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Perceptions of Postpartum Mothers of Their Experiences as a Patient During COVID-19 Crisis: A Phenomenological Study

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Abstract

Coronavirus disease-2019 (COVID-19) pandemic led to drastic changes in in-hospital healthcare delivery causing major policy and protocol changes regarding labor and delivery and postpartum care of maternity patients. We strove to describe and understand the perceptions of laboring and postpartum mothers' care received through interviews in a hospital during the COVID-19 pandemic. Using a phenomenological study design, we interviewed 13 postpartum mothers. Five major themes and 10 subthemes were extracted. Major themes, both positive and negative, included genuine concern of caregivers, adverse breastfeeding experiences, feeling of being left alone, loss of expectations, and uncertainty. Primipara women had a major impact on their psychological well-being and breastfeeding experiences. Isolation and feelings of left alone adversely affect postpartum mothers' coping, newborn care, bonding, meeting basic needs of sleep and hygiene, breastfeeding experiences, and potential postpartum recovery and psychosocial well-being including fear of future pregnancies. Therefore, "partner presence" throughout the labor and delivery and postpartum period should be a "call to action" for the nurses, especially with first-time mothers.

Keywords

laboring mothers, postpartum, pandemic, COVID-19, breastfeeding

Introduction

As the coronavirus disease-2019 (COVID-19) pandemic surge began in March 2020, healthcare systems everywhere experienced a rapid increase in hospitalized patients diagnosed with COVID-19 because of this severe-acute respiratory syndrome-coronavirus-2 (SARS-CoV-2) infection. As strict infection control and isolation procedures became necessary, women admitted to the labor and delivery (L&D) and postpartum units' experienced unforeseen stress when faced with childbirth given the limited support persons and restricted family involvement. Studies examining the stress levels and coping behaviors of perinatal women during the COVID-19 pandemic are limited (1). In the postpartum period, early discharge protocols for low-risk mothers and newborns were established with suspended hospital visitation, while postpartum women endured separation from their families during the anticipated time of joy and newborn bonding. The prolonged pandemic along with infection prevention control measures could greatly affect maternal mental health, potentially leading to a higher incidence of postpartum depression (2). Examining the experiences of postpartum women hospitalized during the COVID-19 pandemic, the focus of this research is crucial to understanding how changing guidelines and practices affected the care of women and newborns while focusing on establishing best practices.

As pregnancy-related medical care requires continued interaction with the health care system, the COVID-19 pandemic placed pregnant women in a vulnerable position

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exacerbated by the need for self-isolation because of the fear of contracting COVID-19 (1, 3). A mixed methods study was conducted of 162 perinatal women in the US to capture quantitative responses regarding stressors and coping along with qualitative responses about stress and resources during the COVID-19 pandemic (1). The qualitative results identified to support the findings that during the pandemic, perinatal women expressed concerns about significant others missing the newborn delivery, newborns contracting COVID-19, and wanting support from friends and family. The COVID-19 pandemic added a new level of stress for perinatal women, while social distancing measures and the fear of the virus heightened symptoms of anxiety and depression (4). In a cross-sectional observational study, which included 524 pregnant and postpartum US women, women reported feelings of grief regarding the loss of support from family and friends during the labor, delivery, and postpartum periods through the pandemic (5). Pregnant and postpartum women recalled grieving the loss of not having their loved ones present for the birth of their newborns while grieving the loss of pregnancy and postpartum-related resources such as childbirth classes (5). According to Shuman et al. (6) perinatal women require increased support along with additional resources during a healthcare crisis to improve mental health and well-being, especially with specific experiences such as breastfeeding. A cross-sectional design was used to collect survey data from a convenience sample that included 371 participants in the US to conclude that perinatal women are vulnerable to heightened stress induced by the COVID-19 pandemic (6). Experiencing unexpected changes during childbirth may lead to women feeling powerless or uniformed without constant communication and reassurance about the changing circumstances (7). The researchers examined the rates of unexpected birth experiences because of the COVID-19 pandemic and the association with women's postpartum mental health symptoms, including depression, anxiety, and posttraumatic stress disorder (PTSD). They conducted a cross-sectional analysis that included 506 postpartum women who reported birth plan changes attributed to the COVID-19 pandemic. The results disclosed that acknowledging the fear of a contagious virus in the hospital while continuously informing women about plans for ensuring their safety may prevent later mental health symptoms. As postpartum women must acquire new skills such as breastfeeding and newborn care, along with recovering from childbirth, early discharge protocols affected the ability of women to transition quickly into the new parenting role. Two other study results indicated that despite knowledge gaps, expedited postpartum discharges during the COVID-19 pandemic were not associated with increased maternal readmission rates (4, 8). Routine postpartum length of stay provides social and educational benefits for postpartum patients revealed through a retrospective cohort study that evaluated 1358 New York birth hospitalizations comparing births from March 2019 through April 2019 to births from March 2020 through April 2020 (8). Breastfeeding success requires both education and support during the immediate postpartum period. Considering that healthcare practices during the COVID-19 pandemic may have had a negative influence on birth experience, women with poor birth experiences reported lower exclusive breastfeeding rates at discharge and the later postpartum period, along with being more likely to report anxiety, stress, and birth-related PTSD (9). This cross-sectional web survey of 237 women in New York City assessed patient-reported experiences and outcomes during the COVID-19 pandemic after the first wave of infections. The results showed that women who gave birth during the peak of the pandemic, especially Black and Latina who were SARS-CoV-2 positive, experienced lower birth satisfaction and higher perceived healthcare discrimination. The purpose of the study was to gather postpartum women and families' hospital experiences during the COVID-19 pandemic.

