Experiences of Social Isolation for First-Time Mothers with Pre-existing Anxiety During the COVID-19 Pandemic: An Interpretative Phenomenological Approach

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Abstract: This study aimed to explore experiences of social isolation for first-time UK mothers with pre-existing anxiety during the COVID-19 pandemic. Six interviews were completed between July-November 2021. Interpretative Phenomenological Analysis revealed four superordinate and twelve subordinate themes reflecting experiences of new motherhood and social isolation during the COVID-19 pandemic, and their influence on mental health, coping and accessing support. Findings contribute to the understanding of the experiences of this population during/beyond pandemic restrictions, with implications for how gestational parents are supported in the aftermath of the pandemic and similar future crises.
Keywords: mother, social isolation, COVID-19, anxiety, mental health

COVID-19 reached pandemic status in March 2020 (World Health Organization [WHO], 2020). On March 26, 2020, the first UK lockdown was implemented, and people were required to remain at home except for essential purposes. Preventative measures were adopted to reduce viral transmission, including social distancing, bans/limits on social gatherings, and travel restrictions (UK Parliament, 2021). Social restrictions varied over time across the UK and continued until the roll-out of the COVID-19 vaccination program. UK citizens faced greater social isolation under these restrictions. Social isolation, defined as "an objective lack of interactions with others or the wider community," has been associated with higher levels of depression, suicidality, mortality, and long-term physical health conditions (Leigh-Hunt et al., 2017, p.158). A

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review investigating viral epidemics demonstrated associations between quarantine measures and poor mental health, prompting warnings that the impact of social restrictions could be far-reaching and long-lasting (Brooks et al., 2020a), particularly for vulnerable populations.

The perinatal period is a vulnerable time, with one in five mothers experiencing mental health difficulties (Mental Health Taskforce, 2016). First-time motherhood has been described as "unfamiliar territory" requiring mentorship and support (Darvill et al., 2010, p.360), and risks to mental health may be greater for first-time mothers (Martínez-Galiano et al., 2019). Anxiety-related difficulties have demonstrated the highest prevalence of lifetime mental health difficulties (28.8%) (Kessler et al., 2005). In perinatal samples, a review of the literature investigating the prevalence of perinatal anxiety found that 2.6-39% of mothers demonstrate an anxiety disorder, with those experiencing socioeconomic, relationship, and historical mental health difficulties at greater risk (Leach et al., 2017). Social support is protective against the impact of stressors, perinatal distress, and managing the maternal transition (Glazier et al., 2004; Cree, 2015). However, during COVID-19 restrictions, UK gestational parents could not access support systems in person. The impact of such on new mothers was therefore highlighted as an area of concern (Brooks et al., 2020b; Halvorsen et al., 2020; Thapa et al., 2020; Topalidou et al., 2020), prompting clinical and epidemiological research worldwide.

Recent literature reviews have demonstrated increased anxiety and depression in gestational parents during the pandemic (Hessami et al., 2020; Iyengar et al., 2021; Shorey et al., 2021; Suwalska et al., 2021); notably, most studies investigated symptom prevalence and pre- and post-pandemic symptom change in pregnant women, with few studies conducted in the UK. Risk factors associated with anxiety and mood-related difficulties were being a younger, single mother, experiencing financial strain, social isolation, changes to perinatal care, family/relationship conflict, and mental health difficulties which pre-existed the pandemic (Iyengar et al., 2021; Suwalska et al., 2021). A recent US study found that perinatal women with pre-existing mental health diagnoses were 1.6-3.7 times more likely than those without to report significant symptoms of anxiety, depression, and PTSD (Liu et al., 2021). Similarly, a cross-sectional UK study investigating postnatal women during the first lockdown found significant increases in anxiety (61%) and depression (43%) when compared to self-reported diagnoses (anxiety18.4%; depression11.4%) and pre-pandemic levels (anxiety13.7%; depression16%) (Fallon et al., 2021).

Such findings suggest that perinatal women with pre-existing mental health difficulties were particularly vulnerable during the pandemic. However, qualitative studies exploring perceptions of and meaning

attributed to these experiences are limited. Recent qualitative and mixed-methods studies investigating community samples of perinatal women demonstrated blessings and curses associated with the pandemic (Joy et al., 2020), increased anxiety and psychological distress (Chivers et al., 2020; Güner & Oztürk, 2021; Kumari et al., 2021; Rice et al., 2021), isolation and needing social support (Güner & Oztürk, 2021; Kumari et al., 2021; Sweet et al., 2021), negative postnatal hospital experiences, breastfeeding difficulties, breaking restrictions to seek support (Rice et al., 2021), concerns about a lack of maternal/infant socialization (Ollivier et al., 2021), varied coping experiences (Güner & Oztürk, 2021; Kumari et al., 2021), and multiple barriers to healthcare (Güner & Oztürk, 2021; Karavadra et al., 2020).

Qualitative investigations of perinatal women with pre-existing mental health difficulties are limited. Anderson et al. (2022) used mixed-methods to examine perinatal women with histories of depression in the US and found that 76.6% reported a worsening of existing difficulties, often attributed to disrupted coping resources. In a sample of perinatal women in Pakistan, Rauf et al. (2021) found that pre-existing anxiety increased with themes linking anxiety to greater financial difficulties, reduced access to healthcare, reduced trust in health professionals, and fear for their own/their baby's safety. These studies largely captured early pandemic experiences. The impact of prolonged socially restrictive measures on new UK mothers with pre-existing mental health difficulties is therefore unclear.

