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The Lived Experience of Expectant Mothers During the COVID-19 Pandemic

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Walden University
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Abstract

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by

Bridgette Schulman

MSNEd, University of North Georgia, 2015

BSN, Kennesaw State University 2003

Dissertation Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

The COVID-19 pandemic has resulted in many changes to obstetric care practices. While the changes aimed to decrease transmission and protect mothers and infants, the study revealed unintended consequences of the changes put in place during COVID-19. Currently, there is a gap in knowledge and understanding of how the changes in obstetric care practices affect women's perceptions of the birth experience. The purpose of the study was to explore the lived experience of mothers who gave birth in the health care setting during the COVID-19 pandemic through the eyes of those who experienced it. The research question was: What is the lived experience of women who delivered a baby in a healthcare setting during the COVID-19 pandemic? Qualitative methodology that applied an Interpretative Phenomenological Analysis approach was used to answer the research question. Individual, in-depth interviews were conducted with 10 participants, eight identifying as White and two as African American, who had given birth during 2020 to 2022 and who met the other inclusion criteria for the study. The six overall themes that emerged from data analysis were (a) birth experience versus reality, (b) fear and isolation, (c) support from spouse or other family, (d) relationship with the health care team, (e) education and understanding, and (f) bright side and lessons learned, with additional subthemes identified within each theme. The insights gained from the study may foster positive social change by aiding in the current understanding of birth under the stressful conditions of a pandemic. The study may also guide practices that include shared decision-making, support during labor, and providing education that can decrease fear and anxiety and create a positive birth experience during challenging times.

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Dedication

I would like to dedicate this study to all of the mothers who delivered a baby during the COVID-19 pandemic. This study is for you; it is meant to hear you and to validate your experiences. A very special thank you to the participants for sharing their most sacred memories and experiences of their birth.

Acknowledgments

There are so many people to acknowledge for their support, guidance, and patience throughout the long process of completing this program and dissertation. I would like to give a big thank you to my committee chair, Dr. M. Terese Verklan, for taking a chance on me and agreeing to be my committee chair. I appreciate your patience and attention to detail throughout this process! Thank you for keeping me focused, for holding me to a high standard, and for believing in me at every stage. You are a wonderful mentor, and this would not have been possible without your guidance. I would also like to give a huge thank you to Dr. Deborah Lewis for joining my committee after circumstances left me with only one committee member. I am grateful for your methodologic expertise and input throughout the process! Thank you for all the calls to keep me on the right path and for the encouragement you provided. To my husband, Rubin, who has supported me through four college degrees in the 29 years we have been married (this is the last one, I promise). Thank you for being my encourager, my rock, and the person who believed I could finish on days when I did not believe it myself. To all my mother, mother-in-law, extended family, friends and colleagues that encouraged me and stepped in during my absences, I could not have done it without all of you! Finally, to my children, Caleb, Kelsey, and Kylee, who went without many dinners and may have missed me at a few activities over the last 5 years: I hope I have shown you that perseverance pays off. You can do anything you set your mind to—I hope I am proof of that to you. With all the love to each one of you, and thank you again for helping me achieve this goal!

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Chapter 1: Introduction to the Study

Introduction

The birth of a child is a unique and personal experience that is perceived differently by every birthing person. A mother's lived experience of giving birth includes her unique perceptions and understanding of the experience. A mother's perception of her birth experience can have a long-lasting impact. A positive birth experience is associated with favorable attitudes to motherhood, feelings of accomplishment, confidence in one's abilities as a mother, and a favorable relationship with one's infant (Barker et al., 2017; Hall et al., 2018; Pereda-Goikoetxea et al., 2019). A negative birth experience can be associated with distress and contribute to an increased risk of posttraumatic stress disorder (PTSD) and postpartum depression (Hall et al., 2018; Pereda-Goikoetxea et al., 2019). A mother's perception of her birth experience can be influenced by several factors, including environment, support during labor, participation in decision-making, and control of the birth experience (Pereda-Goikoetxea et al., 2019). In this manuscript, I use "mother" and "woman" to refer to persons who give birth to infants. I am aware that pregnancy is not the same as the decision to parent and that not all parents who give birth identify as mothers.

The lived experience for women delivering a baby in the health care setting during the COVID-19 pandemic has been affected on many levels by social distancing, isolation precautions, and changes to obstetric care practices put in place to prevent the spread of the virus (Yasa et al., 2020). The coronavirus SARS-CoV-2, which causes the infection known as COVID-19, is a new strain confirmed to be transmitted person to

person (Mimouni et al., 2020; Ryan et al., 2020; Yang et al., 2020). When COVID-19 was first identified in December 2019, there was no natural immunity, nor was there a scientifically validated medication treatment or vaccine to mitigate against infection (Chen et al., 2020). I explored the lived experience of women who have delivered a baby in a health care setting during the COVID-19 pandemic. This knowledge is important because the isolation precautions and obstetric care practice changes put in place during the COVID-19 pandemic may have affected mothers' overall perception of the birth experience. Chapter 1 includes an overview of COVID-19 and the impact of both a positive and negative birth experience. Additionally, I review current literature on COVID-19 and the impact it has had on the birth experience. The study problem, purpose of the study, the research question, the theoretical framework, the methodology, and the study design are also described in Chapter 1.

Background

COVID-19 is a global pandemic, and as of July 2022, there were more than 90.3 million confirmed cases, with over 1 million deaths in the United States (Centers for Disease Control and Prevention [CDC], 2022). U.S. officials put in place many measures, such as lockdowns, social distancing, shelter in place orders, and mandates to wear face coverings while in public, to mitigate the risk of social transmission (Gutschow & Davis-Floyd, 2021). The COVID-19 virus affects populations differently, and symptoms can range from asymptomatic or mild illness similar to a cold to serious respiratory illness, leading to severe and even deadly outcomes (Giesbrecht et al., 2022; Gutschow & Davis-Floyd, 2021; Mimouni et al., 2020). COVID-19 in pregnant women and infants is

particularly concerning as they are vulnerable populations. Pregnancy can make women more susceptible to respiratory illness due to the physiologic changes of the pregnant body, including structural, hormonal, and immunological alterations (Chen et al., 2020).

Because the SARS-CoV-2 has not been previously seen in humans, theoretically there is an increased risk for altered respiratory status during pregnancy that can lead to decomposition more rapidly in the presence of respiratory complications (Chen et al., 2020). Pneumonia is the third leading cause of death in pregnancy, with viral infection having a higher mortality rate, and the COVID-19 virus can lead to COVID pneumonia (Chen et al., 2020). Adverse obstetrics outcomes that can result from pneumonia include premature rupture of membranes, preterm labor, intrauterine growth restriction, and intrauterine fetal demise (Mullins et al., 2020). In theory, infants also may be at increased risk of severe complications due to their immature immune systems, but the precise impact of COVID-19 on infants is unknown (Chandraskharan et al., 2020).

The current information published at the time of writing this manuscript indicates that it is not likely that COVID-19 is vertically transmitted from mother to infant during gestation, and the significant risk for transmission may occur following delivery via horizontal transmission (Chen et al., 2020). In response to the rapid spread of COVID-19, health care settings across the United States have implemented changes to current isolation precautions, personal protective equipment (PPE) requirements, and obstetric care practices to minimize the risk of transmission in the antepartum, intrapartum, and postpartum units of hospitals (Mimouni et al., 2020). Most health care settings in the country, including hospitals and doctors' offices, completely prohibited visitors and

support persons during the height of the COVID-19 pandemic to protect vulnerable patients and to decrease the potential of continued viral spread. The limitation of support for mothers and changes to customary obstetric care practices during COVID-19 could impact whether mothers perceive their birth experience in the health care setting in negative or positive terms (Ravaldi et al., 2020).

Delivering a baby is a very intimate and impactful life experience for new parents and extended family members. The current literature describes the complex birth experience under normal circumstances. Pereda-Goikoetxea et al. (2019) identified factors that may impact whether women report having a positive or negative birth experience, including personal expectations, participation in decisions, control in the birth experience, relationship with caregivers, and immediate contact with the infant. The changes to isolation precautions and obstetric care practices implemented in the health care setting during the COVID-19 pandemic have impacted each of the key factors identified by Pereda-Goikoetxea and colleagues (2019) as being impactful on women's perceptions of their birth experience and further highlights the importance of investigating how the COVID-19 pandemic has impacted mothers' perceptions of their birth experiences. Hall and colleagues (2018) explored how women integrated and interpreted the complex birth experience and noted that unresolved negative emotions could lead to feelings of fear, discouragement, powerlessness, and anger. Bringedal and Aune (2019) emphasized the need for mothers to be part of shared decision-making regarding interventions that impact their health and their newborn babies. It was further noted that informed decisions are best made when women are provided with the risk and

benefits of treatment options and all possible courses of action. The ability for women to make their own decisions and have the resources to make their choices lead to a positive birth experience (Bringedal & Aune, 2019).

Amid the COVID-19 pandemic, decisions were made in the health care setting to balance the risk of transmission between COVID-19 positive mothers and their infants. Recommendations and guidelines for the care of pregnant women and infants in the health care setting have been developed rapidly and have changed many times through the pandemic as more information is learned about the COVID-19 virus. Decisions around customary care such as universal testing of all pregnant women, scheduling frequency of prenatal visits, whether healthcare visits are in person or via telehealth, visitation, the requirement of PPE, and obstetric care practices during and after delivery had to be made to decrease possible transmission and protect mothers and infants (Breslin et al., 2020; Pavlidis et al., 2000).

The CDC set forth recommendations and protocols at the onset of the pandemic that were different from current obstetric care practice and could negatively impact the birth experience. Universal COVID-19 testing of all pregnant women was implemented due to the high number of reported asymptomatic cases (Ryan et al., 2020; Mimouni et al., 2020). The initial recommendation by the CDC (2020) that COVID-19 positive mothers be separated from their infants to decrease the immediate contact between the dyad led to a decrease in direct skin-to-skin contact between a mother and her infant. Skin-to-skin contact in the first hour following delivery has been shown to have a positive impact on maternal-infant bonding and the mother's mental health, as well as the

infant's behavior at 1 and 3 months (Barker et al., 2017; Dumas et al., 2013). Another obstetric care practice affected by CDC's recommendation is that a COVID-19 positive mother should refrain from directly breastfeeding their infants due to the risk of transmission. The current literature available has not shown evidence of the SARS-CoV-2 virus in breast milk (Yang et al., 2020; Chen et al., 2020).

In contrast, the presence of protective antibodies to the SARS-CoV-2 virus in breast milk could benefit infants (Chandraskharan et al., 2020). The risk of transmission must also be weighed against the known benefits of breast milk and the unknowns of the new SARS-CoV-2 virus. The mandatory requirement of PPE for health care setting staff and a face covering for everyone who entered health care settings included all pregnant/laboring women and their support person. In the first year of the pandemic, mothers who tested positive for COVID-19 experienced many of the CDC-recommended obstetric care practice changes with skin-to-skin bonding, breastfeeding, visitation, and PPE mandates when they deliver in health care settings across the United States, regardless of whether they experience any symptoms (Mimouni et al., 2020).

Even women who test negative for COVID-19 have been affected by the many changes in isolation precautions and obstetric care practices as a direct result of the COVID-19 pandemic (Pavlidis et al., 2020). It is also essential to consider not just the experience during pregnancy and birth but also the postpartum period. The maternal role attainment theory (MRAT) includes the postpartum period and the pregnancy and birth periods as critical times of maternal-infant bonding and role attainment (Mercer, 1985). According to Mercer (1985), the postpartum time is when the final phase of the maternal

role is attained. COVID-19 affects the postpartum period as mothers are being discharged home without having the support of family and friends that is common when new mothers come home from the hospital due to social distancing and shelter in place orders put in place during the pandemic.

Gap in Knowledge

Since its identification in December 2019, COVID-19 has become a global pandemic. There is a need to further explore mothers' perceptions of their birth experience during the COVID-19 pandemic. Important decisions around isolation precautions, visitation, and obstetric care practices are being made for mothers and infants in the health care setting before, during, and after delivery during the pandemic that could have a lasting impact on mothers' perception of the birth experience (Chandrasekharan et al., 2020; Davis-Floyd et al., 2020; Giesbrecht et al, 2022; Gutschow & Davis-Floyd, 2021). In reviewing the literature, I was unable to locate any research that specifically addressed the lived experience of women who delivered a baby in the health care setting in the United States during the COVID-19 pandemic. Because the virus was new, and because the COVID-19 obstetric care practices have not been performed in the past, there is a gap in knowledge and understanding of how the changes in obstetric care practices affect women's perceptions of the birth experience. The information gained from the study can clarify the impact of the COVID-19 pandemic on mothers' perceptions of their birth experience. The insight gained could provide nursing professionals with information that they use to develop protocols, interventions, and patient-centered education to mitigate the impact of the care changes experienced during

the COVID-19 pandemic and decrease the risk of long-term complications for mothers and infants.