Table 1. Inclusion/Exclusion Criteria.

Inclusion	Exclusion
Postpartum mothers Between 18 and 45 years of age Delivered between 20 March and 20 May 2020 Had normal vaginal deliveries Discharged within 36 h of delivery from the hospital English speaking	Postpartum mothers who Are non-English speaking Had cesarean deliveries Had postpartum complications (bleeding) Were discharged after 36 h post-delivery

Methods

Study Design

We used a phenomenological study design with an inductive approach for interpretive analysis. Phenomenology is a philosophical approach, and its research method considers the perspective of the subject. It involves interviewing subjects and uses a step-by-step approach to analyze the interview data. The study received expedited approval from the institution's institutional review board (IRB) for COVID-related studies. The IRB-approved informed consent document described the details of the proposed study, the participant roles, and the possible risk of discussing emotionally upsetting situations.

Sample and Recruitment Procedures

The study team identified potential participants from the institution's postpartum discharge documentation. Mothers who delivered in a quaternary care hospital which was also a major center for COVID-19 patients from 20 March 2020 to 20 May 2020, and met the inclusion criteria (Table 1) were contacted via phone by the co-investigators. A

quaternary care is defined as an extension of tertiary care in reference to advanced levels of medicine that are highly specialized and not widely accessed and offered in a limited number of national or international centers. We used a standard script for recruitment. There were 13 mothers who met the eligibility criteria and volunteered to participate in a 45–60-min interview via Microsoft team audio-video conferencing. The approved consent form was sent to the participants prior to the interview date. At the start of the Microsoft team teleconference, the principal investigator reviewed the consent form with the participants for verbal consent for participation in the study and videoconferencing. The demographics (Table 2) were completed after verbal consent. The study institution is geographically situated in an affluent county location and many of its maternity clients are from well-educated moderate- to high-income backgrounds compared to a standard city hospital. Recruitment ended when themes became redundant. Redundancy means there is repeated information from the interviews with no new information or data retrieved from the interviewees.

Interviewing: Data Collection

The co-investigators reached out by phone to all eligible postpartum mothers ($N = 123$) discharged between 20 March 2020 and 20 May 2020 to recruit study subjects.

Table 2. Participant Characteristics.