Rationale and Aims

Perinatal distress can significantly impact maternal and family well-being (Royal College of General Practitioners, 2016) and child outcomes (Glasheen et al., 2010; Rees et al., 2019). Exposure to crises such as COVID-19 threatens child development and maternal mental health (Venta et al., 2021). Evidence suggests outcomes may be worse for children with highly distressed caregivers (Köhler-Dauner et al., 2021; Russell et al., 2020). Research investigating perinatal experiences during COVID-19 has emerged at a rapid pace. However, acute and delayed effects on mental health are likely (Iyengar et al., 2021), which will vary between groups and over time (Kumari et al., 2021). The changing situation globally emphasizes the continued need to understand how COVID-19 affected mothers. Given the context described above, along with the dearth of qualitative research investigating new mothers with pre-existing anxiety, there is a need for further research to better understand maternal experiences. Therefore, this study aims to qualitatively explore experiences of social isolation and early motherhood during the COVID-

19 pandemic for perinatal first-time UK mothers (specifically within the first 12 months post-partum; Public Health England, 2019) with pre-existing anxiety.

Research Question

How did first-time UK mothers with pre-existing anxiety experience greater social isolation during the COVID-19 pandemic?

Method

Ethics

Approval was granted by Staffordshire University Ethics Committee. Issues of informed consent, confidentiality, and safeguarding/risk management were considered throughout. Participants were informed of the potential for distress and reminded of their right to pause interviews, decline to answer, or withdraw. Some participants became tearful during interviews while sharing emotional experiences. Participants were supported, and all were willing to proceed. No negative effects were reported. Participants were debriefed and signposted to support agencies. Participants and family members were assigned pseudonyms to ensure anonymity.

Design

Due to the under-researched, exploratory nature of the research question, a qualitative design was justified to gather detailed experiential accounts. Interpretative Phenomenological Analysis (IPA) seeks to explore how individuals make sense of and develop meaning from experiences (Smith et al., 2009). IPA draws upon theoretical principles of phenomenology (the study of lived experience), hermeneutics (a theory of interpretation), and ideography (in-depth examination of the particular) (Pietkiewicz & Smith, 2014). IPA was selected over other phenomenological approaches, such as Thematic Analysis, due to its focus on investigating individual lived experiences first before looking at similarities and differences, and producing more general claims.

Recruitment

Recruitment took place from June-December 2021. All interviews were completed after July 19, 2021, when most UK restrictions had been lifted (Cabinet Office, 2021). Due to COVID-19 restrictions, participants were largely recruited via an advertisement on parenting and maternal mental health websites, forums, and social media platforms. An

advertisement was also shared in a mother and baby group, and snowball sampling was employed. Mothers who registered their interest via email were provided with the participant information sheet and encouraged to ask questions. Eligible participants signed and returned a consent form and demographics questionnaire via email. Three mothers with young children were consulted on these materials.

Sampling and Participants

Based on guidelines for doctoral research, a sample between four-ten participants/interviews was appropriate (Smith et al., 2009; Turpin et al., 1997, as cited in Pietkiewicz & Smith, 2014). Mothers were eligible if they met pre-defined criteria (table 1). Approximately half of perinatal anxiety cases go undetected (Bauer et al., 2014), suggesting many women would be missed by limiting inclusion criteria to those diagnosed with anxiety disorder. This study, therefore, focused on first-time mothers with self-identified anxiety prior to the COVID-19 pandemic, which would be considered clinically relevant due to its impact on distress or functioning. Self-identified anxiety was operationalized based on DSM-V (American Psychiatric Association, 2013) and ICD-11 (WHO, 2018) criteria for anxiety disorders. Due to global variations in COVID-19, this study sought to investigate UK mothers only. Participants were excluded if they could not speak English, were aged under 18, did not have access to an internet-connected phone or device, required shielding (populations who were considered vulnerable due to pre-existing health conditions), or were experiencing a mental health crisis/accessing mental health services due to the potential for increased distress.

Fourteen mothers across the UK enquired about participation. Four did not meet the inclusion criteria. Three met the inclusion criteria, although they did not return a consent form or respond to follow-up emails. Seven completed and returned consent forms. One participant opted out of participation prior to the interview due to a change of personal circumstances. Six mothers aged 28-36 years participated, with children aged 18-25 months. All participants identified as White British and lived across England. Four participants were employed and working at the time of interview. Participants' educational levels ranged from A-Level/NVQ to Post-graduate degrees. Participants described varied living circumstances though most lived with their partner and baby for most pandemic restrictions (table 2). All participants commented during interviews that they had previously accessed mental health services/therapies.

Procedure

A semi-structured interview schedule was developed based on IPA guidelines (Smith et al., 2009). One mother was consulted on the interview schedule to promote accessibility. Due to pandemic-related working practices, interviews were conducted via video call. A flexible interview style and person-centered approach allowed the exploration of unexpected ideas brought by participants. Interviews lasted an average of 91 minutes and were recorded and transcribed. A verbal and written debrief was provided to each participant.

Analysis

Analysis was conducted based on IPA guidance (Smith et al., 2009). Multiple transcript readings facilitated becoming immersed in the data. Descriptive, linguistic, and conceptual comments were completed for each transcript, and emergent themes were developed. A mapping process to search for connections across emergent themes was conducted, and superordinate themes were identified for each participant. Figures representing superordinate themes facilitated searching for patterns across cases, and recurrent superordinate themes were identified at a group level. During this process higher-order superordinate themes were developed to reflect main themes across cases, and group level superordinate themes were relabeled subordinate themes. Final superordinate and subordinate themes were compiled into tables, including quotes.