Problem Statement

The COVID-19 pandemic has led to many changes to obstetric care practices that impact the birth experience in the health care setting. For some women, the result may likely be an altered birth experience. A woman's perception of her birth experience can be pivotal in healthy outcomes for mothers and infants. A positive birth experience is associated with favorable attitudes and effective maternal-infant bonding, while a negative birth experience can be associated with postpartum depression or PTSD, leading to ineffective maternal-infant bonding (Hall et al., 2018; Pereda-Goikoetxea et al., 2019). The current published literature on COVID-19 and pregnancy focuses on the prevalence of COVID-19 cases and clinical outcomes of mothers and infants (Ryan et al., 2020; Yang et al., 2020; Zaigham & Anderson, 2020). Although the majority of reported clinical outcomes for pregnant mothers and their infants born in the health care setting during COVID-19 have been positive, it is essential to look at both physiologic and psychological outcomes for women who have a baby. Yasa and colleagues (2020) hypothesized that the psychological impact of COVID-19 may be of great concern. Current literature highlights the relationship between a mother's perception of birth and long-term implications on maternal mental health and infant bonding resulting from both a positive and negative birth experience (Hall et al., 2018; Pereda-Goikoetxea et al., 2019). Due to their close intimate relationship, pregnant women and infants represent a uniquely vulnerable population during the COVID-19 pandemic. There is a gap in

understanding the transmission of the virus from mother to infant during pregnancy and after birth. Decisions about isolation, visitation, PPE requirements, and obstetric care practices have been made for mothers in the health care setting during the COVID-19 pandemic. These decisions could have a lasting impact on the mothers' perception of the birth experience (Ravaldi et al., 2020).

Even under normal circumstances, approximately 10-30% of women report a negative birth experience (Aktas & Aydin, 2018; Chabbert et al., 2021). Because COVID-19 is a new virus, and because COVID-19 isolation precautions and obstetric care practice changes have not been done in the past, there is a gap in knowledge and understanding of how the changes will affect mothers' perceptions of the birth and postpartum experience. In this study, I aimed to understand the impact of COVID-19 on the perception of the birth experience of women who delivered a baby in the health care setting during the COVID-19 pandemic.

Purpose of the Study

The purpose of the qualitative phenomenological study was to explore the lived experience of mothers who gave birth in the health care setting during the COVID-19 pandemic. I intended to describe the lived experience of mothers who delivered a baby during the COVID-19 pandemic to determine the impact of the changes to customary obstetrical care practices during COVID-19 on their birth experience in the healthcare setting. Current research has examined the phenomenon of the birth experience and women's perceptions of it (Bringedal & Aune, 2019; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Ravaldi et al., 2020). Yet research appears to be lacking on the perception of

the birth experience of women who have delivered in U.S. health care settings during the COVID-19 pandemic, according to my review of the literature.

Research Question

Amid the ongoing COVID-19 pandemic continues, health care organizations have implemented changes to isolation precaution and obstetric care practice to protect mothers, their neonates, and the staff caring for them. The phenomenon of interest concerned how the changes to isolation and obstetric care practices instituted during the COVID-19 pandemic have impacted the birth experience. The purpose of this qualitative phenomenological study was to explore the lived experiences of mothers who delivered a baby in the health care setting during the COVID-19 pandemic. The research question was: What is the lived experience of women who delivered a baby in a healthcare setting during the COVID-19 pandemic?

Theoretical Framework

Maternal Role Attainment Theory

For the theoretical framework of the study, I drew from Mercer's (1985) MRAT. The concept of maternal identity was introduced in the late 1960s by Reva Rubin, who described it as the process that encompasses a woman's maternal experience during the pregnancy, labor, and postpartum period (Rubin, 1967, as cited in Hoffnung, 1985). Rubin used nursing observations for assessing both a mother's physiologic response and outcomes of pregnancy and birth, as well as maternal behaviors of maternal identity (Hoffnung, 1985). Mercer's study under Rubin influenced her development of the MRAT.

The MRAT addresses the processes that occur in mothers during adaptation to and attainment of the role of motherhood. The actual birth of a child is only one step in the complex process of what makes a mother. The stages of maternal role attainment are anticipatory, formal, informal, and maternal identity (Husmillo, 2017). The anticipatory stage occurs during pregnancy when a mother acclimates psychologically and socially to the idea of the maternal role. The formal stage happens at birth when the mother meets her infant but relies on experts for mothering. The informal stage occurs in the initial postpartum period as the mother learns her own mothering style. The maternal identity stage is characterized by the new normal with the baby in harmony with everyday life (Noseff, 2014). The concepts in Mercer's MRAT include how the initial maternal-infant bond has a fundamental role in the mother and infant's physiologic and emotional well-being. The vital role of nursing in facilitating those experiences is also described. I will discuss Mercer's MRAT in greater detail in Chapter 2.

Effective maternal-infant bonding can positively affect prolonged breastfeeding, increase love and trust, and decrease postpartum depression and anxiety, leading to a positive home life and good health of the mother and infant (Cabrera, 2018). Ineffective bonding can lead to a delay in, or difficulty, in providing basic needs to the infant, leading to a decrease in the healthy growth and development of the infant (Barker et al., 2017). The MRAT offers guidance on the importance of the nursing care provided to mothers and infants during the birth and postpartum period. The care of mothers during the birth and postpartum periods contributes to the birth experience, which may be

negatively impacted by the changes to isolation precautions and obstetric care practices used during the COVID-19 pandemic.

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) combines ideas from Husserl's phenomenology, the Hermeneutics theory of interpretation, and the concepts of group interpretation of ideography to provide structure to a qualitative inquiry of how individuals make sense of significant life experiences (Smith et al., 2009; Kacprzak, 2017). IPA does not attempt to operationalize one specific theorist but instead integrate Husserl, Heidegger, and Hermeneutic phenomenology to better understand the participant's interpretation of their lived experience. IPA also integrates ideography in the context of participants' personal perspectives, both individually and then moving to more general claims (Smith et al., 2009). Combining these key phenomenological theories allows for the exploration of the participant's lived experiences on their terms without predetermined ideas (Smith et al., 2009).

IPA is particularly useful for understanding experiences that are sacred moments or significant life events such a giving birth (Smith et al., 2009). Using IPA, I explored the experience of mothers who delivered a baby in the hospital setting during the COVID-19 pandemic. Data were collected by conducting in-depth interviews with participating mothers. I explored each participant's unique personal lived experience to describe and interpret the individual responses in the larger context of the shared experience. The human life experience is the beginning point that becomes meaningful

through the participants eyes, making it unique to them (Kacprzak, 2017; Smith et al., 2009). IPA will be discussed in greater detail in Chapter 2.

Using IPA, I explored the individual experience of mothers who delivered a baby in the hospital setting during the COVID-19 pandemic. Data was collected by conducting in-depth interviews with participating mothers. I explored each participant's unique personal lived experience to describe and interpret the individual responses in the larger context of the shared experience.

Nature of the Study

This was a qualitative phenomenological study that involved application of an IPA approach. IPA is an approach that helps researchers to make sense of significant life experiences (Smith et al., 2009). In conducting the study, I aimed to understand the individual essence of the lived experience and the essence of shared experience between people who have the same or similar lived experience (see Patton, 2015). The use of the phenomenological approach provided an opportunity to look beyond statistics about the prevalence of birth during the COVID-19 pandemic and hear the stories of the lived experience of birth during COVID-19 through the perspective of those who experienced it. IPA was an excellent approach to gain a deeper understanding and make sense of the lived experience of the birth in the context of the COVID-19 pandemic.

The COVID-19 pandemic created the need for health care settings to change isolation precautions and obstetric care practices to mitigate the risk of virus transmission. The phenomenon that was investigated was the perception of the birth

experience by mothers who delivered a baby during the pandemic. I explored the impact of the changes to isolation precautions and obstetric care practices during COVID-19 on the birth experience of women who delivered a baby in the health care setting during the COVID-19 pandemic.

In-depth interviews were key to exploring the lived experience of mothers who delivered a baby in the healthcare setting during the COVID-19 pandemic and gain a unique perspective that can only be told from those who experienced it. I used purposeful sampling to elicit a homogeneous sample of women who gave birth in the health care setting during the COVID-19 pandemic. The participants were mothers who were at least 18 years old and English speaking; who delivered their baby after October 2020; and who were discharged from the hospitals. Individual interviews were transcribed and analyzed per the IPA protocol. First, each interview transcript was reviewed for emerging themes. The emerging themes were then analyzed for connections between the individual emerging themes. Following the examination of themes in each case, related emerging themes were abstracted to form superordinate themes (Smith et al., 2009).

Definitions

The following definitions are defined in the context of the study to provide clarity and understanding of these terms.

Birth experience: A complex event that is subjective to the individual experiencing it and is both a physiological and psychological process that is influenced by social factors, environment, and personal expectations that affects the well-being of mothers, infants, and families (Pereda-Goikoetxea et al., 2019)

Health care setting: A setting that provides health care to pregnant women. It includes obstetrical care units in an acute care hospital. It does not include home births or birthing centers.

Isolation precautions during *COVID-19*: Specific changes to isolation practices that were put in place during the COVID-19 pandemic to protect against the transmission of COVID-19 (Pavlidis et al., 2020; Puopolo & Kimberlin, 2020). As researchers (Pavlidis et al., 2020; Puopolo & Kimberlin, 2020) noted, these precautions include:

- Changes to personal protective equipment (PPE) requiring N-95 mask, gown, and face shields for health care providers caring for COVID-19 positive patients.
- Requirement of a face covering for everyone who enters the healthcare setting, including staff, patients, and visitors
- Changes to visitation that allow for only one visitor only during active labor, birth, and the postpartum period and that exclude support visitors during in-office visits.

Maternal role attainment: The process in which a mother acquires the competence in the maternal role and integrates maternal behaviors into her established role set so that she identifies as a mother (Mercer, 2004). It includes pregnancy, birth, and the postpartum period (Mercer, 2004).

Obstetric care practices: Customary obstetric care practices that promote maternal-infant bonding, including skin-to-skin contact between mother and infant, minimization of separation between mother and infant, early breastfeeding, and couplet care (Husmillo, 2013; Pavlidis et al., 2020).

Assumptions

The first assumption of the study was that each participating woman had individual perceptions of her own birth experiences, which were defined through her own lived experience. The second assumption was that the mother-infant bond is a unique relationship developed between each mother and her infant that can be affected by the personality and temperament of both the mother and the infant (Noseff, 2014). The third assumption was that a mother's perception of her birth experience can affect both mother and infant's short-term and long-term well-being. The fourth assumption was that participants would share their unique personal birth experiences through the lens of their perception of their own lived experiences.

A key aim of IPA is to allow participants to freely express their lived experience on their own terms (Smith et al., 2009). An integral part of the IPA approach is to gain a deeper understanding of a phenomenon through the participants' eyes. Each interview offered rich data on how participating mothers interpreted their own unique birth experience during the COVID-19 pandemic and provided understanding of the essence of their lived experience.

Scope and Delimitations

The COVID-19 pandemic has led to many changes to isolation precautions and obstetric care practices that impact the birth experience in the health care setting. I determined that qualitative methodology was the best way to explore women's perceptions of their lived experience of delivering a baby in the acute health care setting during the COVID-19 pandemic. Qualitative research aim to explore and understand

people's individual experiences from their perspective and using their own words (Patton, 2015). Phenomenology was the approach that offered the best way to explore how participants described, perceived, judged, felt about, remembered, and talked about their birth experience.

Delimitations of a qualitative study include the parameters that the researcher can control and set as the study's boundaries through inclusion and exclusion criteria. I explored the perceptions of the birth experience of women who delivered infants in the acute health care setting during the COVID-19 pandemic. The study participants included English-speaking women 18 years of age and older who had delivered a baby in the acute health care setting after July 2020, during the COVID-19 pandemic. Therefore, women who had delivered in birthing centers or had a home birth were excluded from the study. The mother's COVID-19 infection status was not used as criteria for participation in the study.

I conducted the study to capture the essence of the birth experience in health care settings during the COVID-19 pandemic. Transferability of the results may be generalizable to populations outside the United States as the COVID-19 is a worldwide pandemic. There is potential for transferability beyond the COVID-19 virus specifically; the results may apply to other illnesses requiring a change in isolation and obstetric care practices.

Limitations

Limitations of a study are those parameters or restrictions that are not within the control or design by the researcher. There are inherent limitations of qualitative research

methodology. Qualitative research aims to explore detailed experiences from a small sample, in contrast with quantitative research, explores specific limited variables in a larger sample (Patton, 2015). Quantitative research aims to explain and predict numerical statistical significance, while qualitative research aims to explore and gains a deeper understanding of the emotion and meaning of experiences. The novel nature of the SARS-CoV-2 virus is a limitation as there is only emerging real time literature on the topic. It is possible to make inferences from previous coronaviruses such as severe acute respiratory syndrome (SARS), which infected 8,098 and had a reported fatality rate of 10-25% and 50% ICU admission rate, and Middle East respiratory syndrome (MERS) that infected 2,519 with a reported fatality rate of 30-34% and a fetal death rate of 30% (DiMascio et al., 2020; Pettirosso et al., 2020). However, SARS-CoV-2 is significantly different than previous coronaviruses, with an infection rate worldwide, as of June 11, 2021, of 175.6 million cases and a fatality rate of about 2.2% (CDC, 2021; see also DiMascio et al., 2020). Additionally, most of the available literature focuses on quantitative measures such as clinical risk, outcomes, and treatment, not the individual lived experience of the phenomenon of giving birth during the COVID-19 pandemic (Ryan et al., 2020; Yang et al., 2020; Zaigham & Anderson, 2020). The use of purposeful sampling to attain participants with the shared lived experience of delivering an infant during the COVID-19 pandemic limits the transferability of the results to outside the context of the COVID-19 pandemic.

Transferability is limited as different acute health care settings across the United States may have established different isolation precautions and care practice changes. The

participants' lived experiences in the study reflect the isolation precautions and obstetric care practice changes that they experienced in the health care setting in which they gave birth. Quantitative research designs rely on the validity of instruments used in data collection and the rigor of standardized processes and prescribed procedures. In contrast, qualitative research designs rely on the researcher's credibility as the researcher is the instrument used to collect data (Patton, 2015).

