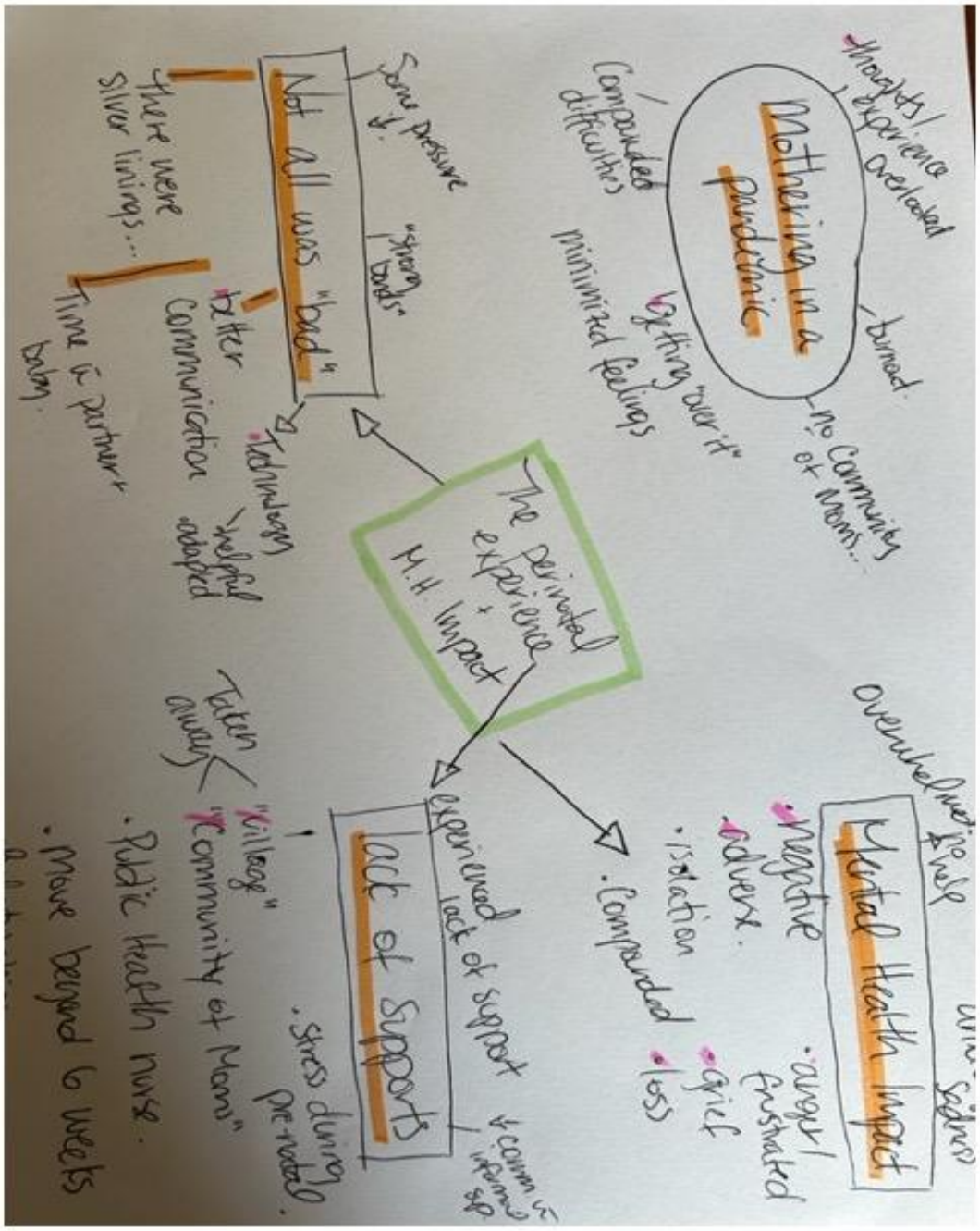
5. How many children do you have? _____

6. Where did you most recently give birth? (Please check which applies)

   Hospital (St. Boniface, HSC Women's Hospital) ___
   Birth Centre ____
   Home Birth ____

7. Did you have the support of a midwife? Yes/No (Please circle)
8. Did you have the support of a doula? Yes/No (Please circle)

Appendix G – Thematic Map



Appendix H – Demographic Table

Participants	Katie	Kayla	Gillian	Chien	Monica	Dawn	Joy	Sam
Age	25-34	25-34	35-44	35-44	35-44	25-34	25-34	25-34
Marital Status	Married	Common-law	Common-law	Common-law	Married	Common-law	Married	Married
Race	Caucasian	Caucasian	Caucasian	East Asian	Caucasian	Caucasian	Caucasian	Caucasian
# Children	1	1	3	1	2	1	1	1
Birth Location	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital
Midwife Support	Yes	No	No	No	No	No	Yes	No
Doula Support	No	No	No	Yes	No	No	No	No