Reflexivity and Epistemology

The researcher was guided by social constructivism, which seeks to understand individuals' subjective meanings towards specific objects/experiences (Creswell & Poth, 2016). This position argues that knowledge and meaning are specific to personal, historical, and cultural contexts and develop through interactions between individuals, objects, and their environments (Kim, 2014; Taylor, 2018). Consistent with IPA and the double hermeneutic process, social constructivism emphasizes that knowledge acquired from research is constructed by all those involved – the researcher cannot be independent of research findings (Mertens, 2014).

Reflexivity is important to consider as research findings are a product of the researcher's sense-making of the participants' sense-making. The researcher is a White British female who shared personal characteristics with participants, had clinical knowledge of anxiety presentations and

parenting experiences, and lived through COVID-19. Although not a parent, the researcher knew mothers with young children and was therefore aware of possible challenges of the target population. Notably, this influenced the researchers' focus when designing this study, which meant that other parents were inadvertently excluded. These factors increase the likelihood of assumptions being made during interviews and analysis, and a reflexive process was required to maintain awareness of personal biases (Smith et al., 2009). For example, the researcher was aware of their own experiences related to pandemic isolation and attempted to bracket initial thoughts via a research diary and supervision. This facilitated reflection on the researcher's thoughts and emotional experiences before and during data collection and analysis and was important to refer back to when interpreting participants' sense-making.

Results

Analysis revealed four superordinate and twelve subordinate themes at a group level (table 3), reflecting early motherhood experiences and social isolation during the COVID-19 pandemic, and their influence on mental health, coping, and accessing support.

Theme 1: The transition to motherhood: "It takes a village to raise a child." (Anna)

Before COVID-19 new motherhood was expected to be a busy, sociable time. The lost opportunity to form a village, from which participants could access support, understanding, and bond with their baby, suggested an impacted and delayed social-emotional transition to a mother-self. Participants continued to feel isolated beyond social restrictions.

"Bonding was difficult." (Faye)

Participants reported that a loss of support from personal and professional networks led to difficulties such as reduced tolerance, low mood, difficulties breastfeeding, feeling “burnt out” (Danielle, line 1212), and constantly busy, impacting bonding experiences and feelings towards baby: "It's impacted on my feelings towards Benji…I think I just like lost tolerance…my tolerance and patience for him was in my boots" (Anna, line 1287-1293). For some, these difficulties added to existing bonding difficulties (for example, associated with complicated or traumatic births) and may have disrupted attachment processes: "I was already challenged to begin with. So bonding was difficult" (Faye, line 879-880).

Several participants referred to missed opportunities to bond with their baby, with and via others in contexts associated with early motherhood, where mothers could interact and receive feedback and reassurance: "From a social perspective, I feel like I've missed out on kind of bonding with Fern through doing that kind of thing [mother and baby groups/activities]" (Emma, line 45-46). Bonding and attachment development was discussed in part as a social process, not only between mother-baby, but between mother-baby-other: "I felt more connected to him and more like a mom when I was able to put him in the settings that mums put them in" (Danielle, line 1304-1305).

Becky and Emma described positive perceptions of partner support which appeared to protect bonding and attachment processes, suggesting supportive partners fulfilled the role of other. In contrast, Anna described a less supportive partner relationship and discussed greater difficulties: "I was stuck at home. Didn't have anywhere to go with an angry baby. Didn't really feel supported or understood by my husband" (Anna, line 189-190). Since restrictions were lifted, mother-baby relationships were generally described positively, further suggesting the importance of maternal social connection in the bonding and attachment process.

"No one knew or understood what I was going through." (Anna)

Most participants described an unmet need for others who understood their experiences of being a new mother, experiencing anxiety, and feeling isolated: "My husband has been absolutely wonderful. But, he's not a first-time mom…my mom at one point was a first-time mom, so she understands some of it, obviously, not from the point of view of a pandemic" (Emma, line 553-557). A belief that only other pandemic mothers could understand was common, although access to other mothers was limited, maintaining a sense of psychological and emotional isolation: "It takes a village to raise a child; I feel like this is unprecedented like no one else had to raise babies like this before" (Anna, line 254-256).

This lack of understanding triggered tension within participants' relationships, maintaining emotional difficulties. Those who did access other parents via support groups prior to and during the pandemic described "solace" (Danielle, line 1377) and emotional understanding from these encounters and difficulties when support was lost: "Because that all stopped [face-to-face parent mental health group] I didn't have anyone else to talk to that understood…that had quite a big impact on me" (Faye, line 621-626).

"I missed the boat." (Caroline)

Four participants described continuing to feel isolated despite the removal of most social restrictions, associated with beliefs that missed opportunities to form connections with other mothers maintained feelings of isolation and loneliness: "To this day I still feel a bit lonely…I don't have any sort of groups of mom friends or anything that I've met through any activities" (Emma, line 38-43). For Danielle, these feelings were surprising as this was counter to her expectation that feelings of isolation would resolve once restrictions had lifted: "I built it up in my head that, oh, at least when restrictions are lifted, things would be different" (Danielle, line 117-118). Many discussed feeling unsure of how to form support networks at this later stage of motherhood due to returning to work or anticipating difficulties socializing with a toddler compared to a young baby: "They've got little tiny babies like six months old and I've got a rampaging toddler and that's not–necessarily going to fit in. So I kind of feel like I missed the boat on that" (Caroline, line 947-949). This subordinate theme suggests the development of a belief that a key social-developmental task (forming connections with other mothers) as a new mother was missed and maintained isolation.