Because the qualitative researcher is the instrument who collects data, there is an inherent risk of bias as the researcher brings their perceptions, knowledge, and life experience to the study. I am an RN with over 19 years of experience in maternal care, with 9 years of bedside nursing in the labor and delivery unit, 4 years as the Labor and Delivery Educator, and almost 6 years in my current role as the Clinical Practice Specialist for the Women and Children's service line at a community hospital in Northeast Georgia. I have had an active role in evaluating the current literature, writing and reviewing the isolation precautions and obstetric care practice changes, and implementing COVID-19 protocols at my organization during the current pandemic. My experience has been the driving force to research the impact of COVID-19 on mothers' perceptions of their birth experience during the COVID-19 pandemic. The nature of the phenomenological approach leads to personal connection and relationship between the researcher and the study participants. This relationship is essential for the establishment of rapport and trust in individual interviews. However, the researcher can have empathetic neutrality during participant's interviews through awareness of personal perspective and self-reflection. (Patton, 2015).

The limitations of the qualitative methodology and the credibility of the research study were addressed through an interviewing protocol that maintains unbiased open-ended questions (Patton, 2015). Consistency of interpretation was achieved using the defined steps of IPA and researcher reflection of potential bias. Caution was taken to ensure my professional experience did not influence interviews or data analysis. I was committed to being open-minded and engaged in active listening during interviewing. I was also neutral in the data collection and analysis.

Significance of the Study

The study provided a unique perspective from the current literature and investigated the lived experience of a mother's birth experience during the COVID-19 pandemic. The customary care of pregnant women has been interrupted due to the isolation precautions put in place during the COVID-19 pandemic. Hearing a mother's personal lived experience can provide insight into developing processes to help improve the care provided during pandemics such as COVID-19. The research results fill a gap in understanding how COVID-19 has impacted mothers' perceptions of their birth experience in the healthcare setting during the COVID-19 pandemic.

Significance to Practice

The nurses' role is vital in facilitating maternal bonding and identifying barriers to bonding (Barker et al., 2017). With a greater understanding of the mother's perception of the birth experience during the COVID-19 pandemic, it is possible for nurses and clinicians caring for obstetrical patients to provide support and targeted education during the COVID-19 pandemic. Obstetric nurses and care providers have the opportunity to

engage with mothers who are delivering a baby during the COVID-19 pandemic. Care providers can encourage discussion about mothers' concerns, encourage maternal-infant bonding in the context applicable in light of the limitations with COVID-19 isolation precautions, recognize warning signs of delay in maternal role attainment, identify early signs and symptoms of postpartum depression and anxiety and provide any needed resources of support (Noseff, 2014).

Significance to Theory

The use of the MRAT allows for the implementation of interventions that facilitate positive birth outcomes for mothers and infants (Cabrera, 2018). I applied the MRAT in the context of a pandemic that could alter effective maternal role attainment and mother-infant bonding. With a greater understanding of the mother's perception of the birth experience during the COVID-19 pandemic, it is possible for nurses and clinicians caring for obstetrical patients to promote maternal-infant bonding and maternal role attainment during changes set forth during the COVID-19 pandemic, decrease long-lasting psychological effects, and promote ideal outcomes for mothers and infants despite the stress of the pandemic (Cabrera, 2018).

Significance to Social Change

Women and children are vulnerable populations, and it is imperative to focus on their emotional and physiologic wellness. Pregnant women are increased emotional stress as they face limitations and restrictions of support during the COVID-19 pandemic (Matvienko-Sikar, 2020). Looking beyond the statistics and listening to the mothers who have given birth during the COVID-19 pandemic will allow opportunities to explore and

understand how giving birth during the COVID impacts perinatal mental health and the overall birth experience in women who are pregnant have delivered a baby during the COVID-19 pandemic. The obstetric healthcare team plays a vital role in providing pregnant women education and support (Matvienko-Sikar, 2020; Barker et al., 2017). The insights gained from the study can create positive social change by empowering the voice of pregnant women in leading change. The study results could aid in the current understanding of birth under the stressful conditions of a pandemic and help guide practices that will include shared decision-making and care that can create a positive birth experience during these challenging times.

Summary

COVID-19 has significantly impacted women who delivered a baby in the healthcare setting during the COVID-19 pandemic. Chapter 1 discussed the background of the COVID-19 pandemic and the current literature on the mother's perceptions of their birth experience. The study's purpose of exploring the lived experience of mothers who gave birth in the healthcare setting during the COVID-19 pandemic and the significance of focusing on mothers' emotional and physiologic wellness was reviewed. The rationale for using the qualitative IPA approach was described as the best approach to capture and interpret the lived experience of mothers who gave birth in the healthcare setting during the COVID-19 pandemic. Finally, the scope and delimitations included English-speaking participants 18 years of age and older who delivered a baby in the acute healthcare setting after July 2020, during the COVID-19 pandemic.

In Chapter 2, a synopsis of current literature on women's perception of their birth experience outside of the current COVID-19 pandemic was reviewed. The origin, application, and rationale for using the MRAT as the study's theoretical framework was discussed. Additionally, justification for study concepts was reviewed, and current literature was related to the study's phenomenon of interest.

Chapter 2: Literature Review

Introduction

The COVID-19 pandemic has led to many changes to obstetric care practices in the health care setting that impact the birth experience. Women may have an altered birth experience. A woman's perception of her birth experience can be pivotal for healthy outcomes for mothers and infants. A positive birth experience is associated with favorable attitudes and effective maternal-infant bonding while a negative birth experience can be associated with postpartum depression or PTSD, leading to ineffective maternal-infant bonding (Hall et al., 2018; Pereda-Goikoetxea et al., 2019). The purpose of this qualitative phenomenological study was to explore the lived experience of mothers who gave birth in the health care setting during the COVID-19 pandemic. By describing the lived experience of mothers who delivered a baby during the COVID-19 pandemic, I sought to determine the impact of the changes to customary obstetrical care practices on their birth experience in the health care setting.

Synopsis of Current Literature

A women's birth experience encompasses physical changes and the mental and emotional changes that occur with the delivery of an infant. The current literature highlights the perception of the birth experience as pivotal in outcomes for mothers and their infants. A woman's perception of her birth is a personal and individual experience. It can result in feelings of accomplishment and empowerment when it is a positive experience, or of pain, dissatisfaction, disconnection, and even trauma when it is a negative experience (Baxter, 2020; Bringedal & Aune, 2019; Hall et al., 2018 Pereda-

Goikoetxea et al., 2019). The literature includes exploration of both risk factors and protective factors contributing to a woman's perception of her birth experience under normal nonpandemic times (Chabbert et al., 2021). The COVID-19 pandemic has led to many changes that impact the perception of the birth experience and successful maternal role attainment. Early literature reviews of COVID-19 and the perinatal population mainly focused on treatment and outcomes.

However, now that it has been over 2 years since the beginning of the COVID-19 pandemic, there has been an influx of literature that merges COVID-19 and the birth experience, originating outside the United States in countries like Italy, Spain, and China (Pettirosso et al., 2020). According to the literature, mothers who gave birth during the COVID-19 pandemic described feeling distressed and having fear, anxiety, and loneliness during birth, which replaced previous feelings of safety, joy, and happiness reported before the pandemic (Lebel et al., 2020; Ravaldi et al., 2020; Yasa et al., 2020). The literature supports the need for more information, education, and shared decision-making during the COVID-19 pandemic.

Chapter Preview

In Chapter 2, I describe the literature search method and explains the databases and key terms used to identify the most relevant literature pertaining to the current study. The justification for the study is explored. Mercer's MRAT and the rationale and relevance of its use in the current study are discussed in more detail. I discuss the existing literature and identify the knowledge gap leading to the need for the current study. The

chapter concludes with a brief description of Chapter 3, which provides more details on the study's methodology.

Literature Search Strategy

I used the Walden University Library to comprehensively search the literature on three primary topics: MRAT, perceptions of the birth experience, and COVID-19 in the perinatal population. Cumulative Index to Nursing and Allied health (CINAHL), Medline, PubMed, and the PsychInfo databases were used for the literature search. The publication dates were limited to include those published between 2016 and 2021.

I used keywords in my database searches for the three pertinent topics related to the study. The keyword phrase *maternal role attainment* yielded 79 results. For the perceptions of the birth experience, the keywords used included *birth experience and childbirth,* which produced 545 matches. To further guide the scope of the results, I added *qualitative research,* which narrowed the search to 27 results. I ran an additional search with the keywords *birth experience* and *COVID-19,* which yielded five results. The keywords used for COVID-19 in the perinatal population included *COVID-19*; *SARS-CoV-2*; *coronavirus*; and *delivery, birth, labor, or childbirth,* which produced 1,224 results. Considering the novel nature of COVID-19, much of the research is global, as is evident in the literature review. Because I was most interested in the care practice changes resulting from the COVID-19 pandemic, I added the keywords *protocol and practice guidelines* to my active search and narrowed the results to 152.

I reviewed each relevant topic search result for relevance and application to the current study. Articles related to the perceptions of the birth experience were further

narrowed by eliminating those that focused on experiences specific to infant loss, preterm deliveries, admission to the Neonatal Intensive Care Unit (NICU), or paternal and grandparent perceptions. Articles relating to COVID-19 in the perinatal population were reviewed, and those focused on therapeutic and medication interventions were eliminated. Those that focused on systematic reviews of perinatal care practices during COVID-19 were reviewed closer. There was a total of 42 articles retained between all of the searches.

Theoretical Foundation

The MRAT served as the theoretical framework for the study. Many factors can influence successful maternal role attainment, including the mother's perception of the birth experience, early mother-infant contact, and social support (Mercer, 1985). Although Mercer developed the MRAT in the 1980s, it is still applicable today. It is particularly relevant when exploring the impact of the changes made in the health care setting due to the COVID-19 pandemic.

The origin of the MRAT started with Reva Rubin's theory of maternal identity, which the researcher developed from field notes of nurses caring for women in pregnancy and the postpartum period (Mercer, 1985). Rubin stated that maternal identity and role attainment were not an automatic response but a process that mothers achieved by progressing through mimicry stages, role play, fantasy, introjection-projection-rejection, and grief work (Mercer, 1981). Mercer was a student of Rubin and expanded her maternal identity theory to create a theoretical framework that includes both mother and infant variables that influence the successful attainment of the maternal role.

Mercer's (2004) MRAT also includes concepts from Thornton and Nardi's 1975 role acquisition theory, which describes four stages for role acquisition: anticipatory, formal, informal, and personal. Mercer applied the four stages of Thornton and Nardi's role acquisition theory to the MRAT and defined them in the context of maternal role attainment. The first stage is the anticipatory stage, which occurs during pregnancy as a mother acclimates psychologically and socially to the idea of motherhood. At birth, the formal stage happens when the mother first meets her infant and provides care for her infant but relies on expert guidance and instructions from others on mothering. The informal stage occurs in the initial postpartum period as the mother learns her own style of caring for her infant and forms confidence in her own maternal role. The final stage is the personal stage, where the mother achieves confidence in herself, and her maternal identity is characterized by the new normal with the baby in harmony with everyday life (Mercer, 1981, 1985; Noseff, 2014).

Mercer (2004) revised her theory over time, suggesting a name change in 2004 to Becoming a Mother as she believed the achievement of becoming a mother happened over time instead of something attained at a specific time. She used new terms to describe the stages in achieving the maternal role. The first stage was renamed *commitment, attachment, and preparation* and occurred during pregnancy. The second stage, occurring from birth to 6 weeks postpartum, was renamed *acquaintance, learning, physical restoration*. The third stage was renamed *moving toward a new normal* and usually occurred between 2 weeks to 4 months postpartum. The final stage, renamed *achievement*

of the maternal identity, is accomplished around 4 months. Although the names changed, the concepts of each stage remained similar to her original stages of the MRAT.

The MRAT has four global concepts centered around mother and infant: human being, the environment, health, and nursing (Cabrera, 2018). The theory's assumptions include the mother as a human being with individual values, morals, and self-esteem that impact maternal role and the mother's current health status on factors in achieving successful maternal role attainment. The environment includes forces outside the mother, such as changes in settings, life experiences, and stress, which must be balanced to successfully attain the maternal role. Health consists of both maternal and paternal current health and factors that may affect the infant's health. Finally, Mercer (2001) described nursing as playing a vital role in promoting the health of mothers and infants through their interactions with mothers in the perinatal and postnatal period (see also Cabrera, 2018). Additional assumptions of the MRAT are that maternal and infant variables can impact maternal role attainment. These factors include maternal age, birth experience, available support, relationship with the father, experienced stress, personality traits, maternal health status, relationships with own mother, maternal depression and anxiety, infant appearance, infant temperament, and infant health status (Mercer, 2006).

Previous applications of the MRAT include the use of concepts from Mercer's MRAT theory to develop a scale intended to measure maternal role attainment. The 23-item Maternal Role Attainment Scale (MRAS) has been validated and comprises questions related to maternal-infant attachment, maternal role competence, and maternal role satisfaction using a 5-point Likert scale (Panthumas & Kittipichai, 2019). Tarkka

(2003) examined factors that impacted maternal role attainment at eight months and further validated the concepts of Mercer's MRAT by finding a correlation between maternal and infant characteristics and social support as essential components of successful maternal role attainment. Maternal role attainment has also been evaluated in planned and unplanned pregnancies and maternal role training in successful maternal role attainment. Kordi and colleagues (2021) found that training first-time moms with unplanned pregnancies based on Mercers MRAT improved maternal role attainment and satisfaction. Maternal attachment style, defined by attributes of ambivalence/anxiety/avoidance, has been explored in relationship with maternal role identity and found that maternal self-image, as well as image of one's own mother, impacted the maternal attachment style as well as the process of maternal role attainments (Zdolska-Wawrzkiewicz et al., 2019). MRAT has also been applied to specific populations such as teen mothers, first-time mothers, NICU mothers, mothers of infants with disabilities, and adoptive mothers.