Demographic characteristics	*N* (%)	Demographic characteristics	*N* (%)
Age		**Race**	
21–30	7 (54%)	African American or Black	4 (31%)
31–40	6 (46%)	Caucasian or white	6 (46%)
		Hispanic	3 (23%)
Education level		**Infant Feeding**	
Undergraduate degree	8 (62%)	Intent to breastfeed	13 (100%)
Graduate degree	4 (31%)	Successful in breastfeeding	6 (46%)
Doctoral degree	1 (7%)	Unsuccessful in breastfeeding	7 (54%)
Parity		**COVID status**	
First-time mothers (primipara)	3 (24%)	Covid test negative	13 (100%)
Second delivery	5 (38%)	Self-quarantined	13(100%)
Third delivery	5 (38%)	Fear about contracting COVID in hospital	13(100%)
		Fear about infant contracting COVID	8 (62%)
Gestational age		**Marital status**	
>37 weeks	13 (100%)	Married	13 (100%)

Table 3. Themes, Subthemes, Coded Phrases.

Theme	Categories/minor themes	Phrases/quotes
Genuine concern	Felt like a community	Care generally good
	Helpful and encouraging	Did the best under the circumstances
		Was well taken care of
		Everyone was very attentive
		Nurses good, calm, patience, encouraging, holding hand
		Tremendously amazing nurses, fantastic
		Calm and patient
Adverse breastfeeding experiences	Lack of support from lactation consultants	Wished more available support
	Stress related to breastfeeding	Got japed in terms of breastfeeding
		Struggled with breastfeeding
		Never felt so alone struggling to latch my baby
Feeling of left alone	No one to advocate	Emotional and anxious when no husband, family
		Need someone to talk to you and calm you down
	Anxiety and confusion	Very scary being alone
		Conflicting messages from staff
		No staff contact
Loss of expectations	No family in the postpartum unit	Missed my husband and not having any support
	Physical and emotional exhaustion	No one came in with food or gifts
		Could not sleep
		Could not take a shower as the baby was alone in the room
		Horrifying experience, totally robbed the postpartum experiences
Uncertainty	Staff unknown about rules, protocols	Staff scared about the contagion
	Patient lack of information	Protocols kept changing
		No one knew a lot of things
		Nurses hesitant about everything
		Did not know a breast pump was an option

Thirteen mothers who met the inclusion criteria were interviewed for the study. Each interview lasted approximately 40 to 50 min. A mutually agreed-upon time was set wup for the interview. The unstructured interview guide prompted the participants to share their experiences focused on broad open-ended questions. These questions focused on their experiences in the delivery suite as well as the postpartum unit during the initial COVID-19 pandemic wave, from 20 March to 20 May 2020, such as tell me about your experience in "triage area," "delivery suite," "labor time support," "postpartum unit," and "baby care." In addition, we asked questions about their expectations prior to admissions and whether these expectations differed from their actual experiences, and their impact on their physical and/or emotional health after discharge. We continued with recruitment and interviews until redundancy (data saturation) in the subthemes was achieved with the 13th interview. The interviews were conducted within 10 to 18 months after the mother's discharge from the hospital.

Data Analysis

The audiotaped interviews were saved in the primary investigator's locked computer and sent to the institution's approved transcription services, approved by IRB for the protection of human subjects. The transcriptions were then printed for coding by the researchers. We compared the transcripts for themes and followed the steps in coding qualitative research data as per Braun and Clarke's thematic analysis (10). The researchers individually coded all transcripts for discrete codes followed by a discussion with co-investigators to confirm the identified codes. Repeated meetings of the researchers to discuss differences, compare results, and refine the working codebook ensured qualitative rigor and credibility with the coding. In addition, the researchers consulted with qualitative experts for possible different hypotheses of the coded transcripts and resulting themes. After finalizing the coding, the investigators, through multiple discussions and in-depth analysis, identified major and minor themes.

Results

Themes

We identified five major themes supported by minor themes considered categories of the coded phrases. The minor themes including exemplar quotes (phrases that were initially discrete codes) are provided in Table 3. Each of the five major themes is described below.

Genuine Concern

The mothers' experiences reported here are from a representative sample of 13 mothers. At the height of the COVID-19 pandemic, everyone experienced fear and anxiety about the unraveling situation and future uncertainties, these mothers reported a genuinely caring and compassionate team within the L&D suites. Two of the mothers stated that the care they received surpassed previous experiences and expectations. Christine said:

> I could not say enough of how thankful I am for the staff, I was well taken care of, I could not be more pleased with my delivery, every single person I met really made me feel like they cared about me. They were like my family.