Theme 2: Physical proximity matters: "We were left on our own." (Caroline)

A lack of physical proximity to a village was challenging, and remote contact did not meet needs sufficiently. Physical separation from professional support triggered feelings of abandonment.

"I'm just much better with face-to-face interactions." (Anna)

All participants described an unmet need for physical proximity to others, not only to access practical support, but to form meaningful relationships, feel comforted, and contribute to an internal sense of security: "The inability to see people in person…you could never feel like 100% comfortable with things as, as you would have done" (Emma, line 773-779). A lack of physical proximity increased anxiety for many due to a lack of comfort and reassurance. Caroline discussed this in the context of developing confidence as a new mother, suggesting that proximity to knowledgeable and trusted others was important to developing maternal self-efficacy.

> You know you have like microaggressions? It's sort of the opposite. Sort of micropositives. Like just being told at various times. Little

> things like, oh no, he looks fine. Oh no, you're doing it right-like just lots of little like reassurances that will build your confidence. (Caroline, line 212-216)

Without physical proximity, all participants accessed personal and professional support remotely (video or phone call and instant messaging). However, this was often described as not meeting needs in the same way as face-to-face contact, leading to increased anxiety and distress for some. For example, Faye described concerns regarding privacy due to not knowing who might read messages or overhear conversations within her home, which meant that she withheld emotional experiences or felt anxious when sharing: "Because I didn't talk to anyone about it, and I didn't feel comfortable putting it in Messenger. I just overreacted with everything" (Faye, line 546-548). Anna described herself as "not great with technology" (line 519) and experienced greater anxiety when accessing support online, meaning she struggled to access some of the main sources of support open to her: "[I] don't like social media–it's not good for me…It becomes a bit overwhelming…I knew that there was support online, but it wasn't really working for me" (Anna, line 87-92).

"I just felt kind of abandoned." (Caroline)

Whilst acknowledging the strains upon health services, five participants described feeling first-time parents were not a priority to policy makers and/or healthcare professionals: "I had all the common warning signs without a pandemic that I probably would struggle, like anxiety during pregnancy, traumatic awful labor, not a huge support network and like there wasn't–no one seemed to care" (Becky, line 1565-1569). This triggered a sense of abandonment, often associated with limited access to, and a lack of confidence in virtual health appointments.

Notably, for some this resulted in unconscious disengagement from professional support, due to developing beliefs that professionals were unable to offer new mothers the kind of support they needed, or that they should be able to cope alone.

> I almost kind of felt like I was on my own. I mean, I know that if I really, really struggled and was really, really in need of support, the support was there. But it was never, it was never in person. (Emma, line 314-317)

This perception of abandoning healthcare may have increased the vulnerability of an already vulnerable group of mothers, maintaining isolation from support and exacerbating distress. For Danielle this continued to impact her in the present: "It kinda has created this idea in

my head that–it's my problem. Uhm, that I need to suck it up…it all has probably made me less open for help" (Danielle, line 968-974). This indicates a rupture in her relationship to help-seeking, leaving her feeling "let down" (line 1391) and as though "mums fell through the cracks during that year" (line 183-184).

Theme 3: More than the usual emotional experience: "Mentally I was worse off than I would have been." (Faye)

Participants discussed difficulties with their mental health beyond pre-existing anxiety during and since social restrictions, expressing beliefs that their mental health had worsened due to increased isolation. A process of comparing experiences with what had been expected from motherhood was associated with many of these difficulties: "I think that's kind of why I got that–kind of really bad mental state because I couldn't manage my expectations" (Danielle, line 300-301).

"A whole layer of other things to worry about." (Emma)

Four participants discussed significant anxiety during pregnancy, often associated with fears of causing unintentional harm to their baby. For Becky, this meant she engaged in protective behaviors to reduce the risk of illness well before COVID-19: "I was living almost like how…they were telling you to live, like before the pandemic started" (Becky, line 1016-1017). Four participants described difficulties tolerating uncertainty related to COVID-19 and their new mother role. For some, isolation from experienced, reassuring others exacerbated uncertainty and anxiety, and impacted maternal confidence due to underlying fears of getting things wrong or causing unintentional harm to their baby: "that [anxiety/fear of harm] was exacerbated in lockdown because I was on my own so I didn't even have someone that could come in and save the day if I made the wrong call" (Danielle, line 806-808).

During their first year of motherhood, all participants expressed beliefs that the pandemic brought many additional worries, describing significantly heightened anxiety characterized by worry and/or panic related to themselves or their baby catching COVID-19: "worrying about COVID, worrying about Fern getting COVID or getting ill generally…that was what was causing me to feel panicky and overwhelmed" (Emma, line 1077-1079). The strongest theme within participants' worries focused on if/how social isolation would impact baby's social skills and development. Ruminating on uncertainty regarding normal development or the future impact of isolation on children was common: "Anxiety wise I was thinking my child's gonna end up being a recluse…Like, she's gonna be scared

of people" (Faye, line 191-194). Half of participants believed social isolation had impacted/was continuing to impact their child, with children described as more wary, fearful, and anxious in new situations or with new people. Remaining participants expressed worry about delayed/future impacts of isolation on their children they feared were yet to manifest: "I worry that in a few years' time you will be able to really tell that that's impacted him" (Danielle, line 1135-1136).