Mercer's MRAT focuses on attaining the maternal role that occurs through a strong maternal-infant bond and leads to competence and confidence. COVID-19 has impacted the birth experience, and using the MRAT as the theoretical foundation aids in understanding the importance of a mother's perception of her birth experience in successful role attainment. The role of nursing is a foundational concept in the MRAT and guides the healthcare team caring for mothers during pregnancy and postpartum can help them successfully transition to their new identity and role as a mother (Mercer, 1985; Mercer, 2004; Zukauskas, 2020;).

Many of the key variables identified in the MRAT, such as health status, birth experience, and having support during birth and postpartum, have been impacted by COVID-19. The purpose of this study is to look beyond the statistics of the COVID-19 pandemic and listen to the lived experience of mothers who have delivered a baby in the healthcare setting during the pandemic. The MRAT provided guidance that healthcare providers can apply to support mothers in transitioning into their new identity and role as a mother and identify when there are barriers to that transition. The principles of MRAT can then be used to educate, support, and intervene to promote bonding and maternal role attainment, which leads to the best outcomes for mothers, infants, and families (Cabrera, 2018).

Conceptual Framework

IPA involves exploring, describing, and interpreting how participants make sense of their experiences. IPA seeks to answer the question, what is it like to experience the studied phenomenon (Peoples, 2021). IPA has been described as a qualitative approach and a conceptual framework (Smith et al., 2009). Many key conceptual underpinnings are essential to understand when choosing IPA for a study. The key concepts of IPA are based on Phenomenology, Hermeneutics, and Ideography.

IPA combines the descriptive aspect of Husserl's transcendental phenomenology, the interpretative aspect of Heidegger's Hermeneutic and Ideography to examine lived experiences. Husserl is known as the father of Phenomenology, and his work focused on how one knows their own experience (Smith et al., 2009). Husserl believed that key parts of a person's lived experience transcend the circumstances and enable them to describe

that experience to others (Smith et al., 2009). Heidegger was a student of Husserl and split off with a new approach known as Hermeneutic to create a less theoretical and more applicable approach to phenomenology. (Smith et al., 2009). Heidegger viewed a person in the context of the experience and engaged in the nature of the world. Hermeneutics is an interpretative reflection on a moment or significant event experienced in life expressed in a person's own terms and then explored in the context of how a person made sense of that experience (Smith et al., 2009). The key concept of Hermeneutics applied to IPA is that humans are part of the world and that being in the world creates a relational perspective. The researcher then makes sense of and interprets the participant's interviews, which is considered double hermeneutics (Smith et al., 2009). Ideography is concerned with understanding life experiences at the group level and examining general laws of human behavior. Ideography seeks to understand an individual's experience, then combine those individual experiences to find commonalities and generalizations. The use of analytical induction is used to analyze the data and gain any shared experiences from a set of cases (Smith et al., 2009).

IPA does not attempt to operationalize one specific theorist. It integrates Husserl's Phenomenology, Heidegger's Hermeneutic, and Ideography in the context of the participant's perception of the lived experience and the interpretation of that experience. Husserl's transcendental phenomenology influences the descriptive nature of the lived experience in the IPA approach. Hermeneutics is influential in IPA with the analysis that always involves interpreting people's meaning of a life experience, thus making their recount of the event as seen through the hermeneutic lens. IPA integrates Ideography in

the context of participants' individual personal perspectives and then finds common themes to make more general claims (Smith et al., 2009). Combining these key phenomenological theories allows for the exploration of the participant's lived experiences on their terms without predetermined ideas (Smith et al., 2008)

IPA began in Psychology and is now being used in health psychology, education, and nursing (Smith et al., 2009). The birth experience is unique to women in itself, however, there is an even more unique population of women who have delivered a baby during the COVID-19 pandemic. The study participants are a group of women who have a shared connection of making sense of a life-changing moment in the context of a pandemic that only women who have lived through it share. IPA is perfectly designed to capture the lived experience of women who delivered a baby in the hospital during the COVID-19 pandemic (Smith et al., 2008).

Literature Review Related to Key Concepts

The Birth Experience

A review of the literature found numerous studies that have explored the birth experience to see the short-term and long-term impacts of the perception of the birth experience on the mother's and infant's wellness and health (Barker et al., 2017; Bringedal & Aune, 2019; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Zeynep, 2020;). The perception of the birth experience is uniquely individual and plays a critical role in a mother's physical and mental well-being and her relationship with her infant. The pre-COVID-19 focus of research on the birth experience included exploring the impact of shared decision-making, having support during labor, the

relationship with the healthcare team, and medical intervention on women's perception of their birth experiences (Bringedal and Aune, 2019; Zeynep, 2020). The findings indicate that a positive perception of the birth experience is associated with favorable attitudes to motherhood and a favorable relationship with her infant (Barker et al., 2017; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019). Current literature between the years 2000-2021 found a consensus that a mother's perception of the birth experience can have short-term and long-term impacts on maternal and infant health. A positive perception of the birth experience is associated with feelings of accomplishment, positive feelings about the infant, successful breastfeeding, and successful adaptation to motherhood. In contrast, a negative perception of the birth experience is associated with an increased risk of impaired mother-infant bonding and an increased risk of mental health disorders for mothers (Aktas & Aydin, 2018; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019).

Shared Decision-Making

Shared decision-making and control during labor have been described as a theme in many qualitative phenomenological and descriptive studies on the birth experience (Bringedal & Aune, 2019; Chabbert et al., 2021; Zeynep, 2020). A woman's ability to cope and make informed choices during birth influenced her birth experience (Bringedal & Aune, 2019; Hemberg & Kock, 2018). Perceived control and inclusion in decision-making during labor were identified as predictive of a positive birth experience. In contrast, inadequate control and exclusion in the decision-making process were risk factors for a negative birth experience. (Chabbert et al., 2021). Agency was described by

Hall et al. (2018) as making decisions during labor with small choices, such as what to wear and freedom of positioning during labor, and more significant decisions around medical interventions such as being induced, receiving an epidural, or having a Cesarean section. The importance of respecting agency was highlighted as a key factor in a mother reporting the birth experience as positive. Women reported the importance of being active in and having control of decisions during birth to harness their inner strength. Finding that inner strength in themselves and being part of the decisions during labor improved their perception of their birth experience (Hemberg & Kock, 2018). Personal expectations and shared decision-making were essential factors in determining women's satisfaction with their birth experience (Bringedal & Aune, 2019). Pereda-Goikoetxea et al. (2019) described the helix priorities of needs in the hospital setting, one of which was receiving accurate information and being part of decisions. The helix of needs was identified as the propelling force for the final perception of birth.

Zeynep (2020) reviewed common medical interventions and their relationship with the birth experience. Three hundred and thirty-three women who delivered term babies completed a questionnaire focused on birth characteristics, interventions used during birth, and the participants' birth experience and expectations. It was found that decreased interventions, adequate support, and shared decision-making were factors that led to an increase in reporting a positive birth experience

Relationship With the Health Care Team

Mothers placed a high value on the connection with family and healthcare team members who were trusted to care for them (Hall et al., 2018; Hemberg & Kock, 2018;

Pereda-Goikoetxea et al., 2019). Connection with the healthcare team made women more likely to feel positive about the birth experience. Pereda-Goikoetxea et al. (2019) described professional care as a healthcare team providing competence and compassionate care. Mothers highlighted the relationship with the healthcare team by saying that a supportive relationship promoted confidence, trust, and a positive birth experience (Bringedal & Aune, 2019). A positive connection with the healthcare team made mothers more likely to report a positive birth experience when they felt listened to and supported by the healthcare team. Hemberg and Kock (2018) explored women's experiences of inner strength during childbirth and factors that impacted that strength. In addition to connection and support from the healthcare team, mothers reported the importance of connecting with their significant other and newborns. Having a supportive relationship with family and the healthcare team was a predictive factor for a positive birth experience. On the contrary, family and the healthcare team's inadequate support were identified as risk factors for a negative birth experience (Chabbert et al., 2021).

Negative Birth Experience

Research has also focused on women who reported having a negative birth experience to explore their attitudes and emotions and factors contributing to their negative birth experience. It is estimated that between 5-33% of women report a negative birth experience (Aktas & Aydin, 2018; Baxter, 2020; Chabbert et al., 2021). A mother's perception of a negative or traumatic birth experience was associated with negative maternal self-esteem, postpartum depression, PTSD, impaired infant bonding, and difficulty with successful breastfeeding (Chabbert et al., 2021). Mothers who reported a

negative birth experience identified three major themes: low-quality relationship with the healthcare team, lack of physical and emotional support during labor, and lack of information to make decisions (Aktas & Aydin, 2018; Baxter, 2020). The type of delivery was a predictive factor, with an emergency Cesarean section or operative delivery being a risk factor for a negative perception of birth. Psychological factors such as a history of sex abuse, mental illness, stressful life events, and uncontrolled pain were also identified as contributing to a negative birth experience (Chabbert et al., 2021). Sharing individual birth stories through debriefings was shown to help make sense of the experience and helped to gain a greater understanding of and validate the experience.

The Experience of COVID-19 During Pregnancy

The Coronavirus SARS-CoV-2, which causes the infection known as COVID-19, was first identified in December 2019. Due to the novel nature of COVID-19, there was no natural immunity, nor was there a scientifically validated medical treatment or vaccine to mitigate against it (Chen et al., 2020). COVID-19 in pregnant women and infants is particularly concerning as they are vulnerable populations. Rapid publications started in January of 2020 of case studies, case series, and systematic reviews from all over the world as COVID-19 positive mothers delivered their infants. The focus of COVID-19 in pregnancy was on the possibility of vertical transmission, prevalence, risk factors, impact on pregnancy outcomes, and maternal and infant outcomes. Early case reports from China, where COVID-19 originated, and studies that completed systematic reviews of the available literature on COVID-19 in pregnancy at different times during the pandemic

were selected to gain a broader knowledge of the published literature and see how that knowledge evolved over time.

Impact and Outcomes

Early case studies from Yang et al. (2020) and Chen et al. (2020) shed the first glimpse of the potential impact of COVID-19 on the pregnant population. Both case reports came from China, where the virus originated; both had limitations due to the stringent protocols for delivery and isolation following delivery. The clinical characteristics were reviewed on sixteen women who tested positive for COVID-19 in the third trimester. All participants had a Cesarean section delivery, did not have delayed cord clamping, and were immediately separated from their mothers for 14 days. Four of the sixteen women delivered preterm, but none less than 36 weeks gestation. None of the infants born to COVID-19 positive mothers had any adverse outcomes following delivery.

As more countries faced the challenge of women worldwide delivering infants that were COVID-19 positive, more case reports and outcomes were reported. Mullins et al. (2020) performed a literature review from research published by April 2020 from twenty-one studies with thirty-two case reviews of COVID-19 positive mothers and the thirty babies they delivered. Of the thirty-two mothers in the review, seven were asymptomatic (22%), two had a severe infection and were admitted to the Intensive care unit (ICU) (6%), fifteen delivered preterm (47%), twenty-seven had a C/S (93%), and two had vaginal deliveries (7%) with no maternal deaths reported. By May 2020, many institutions reported implementing universal COVID-19 testing on all pregnant mothers

admitted to the hospital. There were new reports that 45-90% of cases were asymptomatic (Pettirosso et al., 2020). A review of sixty articles from China, the United States, Italy, Iran, the United Kingdom, and Portugal included 1,287 confirmed positive COVID-19 mothers with one hundred and eleven severe COVID-19 cases (8%), forty critical COVID-19 cases (3%), and eight maternal deaths (0.6%). Literature reviews up to July 2020 found that approximately 85% of pregnant women experienced mild disease, 10% experienced severe disease, and 5% experienced critical disease with the COVID-19 virus, but almost all ending up recovering and being discharged home (Ryan et al., 2020; Zaigham & Anderson, 2020). In pregnant women, comorbidities such as diabetes, hypertension, asthma, HIV, heart disease, and lung disease make them more susceptible to severe and critical diseases (Pountoukidou et al., 2021; Ryan et al., 2020:). The overall outcomes for infants included a slightly higher rate of preterm delivery, usually not less than 36 weeks, and not posing significant adverse clinical outcomes or death (Chen et al., 2020; Ryan et al., 2020; Yang et al., 2020; Zaigham & Anderson, 2020).

Lack of Vertical Transmission

The current consensus of the published literature to date shows no evidence of vertical transmission of COVID-19 during gestation, with the significant risk for transmission occurring following delivery via horizontal transmission (Breslin et al., 2020; Chen et al., 2020; Mullins et al., 2020; Ryan et al., 2020; Yang et al., 2020). The early case reports from Yang et al. (2020) and Chen et al. (2020) performed testing on umbilical cord blood, breast milk, amniotic fluid, and pharyngeal swabs of infants immediately after delivery, and all were reported to be negative for SARS-CoV-2.

Mimouni et al. (2020) summarized available literature up to March 2020 on perinatal aspects of COVID-19. There was no evidence at this time of vertical transmission; however, it was noted that a limitation was that all cases included in the review were COVID-19 positive in the second and third trimesters (Chen et al., 2020; Mimouni et al., 2020; Yang et al., 2020). While there is no current evidence of vertical transmission, SARS CoV-2 specific IgM and IgG antibodies were found in three newborns of COVID positive mothers, suggesting the possibility of transplacental transfer that resulted in the production of the IgM antibody because IgM antibodies are too large to cross the placenta (Mullins et al., 2020). The consensus in the literature is that more research is needed, particularly for women with COVID-19 in the first trimester, to determine if there is any evidence of vertical transmission (Breslin et al., 2020; Chen et al., 2020; Mimouni et al., 2020; Mullins et al., 2020; Yang et al., 2020). There are also recommendations to focus future research on investigating any additional consequences of COVID infection on fetal growth, congenital abnormalities, pregnancy loss, or an increase in preterm labor (Breslin et al., 2020; Chen et al., 2020; Mimouni et al., 2020; Mullins et al., 2020; Ryan et al., 2020; Yang et al., 2020).