Adverse Breastfeeding Experiences

All participants breastfed or attempted to breastfeed their newborns. However, due to social distancing and being alone in the room with no support, and short in-hospital stay after delivery, the mothers expressed concern and frustrations with unsuccessful breastfeeding experiences. Though lactation consultants were available, there was no perception of any support received, as Anna* stated:

> Struggled with breastfeeding, never felt so alone struggling to latch my baby.

Feeling of Left Alone

The 13 mothers interviewed expressed an immense sense of loneliness due to social distancing and COVID-19 infection prevention protocols. They described the feeling of being left alone by their partners, family, and even the caregivers such as nurses and physicians. This feeling led them to anxiety, confusion, sadness, and even a scary feeling to be left alone in a silent room with closed doors with a baby to care for. In addition, all verbalized a feeling of helplessness due to exhaustion after labor and lack of sleep, and inability to care for their newborns as needed/expected. Alina, a second-time mother, explained it this way:

> I really felt like I was left completely alone, I was so exhausted, I was alone, just holding the baby, looking around, like nobody to talk to, it is very sad.

Loss of Expectations

Most of the participants expressed having a sense of isolation after delivery, especially in the postpartum unit as no family was allowed in the unit. All of them verbalized that they were physically and emotionally exhausted after the laboring experience. The expectations of being joyful with a newborn infant, sharing the joy with loved ones, and celebrating the new life and not materializing any of it left the mothers in a state of grieving. They verbalized these losses as traumatic experiences and deviations from their expectations. They were reminiscent of past experiences such as a husband or family members bringing them home-cooked food and

other important aspects of support. Amanda, another primipara, said:

> I am very traumatized by the experience. It was just a horrifying experience: It totally robbed my experience and expectations. Like nobody can come and no one can give you anything. You know and recovering and then not having my husband there and feeling like there was not a ton of support.

Uncertainty

The COVID-19 pandemic significantly impacted and altered the labor and delivery (L&D) and postpartum unit standard policies and protocols such as visitor policies, mask-wearing, and exposure-related safety concerns. These changes drastically affected the L&D postpartum patient expectations and experiences. COVID testing of the mother and her partner prior to admission to the L&D unit and staff fear of contracting the disease expressed as physically and emotionally distancing from the patients until the results are available were some of the concerns verbalized by the participants. Christina who came in for her third delivery stated, "I was in active labor and my admission to the L&D unit was delayed due to the testing protocol, disregarding my physical state." The participants also stated receiving conflicting information about whether husbands were allowed to stay with them in the postpartum unit or whether they could stay more than 24 h in the hospital after delivery. One participant's discharge was delayed because of these confusing messages from the nurses and physicians regarding newborn screening and bilirubin tests. Gowan explained her frustration:

> Staff scared about the contagion, protocols kept changing and no one knew a lot of things.

Discussion

This study was conducted to understand postpartum mothers' experiences in the L&D and postpartum units during the COVID-19 crisis. There is limited research published on perinatal mothers during the COVID-19 crisis. Our themes reflected postpartum mothers' challenges faced before, during, and after giving birth in the hospital. The themes "feeling of left alone" and "loss of expectations" are consistent with other literature that identified pregnant mothers' experiences of self-isolation because of the fear of contracting COVID-19 (1, 3, 5, 6). The feeling of being left alone was based on the social distancing and COVID-19 prevention protocols which restricted partners, family, and medical professionals from supporting the mother during this process. These themes reflected that of another study finding stating anxiety and depression increased due to social distancing (4). However, new findings were uncovered in our study. For example, social distancing measures led to mothers' exhaustion as the family members and the caregivers were not allowed to stay or visit them. Consequently, they may have needed and were expecting more from caregivers whom they perceived were not there to help them in the recovery process and care. This feeling of exhaustion was manifested as helplessness, confusion, sadness, and fear of future pregnancies, especially in primiparous women.