Additionally, Anna, Becky and Emma discussed worrying about the impact that their anxiety and/or low mood was having on their child, which in turn increased anxiety.

> The lack of socialization for, for myself, would have on her–as well as the lack of socialization for her because I was worried that my anxiety, that she'd pick up on my anxiety as well. So that kind of made me more anxious. (Emma, line 88-91)

For Becky, whilst anxiety had subsided with the lifting of social gathering restrictions, she anticipated a need for future therapeutic/emotional support following her experience of isolation: "there will be points in the future where I probably do seek help again or, you know how I was planning another baby, it would be something I would be very forthcoming with to like my midwives" (Becky, line 1292-1295).

"There will always be part of me that kind of grieves for that first year." (Danielle)

All participants experienced relational and experiential losses, for themselves, their baby, and wider support networks. Themes within these losses related to a loss of time, making memories with friends and family, developing new/existing relationships, attending mother and baby groups, and experiential firsts (for example, taking baby swimming). While most participants acknowledged the reality of motherhood was unlikely to meet their expectations, participants conveyed emotions which surpassed sadness and disappointment. Becky, Caroline, and Danielle directly likened their experience to "grief" or "mourning": "There will always be part of me that kind of grieves for that first year-I know it would never be what you would think it will be like anyway, but I really feel like I missed out" (Danielle, line 1182-1185). Participants discussed emotional and cognitive processes including anger, sadness, rumination, and acceptance of/difficulty accepting losses, highlighting the impact of these losses: "I was really like angry and resentful that I didn't get to have the experience that I thought I would" (Emma, line 123-124).

"I feel very stuck in everything that was." (Anna)

All participants described low mood associated with isolation; some participants had been diagnosed with postnatal depression during the pandemic. A loss of coping strategies, relational/experiential losses, high levels of anxiety, and sleep difficulties were some of the factors directly linked to low mood: "It [anxiety/panic] was only really kind of exacerbated and got into these quite low, intense feelings when it was lockdown with Ethan" (Danielle, line 859-861).

Cognitive processes associated with anxiety and depression were apparent for all participants and appeared to be exacerbated by social isolation. Self-attacking thoughts and self-blame often followed the loss of developmental/experiential opportunities for their children, or difficulties in coping with isolated parenting: "I was kind of beating myself up and thinking I wasn't coping, people should be able to do this" (Danielle, line 336-343). These were reflected in perceptions of parenting failure, feelings of guilt, and low mood. This suggests that mothers placed the same/similar expectations on themselves as they would have done in non-pandemic times, and the inability to meet these expectations prompted self-blame and self-attack: "I blame myself a little bit for it. But it wasn't my fault. It wasn't my blame to carry because I couldn't have taken her swimming" (Faye, line 811-813).

For some, difficulties extended beyond social restrictions; participants engaged in ruminative thinking during/since pandemic restrictions, often focused on comparing their motherhood experience with how they imagined things might have been in "normal times" (Anna, line 515), suggesting that grief associated with social isolation may be maintaining low mood.

> I feel very stuck in everything that was and the isolation stuff, I feel very stuck in it and I need to just kind of shake out of it and just find a different way for me and Benji. (Anna, line 1077-1079)

"I shouldn't have the right to feel isolated." (Faye)

Associated with feelings of guilt and self-attack, five participants minimized feelings during interviews suggesting certain feelings/experiences were believed to be disallowed and were internally invalidated; this was perhaps associated with beliefs of not being worthy enough of voicing such difficulties.

> I kind of felt quite selfish for feeling so isolated when I felt like I shouldn't have the right to feel isolated…I was lucky with the fact that I did have like other people around to help me. But then at the same time, I did feel very isolated. And then I felt guilty for feeling isolated. (Faye, line 419-424)

For Anna it seemed this process prevented her from accessing professional support, indicating a maintaining factor for her difficulties: "Any support that they were giving I felt that maybe should be given to those you know, were really in need" (Anna, line 868-870).

"It's taking a bit longer to adjust to a non-pandemic world." (Becky)

All participants experienced fluctuations in their mental health associated with changes in social restrictions. Whilst removal of social restrictions meant greater access to support, it did not mean a steady improvement in mental health, as participants described a difficult adjustment "to a non-pandemic world" (Becky, line 102). Anna, Becky, Caroline, and Emma described a social-emotional dilemma associated with easing restrictions, whereby their need to be around others conflicted with heightened anxiety in social situations, related to fears of being judged as a mother, of others breaking social restrictions, and of catching COVID-19. This posed challenges, maintaining isolation and distress:

> You were in a lose situation–you were either doing something dangerous or illegal, or you were doing something that might cause more anxiety. (Becky, line 348-350)

Furthermore, developmental tasks as a new mother were delayed by social restrictions, such as going out and socializing with a baby and attempting to resume personal interests. The lifting of restrictions meant having to learn and navigate these processes at a later stage with an older child, which increased anxiety and impacted confidence: "Everything stopped, and I never took my baby out very far, and then suddenly everything was on again, and I just was scrambling around saying I physically can't do this" (Caroline, line 758-760). For Anna, maternal social skills were felt to be impacted beyond social restrictions, further suggesting isolation may have impacted/delayed parental self-efficacy and feeling secure within a mother self: "The restrictions still very much are having an impact…I didn't know and still don't really know how to socialize with Benji by my side" (Anna, line 762-763).