Changes to Obstetric Care Practices During COVID-19

In response to the rapid spread of COVID-19, healthcare settings across the United States had to implement changes to current isolation precautions, PPE requirements, and obstetrical care practices to minimize the risk of transmission in the antepartum, intrapartum, and postpartum units of hospitals (Mimouni et al., 2020; Pavlidis et al., 2020). It is important to explore the changes put in place during the

COVID-19 pandemic to evaluate the potential impact of these changes on the birth experience. A systematic review of guidelines during the COVID-19 pandemic through May 2020 specific to obstetrical care practices during pregnancy, birth, and the immediate postpartum period found eighty-one guidelines from forty-eight different United States and international organizations (Pavlidis et al., 2020). Pountoukidou and colleges (2021) completed a literature review through March of 2021 that summarized the consensus on the up-to-date recommendations on managing COVID-19 infection during prenatal, intrapartum, and postpartum periods. There was a consensus across some guidelines for specific interventions and differing opinions on other guidelines, making standard practice changes and protocols difficult for healthcare organizations. The multitude of recommendations from professional organizations and uncertainty around transmission risk has led to many variations in infection prevention and obstetric care practices throughout the COVID-19 pandemic (Gupta et al., 2020).

Visitation and Screening

Healthcare settings implemented changes to visitors and support persons during the height of the COVID-19 pandemic to protect vulnerable patients and decrease the potential of continued viral spread (Davis-Floyd et al., 2020). There was a majority consensus in the literature against denying all visitation and support during childbirth regardless of COVID-19 status but agreed with the recommendation to limit visitors (Pavlidis et al., 2020; Pountoukidou et al., 2021). Guidelines suggested allowing one consistent health support person without rotating additional visitors and required health screening. At the beginning of the pandemic, testing was only done with confirmed travel

to certain areas and if mothers showed symptoms of COVID-19. Breslin (2020) universally tested all mothers admitted to a Labor and Delivery (L/D) unit in a New York hospital for two weeks in March 2020 and reported 33% were asymptomatic COVID-19 positive. The results significantly highlight the need for universal testing to identify the infection early and provide appropriate isolation precautions to protect mothers, infants, and the obstetrical healthcare team. The recognition of the high asymptomatic rates further supported the need to limit or restrict the number of visitors on L/D and NICU units.

Isolation Precautions and Personal Protective Equipment

PPE recommendations were changed for the healthcare team when caring for patients that were COVID-19 positive. During cesarean sections, active pushing and delivery, and infant stabilization, it was recommended to wear N95 masks, gowns, and face shields as they were considered aerosolizing procedures (Pountoukidou et al., 2021). The importance of L/D staff using appropriate PPE was essential to limit exposure and transmission with COVID-19 positive mothers and their infants. It was also recommended that COVID-19 positive mothers and their support person should also wear face coverings throughout their entire admission in the healthcare setting (Ryan et al., 2020).

Mode of Delivery

The early case reports by Chen et al. (2020) and Yang et al. (2020) used strict protocols for the COVID-19 positive mothers, including all patients requiring a Cesarean Section. A meta-analysis of current literature specific to the mode of delivery during the

COVID-19 pandemic reported an increase in Cesarean Section rates in COVID-19 positive women to range between 43-92% (Pettirosso et al., 2020; Ryan et al., 2020). A review of current literature found thirty-two guidelines from twenty-seven organizations on the mode of delivery for COVID-19 positive mothers. There was no reported difference in risk of transmission or outcomes of COVID-19 between vaginal delivery and C/S. Unless there was rapid deterioration of the mother, delivery should not be expedited based solely on COVID status. The majority consensus in the literature was that the mode of birth should not be based on the mother's COVID-19 status but on obstetrical factors (Gujski et al., 2020; Pavlidis et al., 2020; Pountoukidou et al., 2021).

Delayed Cord Clamping

Despite the lack of confirmed transmission, early recommendations were to avoid delayed cord clamping for mothers with a confirmed COVID-19 positive test due to the theoretical increased risk of transmission of COVID-19 from the mother to the baby through the cord blood (Chen et al., 2020; Yang et al., 2020). Pavlidis et al. (2020) reported twenty published guidelines on delayed cord clamping from eighteen organizations. There was a lack of evidence to support the transmission of SARS-CoV-2 through cord blood, but no consensus on whether delayed cord clamping was appropriate with COVID-19 positive mothers. The practice of early cord clamping did not eliminate the existing possibility of maternal-infant transfer. Delayed cord clamping is a standard of care and should continue to be practiced without evidence of increased risk (Pountoukidou et al., 2021). Many organizations recognized that the benefits of delayed

cord clamping outweighed the theoretical risks for infants of COVID-19 positive mothers and continued to allow delayed cord clamping (Mullins et al., 2020).

Skin-to-Skin Contact

The positive impact of skin-to-skin contact on maternal-infant bonding is well documented in the literature (Dumas et al., 2013; Gutschow & Davis-Floyd, 2021). Early in the pandemic, it was recommended to refrain from skin-to-skin after delivery with COVID-19 positive mothers (Chen et al., 2020; Yang et al., 2020). A literature review found twenty-one recommendations from sixteen organizations on skin-to-skin contact during the pandemic (Pavlidis et al., 2020). There is no evidence of increased transmission occurring with skin-to-skin contact when proper hand hygiene and face coverings were used. The majority consensus in the literature was that the benefits of skin-to-skin and maternal-infant bonding outweigh the theoretical risk (Aros-Vera et al., 2021; Pountoukidou et al., 2021). The importance of maintaining the practice of skin-to-skin contact is central to maternal-infant bonding and infant stabilization. (Aros-Vera et al., 2021). The recommendation was to educate mothers on the proper PPE needed to decrease the risk of transmission and encourage skin-to-skin contact between mother and infant (Mullins et al., 2020; Pavlidis et al., 2020; Pountoukidou et al., 2021).

Mother-Infant Separation

A mother and infant's relationship is intimate and involves close contact. Family-centered care promotes keeping mothers and infants together unless there is a medical indication to separate them (Gutschow & Davis-Floyd, 2021). At the onset of the pandemic, there was a debate on whether infants should room in with COVID-19 positive

mothers due to the risk of transmission between mother and infant. After months of case reports worldwide, there was no evidence of different outcomes with rooming-in versus mother-infant separation when appropriate distancing, hand hygiene, and face coverings were used. A literature review found thirty-two published guidelines from twenty-seven organizations on infants rooming in with COVID-19 positive mothers (Pavlidis et al., 2020). Guidelines recommended that mothers be part of the decision with education on the risk and benefits of both rooming-in and separation (Ryan et al., 2020; Mullins et al., 2020). If mothers have severe diseases and cannot care for their infants, they should be separated and cared for by a healthy support person. If rooming-in was done, the recommendation was to keep the infant and COVID positive mothers 6 feet apart in the room when not providing direct care with a curtain or other barrier between the mother and her infant. When COVID-19 positive mothers provide direct care to their infant, they should use strict hand hygiene and wear a face covering (Mullins et al., 2020; Ryan et al., 2020; Pavlidis et al., 2020; Pountoukidou et al., 2021). The separation of mothers from their infants negatively impacts breastfeeding, which has been shown to increase maternal anxiety and distress (Aros-Vera et al., 2021). Reducing separation of the mother and her infant improves maternal and infant outcomes. Additionally, by supporting families in their decisions to room-in, the healthcare team modeled infection prevention practices to care for the infant at home after discharge (Gupta et al., 2020).

Breastfeeding

Early recommendations for confirmed COVID-19 positive mothers who had active infection was to refrain from breastfeeding for at least 14 days (Chen et al., 2020;

Gupta, 2020; Wang et al., 2020; Yang et al., 2020). A literature review found fifty-two guidelines from 41 organizations on breastfeeding (Pavlidis et al., 2020). There is no evidence to date that SARS-CoV-2 is passed through breastmilk (Chen et al., 2020; Mimouni et al., 2020; Mullins et al., 2020; Pavlidis et al., 2020; Ryan et al., 2020; Yang et al., 2020). The majority consensus of the literature is that breastmilk from COVID-19 positive mothers can be given to their infants. Breastfeeding is essential to the health of infants and should be encouraged regardless of a mother's COVID-19 status (Gutschow & Davis-Floyd, 2021). Breastmilk supports neurologic and cognitive development in infants, and lack of breastfeeding has been associated with an increase in infant infection and chronic conditions (Aros-Vera et al., 2021). Mothers who desire to breastfeed should be encouraged to directly breastfeed their infants with proper breast and hand hygiene and face coverings (Mullins et al., 2020; Pavlidis et al., 2020). Lack of inclusion of pregnant and breastfeeding women in the safety and efficacy trials of many medications that treat COVID has limited the knowledge on the safety of breast milk if a mother is being treated with severe COVID-19 infection. Therefore it is recommended to pump her breast milk to maintain milk supply but dispose of the milk (Aros-Vera et al., 2021; Wang et al., 2020). For mothers who are COVID-19 positive with infants requiring care in the NICU, pumped breastmilk should be used when possible (Mimouni et al., 2020; Pavlidis et al., 2020).

Care of Infant

Additional guidelines for managing infants who test positive for COVID-19 were made after the first report of a newborn testing positive for COVID-19 at 36 hours of life.

Infants should be considered a person under investigation (PUI) and isolated in a negative pressure room (Puopolo & Kimberlin, 2020). The infant should be tested at 24 hours of life and again at 48 -72 hours to obtain two negative tests. Criteria were established to be considered recovered from COVID-19 and included a normal temperature for three days, respiratory symptoms improved, and two negative nasopharyngeal swabs taken 24 hours apart. If an infant has tested positive, they should be isolated for 14 days (Puopolo & Kimberlin., 2020; Wand et al., 2020). It was recommended that a mother have two confirmed negative tests taken 24 hours apart before coming to the nursery to see her infant. Early clinical guidelines were made in the resuscitation of infants born to suspected or confirmed COVID-19 positive mothers, including N-95 masks, gowns, and face shields for the healthcare team during a resuscitation (Puopolo & Kimberlin, 2020). Also, it was recommended that infants of COVID-19 positive mothers be immediately bathed and put on droplet/contact precautions until virology status is known to be negative (Puopolo & Kimberlin, 2020).

Birth Experience During the COVID-19 Pandemic

Current literature on the impact of COVID-19 on the birth experience is limited to emerging studies published since the onset of the pandemic. The available research on the COVID-19 pandemic and the birth experience has indicated an impact on the overall birth experience regardless of the mother's COVID-19 test status (Lebel et al., 2020; Ravaldi et al., 2020; Ryan et al., 2020; Yasa et al., 2020). Mothers have reported increased symptoms of anxiety and depression during the COVID-19 pandemic compared to pre-pandemic surveys (Durankus & Aksu, 2020). Perinatal anxiety and

depression is a public health issues. Children of mothers with anxiety and depression have been associated with an increased risk of cognitive and behavioral problems (Lebel et al., 2020; Lok et al., 2021). Pregnant mothers reported increased anxiety about getting adequate prenatal care and fear of getting COVID-19. Mothers also expressed fear and anxiety about the limitation of support during labor, interruption of skin-to-skin contact, and separation from their infants during the pandemic (Durankus & Aksu, 2020; Lebel et al., 2020). Changes to visitation in the healthcare setting have left mothers anxious about having adequate support during labor and being forced to exclude important people in their birth experience. The limitation of support for mothers and changes to customary obstetric care practices during COVID-19 could impact whether the birth experience in the healthcare setting is perceived as a negative or positive one (Ravaldi et al., 2020). Yasa et al. (2020) surveyed 172 pregnant women to explore the psychological impact of COVID-19. It was reported that 80% of mothers were concerned for the safety of their baby due to the pandemic, 50% felt vulnerable being pregnant, 50% had concerns about whether breastfeeding was safe, and 76% didn't know if COVID-19 caused birth defects. Common words used to describe childbirth before the COVID-19 pandemic was joy, safety, love, feeling of closeness, but have been replaced with fear, loneliness, anxiety, danger, and worry (Ravaldi et al., 2020). Pregnant mothers also reported increased symptoms of depression from social isolation during the pandemic (Lebel et al., 2020). Social distancing has increased depression in pregnant mothers, as they reported feeling isolated during pregnancy and postpartum, minimizing families and visitors to keep themselves and their new baby safe (Spatz & Froh, 2020; Davis-Floyd et al., 2020). The

consensus in the literature reflects the importance of addressing the mothers' mental health and providing adequate antenatal and postpartum support during the unprecedented time of lockdown and social isolation related to the pandemic (Ryan et al., 2020).