Relationships and people to share postpartum mothers' feelings, experiences and joy play a key role in the mother's perinatal recovery. Not celebrating and sharing the news of the birth of their child felt like a loss for the mother. These are consistent with previous findings (1). The primiparous women especially verbalized a state of grieving and trauma associated with social isolation found in our study. Mothers also felt a cultural loss as they did not receive the expected rest, sleep, attention, help, and food during the COVID-19 crisis. Mothers' descriptions of uncertainty, anxiety, helplessness, frustrations, and concerns that emerged during the L&D and postpartum stay during the COVID-19 crisis can have major consequences. Accumulation of these stressors can be challenging for the mothers after being discharged from the hospital.

One area was their lack of confidence as new mothers in caring for their newborns. This was especially true with first-time mothers. They expressed traumatic feelings of being incompetent as a mother and fear of going through another pregnancy and delivery. They also stated going through a period of depression and seeking care related to their postpartum experiences, especially the intense feelings of isolation and being left alone with newborns. All the participants verbalized the need for support with breastfeeding and newborn care in the postpartum period. Much of this may have been due to the lack of other support systems and thus more reliance on staff for supportive interventions. Even mothers with previous delivery experiences stated the need for some support with self-care, sleep, and even meeting their personal hygienic needs during hospitalization. All of them suggested the difference it could have made if their partners were allowed to stay with them during the immediate postpartum period, especially with all single postpartum rooms.

Yet, all the mothers expressed absolute satisfaction and excellent experiences during delivery with their care providers. In fact, six of the mothers stated that their delivery experiences were better than that of the pre-COVID time. They attributed the experiences to the care and compassion exhibited by the care team, especially the L&D nurses. This shows that under any circumstances, especially during trying times, genuine and compassionate care by the nursing staff promotes patient experiences and satisfaction.

All mothers who participated in the study expressed some negative perceptions about the lactation support they received in the postpartum period. Again, their expectations especially being first-time mothers, and the normal anxiety with the current situation may have greatly influenced and dictated their perceptions. Though lactation consultants were available, participants perceived what they considered not enough or adequate support. Because this study was

focused on patient perceptions, these perceptions of course were not validated by the staff. It may have again been that expectations and fears about lactation especially for first-time mothers coupled with the lack of overall support from partners and families and the ever-changing nursing pandemic guidelines may have influenced these views.

Hands-on, one-on-one lactation support is essential for postpartum mothers who intend to breastfeed. Nurses are the key advocates for breastfeeding promotion to support individual mothers' personal breastfeeding goals. Other literature has emphasized that this is one facet the nursing staff could focus upon to improve the postpartum mothers' hospital experiences and satisfaction (11, 12).

*Not real names of participants.

Conclusion

Postpartum mothers' feelings of being left alone adversely affected their postpartum coping, newborn care, potential postpartum recovery, and psychosocial well-being including fear of future pregnancies. Therefore, "partner presence" throughout the L&D and postpartum period needs to be considered, especially with first-time mothers. All study participants expected nurses to have up-to-date information on changing protocols, policies, and guidelines, both internal and external to get better prepared for what to expect. However, the mothers felt that nurses were not well informed and had conflicting information provided to them which increased their anxiety and stress. Especially during a pandemic, when everyone is in a heightened stress mode, nurses have a responsibility to provide clear, timely, effective, and accurate information and support as anticipatory guidance to decrease stress and anxiety.

Author Contributions

AJ conceived the idea and designed the study, analyzed the data, wrote the manuscript. TT identified and contacted the potential study subjects, sorted and extracted themes, analyzed the data and co-wrote the manuscript. JA identified and contacted the potential study subjects, wrote the literature review and formatted the reference list. AJ, TT, and JA reviewed the manuscript, finalized the themes and categories.

Declaration of Conflicting Interests

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Ethical Approval

This study was approved by the institution's IRB, the consortium for COVID-related research, and Institutional approval IRB No. 20-0801.

Statement of Human and Animal Rights

The study was conducted according to the guidelines of the Declaration of Helsinki and all procedures in this study were conducted in accordance with the IRB.

Informed Consent

Verbal informed consent was obtained from the patients for their anonymized information to be published in this article.

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