Theme 4: Coping counts: "I tried to cope" (Caroline)

All participants discussed making active efforts to cope with challenges associated with isolation, though they encountered difficulties in coping.

An "illusion of coping." (Danielle)

Five participants expressed not coping well with anxiety and distress associated with social isolation. This finding conflicted with narratives highlighting varied coping strategies, suggesting participants lacked coping self-efficacy. Problem-focused coping methods were most commonly reported, including active efforts to keep busy, problem-solve, establish social connection remotely, seek advice, communicate needs with partners, and "bending the rules" (Faye, line 777-778) to maintain proximity to support: "I was really concerned about my mental health. So I was trying to actively take steps to make sure that I was engaged and I was getting feedback" (Caroline, line 115-117). As all participants experienced historical difficulties with anxiety, many discussed previously learned emotion-focused coping strategies they utilized (mindfulness, accessing the outdoors, exercise, etc.), which may have reduced their vulnerability to social isolation: "There was a point where I was starting to feel it [anxiety/panic] coming in…at that point I went through about a month of just like, walking Benji for every nap" (Anna, line 954-958).

Anna, Danielle, and Caroline engaged in coping strategies (emotional avoidance/denial and overfilling schedules) with unintended consequences. Danielle described her emotional denial building to the point that she began self-harming and experiencing suicidal thoughts, which led her to seek help.

> This kind of illusion of coping that I was kind of creating to convince myself that I was OK. So, I think the impact it had was that it took a lot longer for me to realize that I needed help. (Danielle, line 571-574)

As suggested by Danielle, conflicting narratives, including perceptions of not coping well while discussing a range of coping behaviors, may suggest that for some, difficulties coping may have outwardly presented like effective coping, leading to suicidal ideation in this case.

"If I hadn't been proactive…" (Becky)

Becky, Caroline, Danielle, and Faye accessed psychological support/therapies during pandemic restrictions which facilitated coping, including CBT, EMDR, and "talking therapy" (Becky, line 1265) via perinatal mental health teams, crisis teams and privately funded therapy: "It was a massive help to be able to speak to someone, like a professional that understood" (Faye, line 1221-1222).

Although therapy was helpful once completed, Becky and Danielle described having to be highly proactive at times of distress to access support and navigate self-referral procedures: "If I hadn't been proactive, even like I did seek mental health support like during the pandemic and I had to self-refer myself, and I had to-I had to do everything myself" (Becky, line 772-775). Further difficulties impacted the perceived helpfulness of therapy due to approaches not being tailored to new mothers in the context of pandemic isolation, therapy provision not accommodating working mothers, and heightened anxiety accessing online therapy associated with privacy concerns and use of technology: "It would give me anxiety, the thought of having to do the video call. So I'd kind of I'd send myself spiraling before I even got to talking" (Faye, line 521-522).

Discussion

Expectations of the first maternal year being a busy, sociable time were prominent, reflecting unmet hopes to form a village (Babetin, 2020). Although expectations of normal early motherhood varied for all involved (the researcher and participants), comparisons of maternal experiences to normal motherhood ran through participant narratives. In contrast to Jackson et al. (2021b), who identified improved well-being with easing restrictions in a UK perinatal community sample, participants described difficulties adjusting out of social restrictions associated with increased anxiety and unpracticed parental skills. Continued isolation beyond social restrictions suggests some participants lacked a psychologically supportive environment within their mother self (Babetin, 2020), impacting maternal self-efficacy and indicating an impacted or perhaps delayed maternal transition. This finding further suggests that participants held expectations of what they should be able to do at certain stages of motherhood and when it is acceptable and possible to form connections with other mothers.

As recently indicated (Güner & Oztürk, 2021; Jackson et al., 2021a), positive perceptions of partner support protected bonding experiences and maternal well-being. Consistent with research linking greater perceptions of social support to improved maternal responsiveness (Burchinal et al.,

1996) and mother-child interactions (Green et al., 2007), participants described isolation from support as impacting on mood, tolerance, and ability to manage household and parenting demands, which in turn contributed to bonding difficulties. These findings may be understood from an evolutionary perspective, which theorizes that humans have evolved to depend on others for survival. Heightened anxiety, vigilance to threat, and proximity to others were necessary to promote internal and external safety conditions to enable mother-infant bonding (Cree, 2015). From an anthropological perspective, mothers across cultures sharing their baby with others serves adaptive functions: signaling to the support network that she and her baby will need help and bonding others to her baby to secure support and safety, meaning maternal resources can be focused on nourishing and bonding with baby (Blaffer-Hrdy, 2009).

Consistent with these ideas and social constructivism, this helps to understand why bonding in this context was challenging, as participants described an unmet need for bonding (mother-baby) to be achieved in completion with and via others (mother-baby-others) in settings associated with early motherhood. Despite challenges, participants demonstrated resilience and overall described experiencing improved mother-baby relationships with greater access to support. However, challenges to bonding and maternal mental health suggest that children of mothers with pre-existing anxiety during pandemic isolation may be at greater risk long-term of poorer emotional and developmental outcomes (Winston & Chicot, 2016), particularly where mothers continued to feel isolated or were less well-resourced (Singh et al., 2021).

In anticipation of difficulties associated with new motherhood and reflective of the protective effects of postnatal support groups (Seymour-Smith et al., 2017; Sikorski et al., 2018), some participants discussed planning to participate in mother-baby/parent groups prior to the pandemic to support their mental health. Consistent with recent qualitative research investigating perinatal women's pandemic-related experiences (Jackson et al., 2021b; Chivers et al., 2020), feelings of grief for the loss of opportunities to engage in mother-baby groups, activities to promote bonding/development, and to form memories with family and hoped-for friends were prominent.