Previous research explored the impact of a mother's perceptions of birth experiences on short- and long-term outcomes. A positive perception of the birth experience can result in feelings of accomplishment and empowerment or of pain, dissatisfaction, disconnection, and even trauma when it is a negative experience (Baxter, 2020; Bringedal & Aune, 2019; Hall et al., 2018; Pereda-Goikoetxea et al., 2019) Current research has also identified factors that impact whether a birth experience is perceived positively or negatively, including labor support, participation in decisions, medical intervention, relationship with caregivers, and immediate contact with the infant (Pereda-Goikoetxea et al., 2019). The strength of the literature has provided a greater understanding of the impact of the birth experience and the key factors that may impact the perception of the birth experience. The limitation of the current literature is the gap in exploring the birth experience under the conditions of the COVID-19 pandemic. Most research on COVID-19 in pregnancy is quantitative and focused primarily on symptoms, treatment, management, and outcomes, using case studies and case series. Due to the novel nature of the COVID-19 virus, it was a top priority to understand prevalence, transmission, and outcomes to help drive policy and practice recommendations and guidelines. The strength of current research is that it resulted in the development of guidelines and recommendations that led to changes in obstetric care practices in the

healthcare setting to protect mothers, infants, and the healthcare team. The weakness of the current literature on COVID-19 in pregnancy is limited information on the impact that the COVID-19 pandemic has had on the birth experience of mothers who have delivered in the healthcare setting in the U.S. The current literature on the birth experience during the COVID-19 pandemic has originated from countries outside the United States (Lebel et al., 2020; Ravaldi et al., 2020; Ryan et al., 2020; Yasa et al., 2020). There is limited research that specifically explores the birth experience of women who have delivered a baby in the healthcare setting in the U.S. during the COVID-10 pandemic from a phenomenological approach.

A woman's perception of her birth experience is a unique individual experience that can have short- and long-term effects on both the mother's and infant's health (Bringedal & Aune, 2019; Barker et al., 2017; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Zeynep, 2020;). Mercer also identified the importance of a mother's perception of her birth experience as a key variable to successfully maternal role attainment in her MRAT. The literature identified support during labor, shared decision-making, and minimal separation from infants as key factors contributing to a positive birth experience (Bringedal & Aune, 2019; Zeynep, 2020). These key factors were impacted when changes were made to obstetric care practices during the COVID-19 pandemic (Davis-Floyd et al., 2020; Mimouni et al., 2020; Mullins et al., 2020; Pavlidis et al., 2020; Pountoukidou et al., 2021). I chose the phenomenon of the birth experience during the COVID-19 pandemic to explore the lived experience of mothers who are delivering infants in the healthcare setting in the U.S. during the pandemic.

The birth experience stays with a woman for life. What is currently known is that a positive perception of the birth experience is associated with favorable attitudes to motherhood and a favorable relationship with her infant (Barker et al., 2017; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019). It is known that a mother's perception of her birth experience can be influenced by several factors, including environment, support during labor, and participation in decision-making, and bonding with her infant (Bringedal & Aune, 2019; Pereda-Goikoetxea et al., 2019). The changes set forth in the healthcare setting during the COVID-19 pandemic have impacted the key factors influencing women's perceptions of their birth experience. The recommendations made in the first 6-8 months of the pandemic based on theoretical risk of transmission were slowly replaced with recommendations backed with outcomes over time that allowed for more shared decision-making between mothers and the healthcare team (Gutschow & Davis-Floyd, 2021; Mimouni et al., 2020; Pavlidis et al., 2020; Pountoukidou et al., 2021). A year into the pandemic, obstetric providers described a shift from fear and uncertainty experienced at the beginning of the pandemic to action in implementing protocols based on evidence and outcomes learned as the pandemic evolved (Gutschow & Davis-Floyd, 2021; Pountoukidou et al., 2021). Many organizations made additional adjustments to identify COVID-19 mothers early with universal testing, continued using appropriate PPE for patients, their support person, and staff; but allowed delayed cord clamping, skin-to-skin, rooming-in, and promoted breastfeeding when desired (Gutschow & Davis-Floyd, 2021; Pountoukidou et al., 2021). Since the virus was new, and the COVID-19 obstetric care practices had not been done in

the past, there is a gap in knowledge and understanding of how the changes in obstetric care practices will affect women's perceptions of the birth experience. The impact of changes made during the COVID-19 pandemic on a mother's lived experience giving birth during the COVID-19 pandemic remains to be studied. IPA is committed to exploring, describing, and interpreting the perception of a participant's experiences and how they make sense of that experience (Smith et al., 2008). IPA is perfectly designed to capture the lived experience of women who delivered a baby in the hospital during the COVID-19 pandemic (Smith et al., 2008).

Summary and Conclusions

In the literature review, Mercer's MRAT was reviewed that focuses on attaining the maternal role, which occurs through a strong maternal-infant bond and leads to competence and confidence. I discussed IPA and explained the use of the approach in this study. Next, I summarized the current literature on the importance of the birth experience in maternal and infant well-being. I identified the emergence of COVID-19 and the increased risk the virus theoretically posed to pregnant mothers and infants. I reviewed the specific changes to isolation practices and obstetric care practices that have been made in the healthcare setting to decrease the risk of COVID-19 transmission. Then I explained the convergence of the COVID-19 isolation precautions and practice changes and the potential impact on the birth experience.

The literature has established that a mother's perception of her birth experience has short- and long-term impacts on her well-being and that of her infant (Barker et al., 2017; Chabbert et al., 2021 Hall et al., 2018; Pereda-Goikoetxea et al., 2019). It is known

that a mother's perception of her birth experience can be influenced by several factors, including environment, support during labor, and participation in decision-making, and bonding with her infant (Bringedal & Aune, 2019; Pereda-Goikoetxea et al., 2019). The changes set forth in the healthcare setting during the COVID-19 pandemic have impacted the factors identified as being impactful on women's perceptions of their birth experience. There is a gap in knowledge in understanding the lived experience of giving birth during the COVID-19 pandemic.

The study is built on the current understanding of the birth experience and filled the gap of knowledge by exploring the phenomenon of the birth experience under the condition of the COVID-19 pandemic. IPA was used to explore the mother's perception of her birth experience in the healthcare setting during the COVID-19 pandemic to gain an in-depth understanding of the lived experience. The use of individual interviews using semi-structured questions allowed women to tell the stories of their birth from their personal perspectives and how they made sense of it.

Chapter 3 presented the methodology, including the study population, sampling strategies, recruitment, and consent procedure. The role of the researcher and ethical considerations was described. Finally, I also provided details on the interview protocol that was used in the study.

Chapter 3: Research Method

Introduction

The purpose of the qualitative IPA study was to explore the lived experience of mothers who gave birth in the health care setting during the COVID-19 pandemic. I sought to determine the impact on their perceptions of their birth experience during the COVID-19 pandemic. Though the birth experience is a phenomenon that is well researched in the current literature (Bringedal & Aune, 2019; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Ravaldi et al., 2020), there is limited literature that is specifically focused on the perception of the birth experience of women who have delivered in health care settings in the United States during the COVID-10 pandemic from a phenomenological perspective.

In Chapter 3, I will define the birth experience as the phenomenon of interest and provide the rationale for choosing IPA to explore the lived experience of women who gave birth during the COVID-19 pandemic. I discuss the target sample size and sampling strategy of purposeful and snowball sampling for participant recruitment. The data collection and analysis plan is also described. The role of the researcher will be explained, including potential bias and how it was handled. The recruitment process, flyer, and inclusion criteria will be discussed in detail. The study's key ethical considerations will be highlighted, and the consent process will be described in detail. Finally, issues of trustworthiness such as validity, transferability, and dependability will be detailed.

Research Design and Rationale

As the COVID-19 pandemic continues, health care organizational leaders have implemented changes to isolation precautions and obstetric care practices to protect mothers, neonates, and the staff caring for them. The impact of these changes had yet to be explored from a phenomenological perspective. The research question was: What is the lived experience of women who delivered a baby in a healthcare setting during the COVID-19 pandemic?

The phenomenon of interest concerned how mothers' perception of their birth experience has been impacted by the changes to isolation and obstetric care practices instituted during the COVID-19 pandemic. A women's birth experience encompasses physical, mental, and emotional changes that occur with the delivery of an infant. The perception of the birth experience is uniquely individual and plays a critical role in the physical and mental well-being of a mother and her relationship with her infant. A positive perception of the birth experience is associated with favorable attitudes to motherhood and a favorable relationship with her infant and can be pivotal for healthy outcomes for mothers and infants (Barker et al., 2017; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019).

The study was a qualitative phenomenological study. I chose IPA because it is both descriptive and interpretive. IPA combines the descriptive aspect of Husserl's phenomenology and the interpretative aspect of Heidegger's hermeneutic and ideography to examine participants' lived experiences in their terms without predetermined ideas (Smith et al., 2009). Researchers use IPA to understand the lived experience of individual

participants and explore how they make sense of that experience in their own personal context (Smith & Nizza, 2021). Additionally, IPA allows a researcher to interpret patterns of similarities and differences of participants who have a shared experience (Smith & Nizza, 2021; Smith et al., 2009). By hearing the stories and emotions from those who have experienced it, the researcher is able to closely discern the experience. Using IPA, I explored each participant's unique personal lived experience to describe and interpret the individual lived experiences of mothers who gave birth during the COVID-19 pandemic and analyze the responses in the larger context of the shared experience.

When considering the research tradition to use in the study, I considered the ultimate goal to explore the lived experiences of women who gave birth during the COVID-19 pandemic. Quantitative research is a deductive process in which specific variables and hypotheses have been predetermined prior to the execution of the research (Smith & Nizza, 2021). Qualitative phenomenological research is an inductive process in which there is no predetermined hypothesis of results; this allows themes to emerge after the individual interviews have been conducted. IPA is particularly useful with experiences that are sacred moments or significant life events (Smith et al., 2009). The human life experience of a phenomenon is the beginning point that becomes meaningful through the participant's eyes, making it unique to them (Kacprzak, 2017; Smith et al., 2009). With IPA, the participants are the experts in their experience, and the language they use in the individual interviews is analyzed to interpret the meaning of their experiences (Smith & Nizza, 2021). Using IPA, I explored the detailed individual

account of the human experience gained from interviews with mothers who delivered a baby in the hospital setting during the COVID-19 pandemic.

Role of the Researcher

Qualitative research designs rely on the credibility of the researcher, who is the instrument used to collect data (Patton, 2015). Because the researcher is the instrument who collects the data, there is an inherent risk of bias as the researcher brings their perceptions, knowledge, and life experience to the study. It is debated whether the researcher's knowledge of the phenomenon of interest is a hindrance, as it leads to the possibility that they may be interjecting their own thoughts and theories in the interviews. However, it is argued that some knowledge of the phenomenon is helpful in IPA because knowledge of the phenomenon of interest provides the context and knowledge to ask essential and applicable questions (Smith &Nizza, 2021).

I am an RN with over 19 years of experience in maternal care, with ten years of bedside nursing in the Labor and Delivery unit, 4 years as the labor and delivery unit educator, and almost 6 years in my current role as the Clinical Practice Specialist for the Women and Children’s service line at a community hospital in the southern United States. I had an active role in evaluating the current literature, writing and reviewing the isolation precautions and obstetric care practice changes, and implementing COVID-19 protocols at my organization during the current pandemic. My experience was the driving force to research the impact of COVID-19 on mothers’ perceptions of their birth experience during the COVID-19 pandemic. I had no professional authority relationship with any of the participants in the study.

The nature of the phenomenological approach leads to personal connection and relationship between the researcher and the study participants. The relationship created is essential for the establishment of rapport and trust in individual interviews. However, the researcher had empathetic neutrality during participants' interviews through awareness of personal perspective and self-reflection (Patton, 2015). During the interview, I was aware of my own personal ideas and lived experiences to allow the participant to be the expert in their own experience (Smith & Nizza, 2021).

The diagnosis of COVID-19 may be a sensitive topic or may carry somewhat of a stigma for mothers participating in the study. I reiterated that the interview is a safe environment for the mother to share her birth experience and reinforced that information will be kept confidential. Postpartum anxiety or depression occurs in approximately 20-25% of the population and could potentially be higher during the COVID-19 pandemic due to social isolation and shelter in place orders in many states. The mental health of the participants was considered during and after the interview. Participants who express or report emotional/psychological distress or trauma were offered resources from Postpartum Support International (PSI).

Methodology

Participant Selection Logic

The target population of interest for this study was mothers who have given birth during the COVID-19 pandemic. Eligible participants were at least 18 years of age, English speaking, delivered a live infant in the healthcare setting during the COVID-19 pandemic, and were discharged home from the healthcare setting. The mother's COVID

status was not be included in the inclusion criteria because the birth experience of all mothers has significantly been impacted by the response to COVID in the healthcare setting (Mullard & Wittmaack, 2021).

IPA research does not attempt to have a representative or random sample population. Instead, purposeful sampling creates a like population based on the inclusion criteria and includes participants with a shared lived experience (Smith and Nizza, 2021). Snowball sampling was used when participants knew someone who met the criteria to meet the target number of participants. Perspective participants reached out to the researcher through the Facebook messenger, phone, or email provided in the recruitment flyer.

Inclusion criteria was that the mother was at least 18 years old, English speaking, delivered a live infant in the healthcare setting in the after October 2020, and was discharged home from the healthcare setting. Exclusion criteria include women less than 18 years of age, who do not speak English, delivered a non-viable infant, delivered outside the healthcare setting before October 2020, or had not been discharged home.

To recruit participants, I posted a flyer (see Appendix A) on the Facebook social media platform. The flyer provided my contact information for potential candidates to reach out with their interest in participating in the study. I screened participants based on the inclusion criteria during the initial contact with potential participants.

Qualitative research yields rich data from in-depth interviews with participants as they share their lived experiences. Smith and Nizza (2021) recommend a sample size of

between 10-12 participants for doctoral students and post-doctoral researchers. My target sample size was ten mothers to participate in the study or until saturation is reached.

Recruitment occurred online using the Facebook social media platform, with a purposeful sampling recruitment method and the use of snowball recruitment to reach a targeted sample size of 10. The Facebook post was a flyer that included the purpose of the study, inclusion criteria, and my information to contact if interested in participating. Once a participant responded to the social media post via direct messenger on social media, telephone, or email, initial contact was made, and the prospective participant was screened with the set inclusion criteria. If the participant met the inclusion criteria and wished to participate, an invitation email was sent to the participant that includes the purpose of the research, the time requirement, and an electronic informed consent. After the participant returned the email and the confirmation of completed consent was made, an interview time for the recorded Zoom interview was agreed upon that was convenient for the participant. A five to ten minute technical check meeting was offered before the actual interview. A final email was be sent to the participant with a link to the interview. After starting the recorded individual interview, the informed consent was reviewed again, and verbal consent to continue was obtained. Before all interviews, approval for human subject's research was obtained through the Walden University's Institutional Review Board (approval no. 02-15-22-0762741).

The target sample size for this study was 10 participants, or until saturation is reached. The study aimed to fully describe the phenomenon of interest through individual in-depth interviews. There is no concrete or standard sample size in qualitative research.

Therefore, a sample size of between 10-12 participants is commonly recommended depending on the qualitative approach used (Smith et al., 2009; Smith & Nizza, 2021).

A key concept in qualitative research is that of saturation. Saturation is the exploration of a concept or phenomenon until it is fully described and no new emerging concepts come to light. At that point, additional interviews do not contribute new ideas or concepts to the overall understanding of the concept or phenomenon, and data collection will be halted.

Instrumentation

I collected data by conducting in-depth, individual, semistructured interviews. For the interviews, I followed an interview protocol that contained the interview questions (see Appendix B). Due to the COVID-19 pandemic, the individual interviews were conducted and recorded by me via the Zoom platform. Interviews last between 30-60 minutes. I also created notes in a reflective journal following each interview.

There are different ways to collect data in qualitative research, such as interviews, diaries, pictures, and paintings. In-depth, semi-structured interviews are the most common approach for IPA studies because they allow for the first-hand account of the participant. In-depth interviews allowed the attainment of descriptive and reflective data as participants freely express the thoughts and ideas that are most significant to them without predetermined structures.

Smith and Nizza (2021) recommend using both descriptive and reflective questions in IPA research interviews. It is also recommended to carefully consider the order of questions, starting broader and then moving to more specific questions.

Questions were asked about the pregnancy, birth, and postpartum period which all contribute to the overall perception of the birth experience based on Mercer's MRAT (Mercer, 19885; Mercer, 2004). My literature review highlighted key factors that influenced the birth experience, such as shared decision-making, having support during labor, the relationship with the healthcare team, and medical intervention (Bringedal & Aune, 2019; Zeynep, 2020). The interview guide for the research project contained both descriptive and reflective questions, as Smith and Nizza (2021) recommended.

Validity in qualitative research includes designing questions that answer the research question and facilitating open conversations for the participant to fully express their experience (Smith et al., 2009; Smith & Nizza, 2021). In the planning phase of the interview guideline, I evaluated each question to make sure they are free from leading statements and assumptions. During interviews, it was also important to minimize over-empathetic, manipulative, and leading feedback from the interviewer. I kept my own verbal input to a minimum and listen carefully to the participant's experience.

With IPA, interview questions are designed to facilitate fully developed responses from participants (Smith & Nizza, 2021). Each interview is a unique exchange between the interviewer and participant. The interview guideline was not meant to be prescriptive but as .a loose guide. The use of open-ended questions helped facilitate in-depth responses. Interviewing in IPA is also an iterative process that allowed for follow-up and probing questions when further depth is warranted.

Procedures for Recruitment, Participant, and Data Collection

The study used individual in-depth interviews via the virtual platform Zoom meeting with open-ended, semi-structured questions about the lived experience of giving birth in the healthcare setting during the COVID-19 pandemic. I was the only person to screen and interview the participants in the study. Once a participant was identified, a Zoom call was scheduled at a convenient time for the participant. Each individual interview was recorded and lasted between 30-60 minutes via Zoom. There was no additional interview or follow-up scheduled in the study. The participants were informed that their information will be securely stored. They were available to be contacted for follow-up only if there is a need for clarification, technology interruption, or failure.

Data Analysis Plan

To explore the lived experience of mothers giving birth during the COVID-19 pandemic, I used the steps of IPA to analyze the data collected from the individual in-depth interviews conducted. Manual coding allowed the researcher to become part of the process and avoids the steep learning curve of many qualitative data analysis programs (Saldana, 2016; Smith & Nizza, 2021). The comments in the interviews were the primary data to be analyzed, so I first completed a verbatim transcription in a Word document. The Word document was divided into two columns allowing for the transcription to be in the left column and notes for analysis in in the right columns. Once the individual interview was transcribed verbatim, the analysis was a three-part process. The central focus of the analysis in IPA is interpretation (Smith & Nazzi, 2021). There is software

that assists in analyzing qualitative data; however, I did not use any software and completed the analysis manually (Smith et al., 2009).

The first step of analysis was making exploratory notes on words or sentences of interest or importance throughout the verbatim transcript and listing them in the right column of the Word document (Smith & Nazzi, 2021). The exploratory notes stage differentiated descriptive notes, linguistics notes, and conceptual notes. Descriptive notes were typed and described and highlighted general keywords and phrases used by participants. These notes were taken at face value with the participant's perspective in mind (Smith et al., 2009). Linguistic notes focused on the specific language used and reflected how it conveyed the participants meaning of the event. The linguistic-specific notes were underlined during the exploratory note step (Smith & Nazzi, 2021; Smith et al., 2009). Conceptual notes go beyond face value and usually take the form of a question (Smith & Nizza, 2021). The purpose of the conceptual notes was to question the range of potential meanings to understand the participant’s perspective better. Conceptual notes were differentiated by italicizing them.

Step two began the formulation of experiential statements that interpreted the meaning of the experience verbalized by the participant. The experiential statements are open phrases that concisely summarize what emerges as important in the transcript. Each time the participant spoke, multiple experiential statements emerged that succinctly summarize the important ideas to the participant and were recorded in the right column of the Word document (Smith & Nizza, 2021). These experiential statements were taken

from and were directly supported by the transcript, keeping the participant's voice active in the analysis.

The third step of the analysis was clustering and connecting the experimental statements, and developing emergent themes (Smith et al., 2009; Smith & Nizza, 2021). Themes become the words spoken by the participants and the interpretation of the one doing the analysis (Smith et al., 2009). The entire list of experiential statements were reviewed to eliminate duplicates and refined by clustering similar statements together. After that was completed, the list of statements that remain were printed, cut into individual themes, and placed on a surface to allow freedom of movement as they are reviewed. Each cluster was named as a theme. Experiential statements from individual interviews were supported by each theme. During the analysis, subthemes may also emerge (Smith & Nizza, 2021).

Step four was searching for connections across emergent themes. IPA is also idiographic, requiring each individual interview to be analyzed, but then includes a final step in the analysis that involves comparing the themes of each individual interview, looking for patterns of similarities, differences, and frequency across individual interviews (Saldana, 2016; Smith & Nizza, 2021).

Issues of Trustworthiness

Qualitative research is not evaluated for validity and reliability the same way as quantitative research. Smith et al. (2009) described four broad ways to assess the quality and validity of qualitative research which encompass the domains of credibility, transferability, dependability and confirmability.

Credibility

Credibility in qualitative research is comparable to internal validity in quantitative research. It will be accomplished with skillful empathetic interviewing and sensitivity to the interview and analysis context. Verbatim transcription will be done by myself as it gives me the ability to have a more in-depth understanding of the data. The transcription was completed via the audio-only recording converted from the Zoom recording. Then the audio recording was used to validate the transcription. This two-step validation process helped increase the transcribed data's credibility. I maintained sensitivity to the context of the data and included quotes from participants to support themes and keep the participant's voice in focus (Smith et al., 2009).

Transferability

Transferability in qualitative research is similar to external validity in quantitative research. The study participants will be a unique group of women who have given birth in the United States in a set time frame during the COVID-19 pandemic. The impact and importance of the lived experience of women delivering during the COVID-19 pandemic remained the focus and filled a gap in knowledge and understanding. The inclusion/exclusion recruitment criteria made the study results transferable beyond one participant or one state in the United States. Still, they aided in a greater understanding of the birth experience shared by the thousands of women giving birth around the United States.

Dependability

Dependability in qualitative research could be compared to reliability in quantitative research. Careful and accurate transcription of individual interviews is key in establishing dependability. Transparency through all steps of the process is also important and was achieved with detailed notes of the analysis process. I used transparent audit of the interview guidelines and analysis to maintain dependability in the study. I also kept a detailed reflective journal throughout interviewing and data analysis to detail the process of data collection and analysis.

Confirmability

Confirmability in qualitative research is the counterpart to objectivity in quantitative research. Although the interview questions were open-ended to allow each participant to express their unique birth experience, they were semistructured to help guide the content to reflect the research purpose. I intentionally acknowledged my own bias during participant interviews and maintained empathy through awareness and self-reflection (Patton, 2015).

Intra- and Intercoder Reliability

The analysis method, including exploratory notes, creating experiential statements, and clustering and final themes, were be done by me. With only one person is doing the analysis, inter-coder reliability is not questioned. To increase reliability, the committee chair and committee member reviewed the analysis process of each interview and after the analysis is complete for agreement.

Ethical Procedures

The diagnosis of COVID-19 may be a sensitive topic or may carry somewhat of a stigma for mothers participating in the study. I reiterated that the interview is a safe environment for the mother to share her birth experience and reinforced that information is kept confidential. Postpartum anxiety or depression occurs in approximately 20-25% of postpartum mothers and could potentially be higher during the COVID-19 pandemic due to social distancing and isolation. The mental health of the participants was considered during and after the interview. Women who had a negative birth experience reported a greater need to share their experiences (Baxter, 2020). Sharing and reflecting on the birth experience can be helpful for all mothers to make sense of their individual experiences. The study provided the opportunity for mothers who have delivered an infant in the healthcare setting to share their experiences through in-depth, semi-structured interviews. Participants who expressed or reported emotional/psychological distress or trauma during or after the interview were provided resources from Postpartum Support International (PSI).

Pregnant and postpartum mothers can be considered a vulnerable population, but the study was non-interventional and low risk. Interviews took place after the participant's delivery and discharge from the healthcare setting. Interviews were kept under 60 minutes at a mutually convenient time. All participants were given informed consent to participate in the study. Approval to conduct human subject research was obtained from the Walden University Institutional Review Board before any participant recruitment or interviews (approval no. 02-15-22-0762741).

Recruitment material was posted on the Facebook social media platform. Participation in the study was entirely voluntary, and no incentive was provided for participation. There was minimal risk to the participants, as the non-interventional study used individual interviews for data collection. There may be a benefit to the participants in sharing their birth stories and processing their experiences.

If the participant met the inclusion criteria and wished to participate, an invitation email was sent to the participant that included the purpose of the research, the time requirement, and an electronic informed consent. After the participant returned the email and the confirmation of completed consent was made, an interview time for the recorded Zoom interview was agreed upon that was convenient for the participant. Before starting the recorded individual interview, the informed consent was reviewed again, and verbal consent to continue was obtained.

Smith and Nizza (2021) described the ethical responsibility researchers have to uphold the elements of informed consent. Beyond explaining and attaining informed consent from participants, it is important to make sure participants know that they can choose not to answer any question if they do not wish to. It is also important that participants know they can end the interview at any time, and they can take back their consent to participate, at which time any information obtained from them would not be used in the study. I advocated for the ethical treatment of participants and reiterated their rights before the interview.

All data collected on paper was locked in a file cabinet and only accessed by myself. All data collected, transcribed, and analyzed in electronic format was stored on a

password-protected computer. All participants' names were removed, identified by assigned numbers, and kept in an electronic log on a password-protected computer that only I have access to. No identifying data were reported. All data will be deleted after five years.

Summary

The purpose of this qualitative phenomenological study was to explore the mother's perception of maternal-infant bonding during birth with the isolation practices in place during the COVID-19 pandemic. The research filled a gap in understanding mothers' perception of their birth and postpartum experience during the COVID-19 pandemic. The study was unique because, while there are studies on mothers' prevalence and care management during the COVID-19 pandemic, none specifically investigated how it impacts the mother's perception of the birth and postpartum experience. The study provided a much-needed insight into the mother's perceptions of the birth experience during COVID-19. The mother-infant bond is important, which has been interrupted due to the isolation precautions during the COVID-19 pandemic. Understanding the mother's personal perspective can provided insight into care practices that may be developed to help improve the care provided during pandemics such as COVID-19. Women and children are some of the most vulnerable populations, thus, it is imperative to focus on mothers' and infants' emotional and physiologic wellness, both while they are in the hospital and after discharge home. Looking beyond the statistics and listening to the mothers giving birth during the COVID-19 pandemic can create positive social change by empowering their voices in leading change. The results of the study aid in the current

understanding of birth under the stressful conditions of a pandemic and help guide practices that include complex decision-making and care that can still create a positive birth experience during this challenging time.

Chapter 4: Results

Introduction

The purpose of the qualitative phenomenological study was to explore the lived experience of mothers who gave birth in the health care setting during the COVID-19 pandemic. The findings describe the lived experience of mothers who delivered a baby during the COVID-19 pandemic. I sought to determine the impact of the changes to isolation practices and customary obstetrical care practices during COVID-19 on their birth experience. The birth experience is a phenomenon that is well researched in the current literature (Bringedal & Aune, 2019; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Ravaldi et al., 2020). There is limited current literature from other countries on the perception of the birth experience of women who delivered in health care settings during the pandemic, but none in the United States during the COVID-19 pandemic, according to my review of the literature. The research question was: What is the lived experience of women who delivered a baby in a healthcare setting during the COVID-19 pandemic?