Consistent with a recent study of minority ethnic mothers in London (Pilav et al., 2022), participants expressed preferences for face-to-face contact with personal and professional support systems. In the absence of face-to-face contact, remote contact was maintained to varying degrees which often reduced the perceived quality of support or even prevented seeking support due to heightened anxiety. Interestingly, a national UK study highlighted that women who had babies before the first lockdown reported significantly less contact with health professionals and support

groups than women who had babies during the lockdown (Vazquez-Vazquez et al., 2021), suggesting that professionals prioritized women who became mothers during the pandemic. In line with this finding, a sense of abandonment by health professionals was described by mothers in the present study, corroborating research in community samples of perinatal women (Jackson et al., 2021b; Ollivier et al., 2021), where loss of General Practitioner (Janjua et al., 2021) and feeding support (Vazquez-Vazquez et al., 2021) were particularly challenging. These findings can be understood using Attachment Theory, which posits that a secure base from a caregiver via proximity and consistent responsivity is required to develop an internal sense of security, without which insecurity, anxiety, and fearful behavior can manifest (Bowlby, 2012; Cree, 2015). Isolation from professional support, therefore, may have triggered an attachment response in mothers during this vulnerable period, further impacting maternal confidence and anxiety.

Consistent with quantitative literature (Fallon et al., 2021; Liu et al., 2021), participants described significantly heightened anxiety, often followed by low mood/depression associated with social isolation and losses/grief. Self-attacking thoughts were reflected in perceptions of maternal failure and poor coping, which impacted maternal self-efficacy. In practical terms, participants described many forms of coping, suggesting the gap between perceptions of not coping and active coping behavior is where self-attack, followed by increased anxiety and low mood, may have developed. In Italian parents, greater parental self-efficacy during pandemic restrictions was associated with greater well-being and effective emotional regulation in their children (Morelli et al., 2020). These findings suggest that the experience of self-attacking thoughts, thoughts of failure, and impacted parental self-efficacy may be risk factors, increasing the vulnerability of mothers and their children.

These findings are consistent with recent research, which found repetitive negative thinking (rumination and worry) in postnatal mothers during the UK lockdown was significantly associated with anxiety and depression (Harrison et al., 2021). This research also demonstrated that perceived social support from friends, partners, and family moderated depression symptoms, whereas only social support from friends (with parent friends rated most important) moderated anxiety symptoms. Beyond social losses and associated grief, this facilitates understanding of the need of participants in this study to access other parents who could understand their experiences and moderate their anxiety via peer support.

Beyond pandemic restrictions, worries remained for all participants focused on the impact of isolation on children's development. This demonstrates how maternal worries may have changed over time as earlier in the pandemic, an international study of perinatal women

identified worries (not related to pregnancy/delivery) focusing on issues such as separation from family, baby catching COVID-19, and childcare issues (Basu et al., 2021), suggesting a need to understand maternal worries. Such worries reflect the fact that COVID-19 brought with it significant uncertainty, both during and since pandemic isolation. Intolerance of uncertainty (IU) reflects a tendency to find it intolerable that a negative event may occur (Einstein, 2014) and is a central feature of generalized anxiety presentations. More recently, IU has been understood as a common feature across many emotional difficulties (Boswell et al., 2013). Anxiety experiences shared within this study indicate difficulties tolerating uncertainty; IU has been found to increase in populations with comorbid anxiety and depression (Mahoney & McEvoy, 2012), further suggesting that investigation of IU in the context of remaining worry may be warranted.

Perhaps consistent with research associating worry and poor problem-solving confidence (Davey et al., 1994), participants expressed perceptions of poor coping although actively engaged in a range of coping behaviors. Consistent with a study of pregnant women in which greater social isolation was associated with problem-focused and dysfunctional coping (Khoury et al., 2021), participants discussed engaging mostly in problem-focused coping with a particular focus on seeking social and therapeutic support. Such coping may partly reflect difficulties tolerating uncertainty observed within this sample (Rettie & Daniels, 2021). Findings may also reflect sample demographics, as during the first UK lockdown seeking social support, problem-focused, and emotion-focused coping were frequently observed in women and those with higher educational attainment (Fluharty & Fancourt, 2020). Whilst reassurance seeking has the potential to maintain anxiety as postulated in cognitive-behavioral models of anxiety (Dugas et al., 1998; Salkovskis et al., 2003) and transdiagnostic models of IU (Einstein, 2014), in the context of social isolation during the maternal transition, reassurance seeking and attempts to maintain proximity were important and adaptive.

Clinical Implications

First-time mothers with pre-existing anxiety during pandemic isolation and their children may be more likely to require services in the future. The range of difficulties disclosed suggests the need for transdiagnostic approaches to support while targeting methods of coping in intervention (Khoury et al., 2021). Peer support groups that accommodate working mothers may be particularly valued, given missed opportunities for peer support and potential lasting isolation. In the event of similar crises, as well as for mothers at greater risk of social isolation,

such as migrant mothers, these findings demonstrate the importance of protecting and promoting professional and peer-support opportunities.

Accessing remote health services and support were widely utilized during the pandemic (Fisk et al., 2020; Hardoon et al., 2021), although many participants described difficulties with remote support. This finding has important implications as services may maintain/increase telehealth provision (BPS, 2021; Fazal et al., 2020; Fisk et al., 2020), emphasizing the need for flexible, individualized support and options for face-to-face provision (Pilav et al., 2022).

Mothers may have demonstrated varied coping behaviors during pandemic restrictions while privately struggling. They may minimize feelings associated with the pandemic/isolation to professionals, particularly those who may be perceived as having a greater reasons to have struggled having worked through the pandemic. It is, therefore, important for professionals to normalize difficulties in the context of pandemic isolation for this population to facilitate disclosure and acceptance of support. Furthermore, mothers feeling abandoned by professionals suggest the need for professionals to repair potentially ruptured relationships to help-seeking and understand lasting support needs.

Strengths and Limitations

This study provides insight into the experiences of a population at greater risk due to pre-existing anxiety during and after pandemic restrictions. Extracts of analysis at each stage were cross-referenced by a researcher experienced in IPA to enhance robustness. Care was taken not to impose a third person's interpretation, thereby compromising the double hermeneutic procedure. Participants were invited to comment on a summary of finalized themes to check the credibility of the themes. One participant responded and confirmed that the themes felt consistent with her lived experience.

While online recruitment facilitated a greater reach to potential participants and was necessary due to COVID-19 restrictions, the need to access a phone or device and the internet excluded those without such resources. Parents who did not identify as mothers were excluded and findings can only be applied to mothers. Most participants were highly educated, and the final sample lacked mothers from younger groups and Black and Minority Ethnic (BAME) communities. These mothers may have been inadvertently excluded due to recruitment via websites and social media groups/platforms, which may be less frequently accessed by these groups. Advertising via influencers from BAME communities or recruitment of mothers via community groups serving diverse populations may have helped to give voice to those disproportionately negatively

affected by COVID-19 and, therefore, may have experienced even greater difficulties. For example, a UK survey found that Asian/Asian British parents self-reported that their coping ability was significantly more impacted than other groups early in the pandemic (Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, 2020).

Future Research

Continued investigation of the impacts of social isolation on this population and their family systems is warranted as the implications of COVID-19 continue to unfold. Further research is required to develop an understanding of the experiences of UK mothers with pre-existing vulnerabilities during pandemic isolation related to mental health, physical health, socioeconomic factors, and racial and cultural identity as such women are disproportionately affected in their perinatal physical and mental health (Womersley et al., 2021). Concentrated efforts to reach these mothers are necessary if missing voices are to be represented in future research.

Conclusion

This study aimed to explore experiences of social isolation for first-time mothers with pre-existing anxiety during the COVID-19 pandemic and understand the longer-term impacts of associated restrictions via semi-structured interviews and IPA. This exploration was important due to the increased vulnerability of this already vulnerable group and the potential consequences for families in the aftermath of the pandemic. Findings reflect difficulties in the transition to motherhood, unmet needs for face-to-face support, and negatively impacted mental health and coping. Increased distress suggests that this cohort of mothers and children may be more likely to require mental health support in the future. Peer support may be particularly beneficial as these opportunities were lost during the pandemic. Findings highlight considerations for clinical practice, both in the aftermath of COVID-19 and how professionals engage mothers in similar crises. Mothers from diverse communities and other UK countries are missing from this study which should be considered when interpreting the findings and planning future research.

Table 1

Eligibility criteria

Inclusion criteria	Exclusion criteria
First-time mother (aged 18 years+) First child born between 01/09/2019-20/02/2020 Self-identified anxiety prior to the COVID-19 pandemic (appendix I) UK resident during the COVID-19 pandemic Access to a phone/video device	In mental health crisis and/or accessing mental health services 'Shielding' during the COVID-19 pandemic Non-English speaking

Table 2

Participant demographics

Pseudonym	Age	Ethnicity	Education level	Working	Country/Region	Age of child	Relationship status	Household support
Anna	34	White British	Post-graduate Diploma	Yes	England/North West	18 months	Married	Lived with family and relatives until June 2020. From June 2020 lived with husband and baby.
Becky	29	White British	Bachelor's Degree	No	England/South East	18 months	Married	Lived with husband and baby for duration of pandemic restrictions.
Caroline	35	White British	PhD	Yes	England/South East	19 months	Married	Lived with husband and baby for duration of pandemic restrictions.
Danielle	28	White British	A-Level/NVQ	Yes	England/Midlands	19 months	In a relationship	Lived with partner and baby during most pandemic restrictions. Lived alone with baby from January 2021.
Emma	36	White British	Master's Degree	Yes	England/Midlands	24 months	Married	Lived with husband and baby for duration of pandemic restrictions.
Faye	35	White British	Bachelor's Degree (partially completed)	No	England/Midlands	25 months	Single	Lived with parents and baby for duration of pandemic restrictions.

Table 3

Superordinate and subordinate themes

Superordinate themes	Subordinate themes
The transition to motherhood: "It takes a village to raise a child"	*"Bonding was difficult"* *"No one knew or understood what I was going through"* *"I missed the boat"*
Physical proximity matters: "We were left on our own"	*"I'm just much better with face-to-face interactions"* *"I just felt kind of abandoned"*
More than the usual emotional experience: "Mentally I was worse off than I would have been"	*"A whole layer of other things to worry about"* *"There will always be part of me that kind of grieves for that first year"* *"I feel very stuck in everything that was"* *"I shouldn't have the right to feel isolated"* *"It's taking a bit longer to adjust to a non-pandemic world"*
Coping counts: "I tried to cope"	*An "illusion of coping"* *"If I hadn't been proactive…"*

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