In this chapter, I describe the setting and demographics of the participants. This description is followed by an overview of the data collection process, including number of participants, location of data collection, and how the data were collected and recorded. Next, the data analysis process is described including the IPA process used for identification of emergent themes. I then discuss how credibility, transferability, dependability, and trustworthiness were addressed throughout data collection and analysis. Finally, I present the results of the study. The presentation encompasses the

themes and subthemes that emerged during the analysis as well as supporting quotes from individual interviews.

Setting

The setting of the interview was online due to the state of COVID-19 and barriers to in person, face to face meetings. I interviewed the 10 participants via the Zoom platform. Participants were informed that the interview would take between 45-60 minutes and were allowed to provide a time that they would be in a place to be free of distractions for the interview. All of the participants were mothers who recently had a baby, and I encouraged them to plan the interview at a time that was best for them to have the minimum distractions and responsibilities from their children. All participants were at home when the interview was conducted, and I was in my home office during interview to provide privacy and decrease distractions and interruptions on my end.

Demographics

The 10 participants were mothers who delivered in acute health care settings during the COVID-19 pandemic and met all inclusion criteria. The participants provided demographic information in the beginning of the interview (see Table 1). Participants were between 29 and 46 years old, all were married, and nine out of the 10 participants were employed with one reported being unemployed. Eight participants described their ethnicity as White, and two described themselves as African American. Four participants reported having one birth, four reported having two births, one reported having three births, and one reported having five births. One delivered in 2020, five delivered in 2021, and two delivered in 2022.

Table 1

Participant Demographics

Participant No.	Age (years)	Ethnicity	No. of births	Month/year of birth
1	29	White	1	October 2021
2	38	White	2	January 2022
3	33	White	1	June 2021
4	30	White	2	December 2021
5	31	White	1	August 2021
6	26	White	1	January 2022
7	31	White	5	November 2021
8	46	White	3	November 2020
9	29	African American	2	November 2021
10	29	African American	2	January 2022

Data Collection

I conducted individual, in-depth, semistructured interviews. For the interviews, I developed an interview protocol with questions that were focused on the lived experience of women who gave birth in a health care setting during the COVID-19 pandemic (see Appendix B). Interviews were conducted on the 10 participants who met the inclusion criteria using the online Zoom platform. Due to climate of the COVID-19 pandemic, which continued to cycle through times of low cases and times of surges with high volumes of case, it was decided that the safest way to conduct interviews to create a safe

space for the participants was to complete the interviews using the online Zoom platform. The individual interviews were recorded and lasted between 30-60 minutes. There were no additional interviews or follow-ups scheduled in the study. Participants were informed that they would only be contacted for follow-up if there was a need for clarification, technology interruption, or failure.

Once participants were screened for inclusion and consent was reviewed and signed, a Zoom call was scheduled at a convenient time for the participant. Participants were offered a technical check prior to the scheduled interview, but all participants were familiar with Zoom and declined the offer. The interviews were recorded, and at the conclusion of the interview, the recording was stopped, and the audio file was converted and saved using a numeric representation of the interview (ex. Participant 1)

Data Analysis

To explore the lived experience of mothers giving birth during the COVID-19 pandemic, I used the steps of IPA to analyze the data collected from the individual in-depth interviews conducted. The comments in the interviews were the primary data to be analyzed, which were first transcribed verbatim in a Word document. The Word document was then divided into two columns allowing for the transcription to be in the left column and notes of analysis in the right column. Once the individual interview was transcribed verbatim, the analysis was a three-part process. The central focus of the analysis in IPA is interpretation (Smith & Nazzi, 2021). There is software that assists in analyzing qualitative data; however, I did not use any software and completed the analysis manually (Smith et al., 2009).

The first step of analysis was creating exploratory notes from words or sentences of interest or importance throughout the verbatim transcript and listing them in the right column of the Word document (Smith & Nazzi, 2021). The exploratory notes were typed in the right column and highlighted general keywords and phrases used by participants. These notes were taken at face value with the participant's perspective in mind (Smith et al., 2009). Linguistic notes focused on the specific language used and reflected how it conveyed the participant's meaning of the event (Smith & Nazzi, 2021; Smith et al., 2009). Conceptual notes go beyond face value and usually take the form of a question (Smith & Nizza, 2021).

Step two was taking the exploratory notes and formulating experiential statements that interpreted the meaning of the experience verbalized by the participant. The experiential statements are open phrases that concisely summarized the exploratory notes that emerged as important in the initial review of the transcript. These experiential statements were taken from and were directly supported by quotes from the transcript, keeping the participant's voice active in the analysis.

The third step of the analysis was clustering and connecting the experimental statements, and developing emergent themes (Smith et al., 2009; Smith & Nizza, 2021). Themes were identified from the words spoken of the participants that were then interpreted by me (Smith et al., 2009). The experiential statements that emerged were reviewed to eliminate duplicates and refined by clustering similar statements together. After clustering was completed, and duplicates were removed, the list of experiential

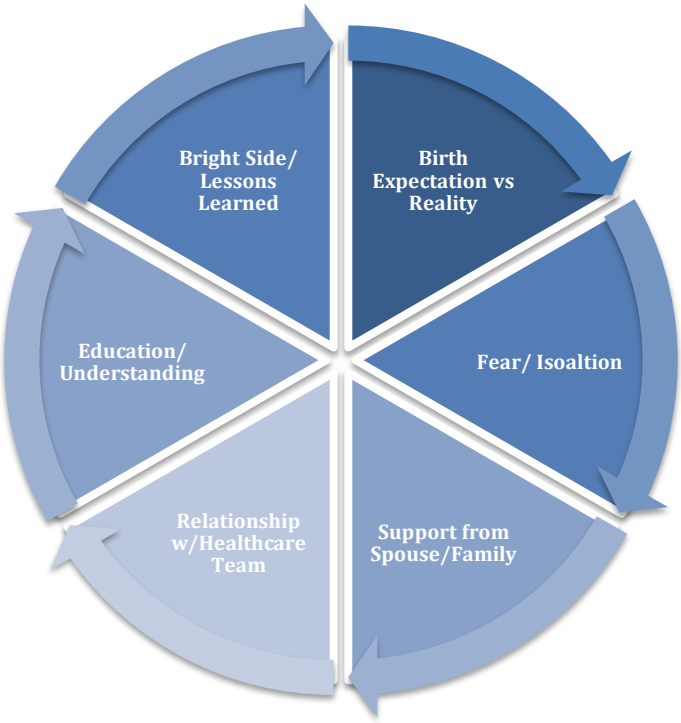
statements that remained were reviewed and separated into groups based on similarity of idea and was named as a theme. That process was repeated for each of the 10 interviews.

Step four was searching for connections across emergent themes. IPA is also idiographic, requiring each individual interview to be analyzed, but then includes a final step in the analysis that involves comparing the themes of each individual interview, looking for patterns of similarities, differences, and frequency across individual interviews (Saldana, 2016; Smith & Nizza, 2021). During this time sub-themes emerged within each overarching theme.

There were six overall themes that emerged from the data analysis that will be discussed in detail in the results section (see Figure 1). The themes were (a) birth experience versus reality, (b) fear and isolation, (c) support from spouse/family, (d) relationship with the healthcare team, (e) education/understanding, and (f) bright side/lessons learned.

Figure 1

Emergent Themes



Evidence of Trustworthiness

Credibility

Credibility in qualitative research is accomplished with skillful and empathetic interviewing that is sensitive to the context and meaning of the participant's experience and is most comparable to internal validity in quantitative research. Credibility was accomplished in the study through empathetic interviewing. Verbatim transcription was performed by myself into a Word document. Performing the verbatim transcription gave me the ability to have an in-depth understanding of the data. The transcription was completed using the Zoom audio recording converted from the recorded Zoom interview.

The audio recording was then reviewed again to validate the accuracy of the transcription. The two-step validation process helped increase the transcribed data's credibility. I maintained sensitivity to the context of the data and included quotes from participants to support themes and kept the participant's voice in focus (Smith et al., 2009).

Transferability

Transferability in qualitative research is similar to external validity in quantitative research. The study participants were a unique group of women who had given birth in the healthcare setting in the United States during the COVID-19 pandemic. The impact and importance of the lived experience of women delivering during the COVID-19 pandemic remained the focus to fill the gap in knowledge and understanding. The inclusion/ exclusion recruitment criteria made the study results transferable beyond one participant or one state in the United States. Still, they aided in a greater understanding of the birth experience shared by the thousands of women giving birth around the United States.

Dependability

Dependability in qualitative research is comparable to reliability in quantitative research. Careful and accurate transcription of individual interviews is key in establishing dependability. Transparency through all steps of the process was used throughout the interview process including detailed notes of the analysis process. I maintained a transparent audit of the analysis to maintain dependability in the study. I kept a detailed

reflective journal throughout interviewing and data analysis to detail the process of data collection and analysis.

Conformability

Conformability in qualitative research is the counterpart to objectivity in quantitative research. While the interview questions were open-ended to allow each participant to express their unique birth experience, it was semi-structured to help guide the content to reflect the research purpose. I intentionally acknowledged my own bias during participant interviews and maintained empathy through awareness and self-reflection (Patton, 2015).

Results

Previous research explored the impact of a mother's perceptions of her birth experiences on short and long-term outcomes. A positive perception of the birth experience can result in feelings of accomplishment and empowerment or of pain, dissatisfaction, disconnection, and even trauma when it is a negative experience (Baxter, 2020 Bringedal & Aune, 2019; Hall et al., 2018; Pereda-Goikoetxea et al., 2019). Mercer's MRAT also identified the importance of a mother's perception of her birth experience as a key variable to successful maternal role attainment. Effective maternal-infant bonding is important because it can positively affect breastfeeding, increase love and trust, and decrease postpartum depression and anxiety, leading to a positive home life and good health of the mother and infant (Cabrera, 2018). While delayed or lack of maternal role attainment can lead to ineffective bonding and lead to a delay in, or difficulty, in providing basic needs to the infant, leading to a decrease in the healthy

growth and development of the infant (Barker et al., 2017). Current literature identified that a mother's birth experience is influenced by factors including environment, support during labor, participation in decision-making, expectations of birth (Barker et al., 2017; Bringedal & Aune, 2019; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Zeynep, 2020). Many of the overreaching themes identified by the research participants were congruent with the factors described in the literature as influential to the perception of the birth experience. The overarching themes that emerged were (a) birth experience versus reality, (b) fear and isolation, (c) support from spouse/family, (d) relationship with the healthcare team, (e) education/understanding, and (f) bright side/lessons learned. Table 2 displays the presence of each theme by participant.

Table 2

Themes Reflected in Participant Responses

Participant No.	Birth expectation vs Reality	Fear, anxiety, and Isolation	Relationship with health care team	Support from spouse and family	Education and knowledge	Bright side and lessons learned
1	X	X	X		X	X
2	X	X	X			X
3	X	X	X		X	X
4	X	X	X			X
5	X	X	X		X	X
6	X	X	X	X	X	X
7	X	X	X	X		X
8	X	X	X	X		X
9	X	X	X	X		X
10	X	X	X	X		

Theme 1: Birth Expectation Versus Reality

Personal birth expectations has been identified as an essential factors in determining women's satisfaction with their birth experience (Bringedal and Aune, 2019). In response to the rapid spread of COVID-19, healthcare settings across the United States

were forced to implement changes to current isolation precautions, PPE requirements such as masks, and obstetrical care practices to minimize the risk of transmission in the antepartum, intrapartum, and postpartum units of hospitals (Mimouni et al., 2020; Pavlidis et al., 2020). These changes were made to decrease transmission of the virus and protect mothers and infants. A strong theme that emerged throughout the participants' interviews described ways that their birth experiences differed from their expectations. Topics discussed by participants in the interviews highlighted the impact of many of those changes and included their experiences during doctor's office visits and descriptions of the environment in the hospital when they gave birth. Additionally, the participants described aspects of their birth plan that changed, how complications impacted their birth, and shared vivid memories they recalled of their birth experience. The mask requirements and visitation restrictions were also discussed by many participants as they shared aspects of their birth experience that were not as they expected. The similarities between participants during the analysis were identified and emerged into 7 sub themes. The subthemes were (a) wearing masks, (b) husband at office visits, (c) birth plan, (d), memory of birth, (e) pregnancy and birth complications, (f) hospital stay and (g) visitors in hospital and postpartum (see Table 3).

Table 3

Subthemes and Responses Theme 1: Birth Expectation Versus Reality

Subthemes	Quotes
1a. Wearing masks	P1: "I had to PUSH with a mask on! Which is kind of hard because you are trying to get you my air in" P2-"Everyone in LD is wearing N-95 mask regardless of patients COVID status" P3-"I remember when they put my baby on my chest I remember looking up at my husband and being bothered that I could not see his whole face" P4- Was cautious during pregnancy, I always wore mask" P7-"I could not imagine birthing a baby with a mask on" P8-" My husband is really anti-mask so he just never wore it and no one ever said anything to him P9- "Masks were required when I was coming into the hospital but not once I got in a room by myself- my husband had to wear a mask the whole time"
1b. Husbands at office visits	P1-"he was never able to come appointments- and when he did come for the ultrasound he had to wait outside until I was called back" P2- "You are already in a high stress situation - and not even having a second set of ears to catch what they said or ask questions" P4-"Doing the miscarriage visit by myself was very hard!" P5-"I could not fathom not having him at my appointments. That has always been my dream is for my husband to be next to me through all that" P7- "The appointment we found out we lost her he was on facetime with the kids – I was by myself " P8- I was 44 and I am going in for the 20-week ultrasound and God forbid something was bad- I would not have had any support there with me" P9- My husband was not allowed to come to half the visit. Which made him upset because he is super involved husband" P10- "Not being able to take my partner to any of the appointments with me. That was impactful"
1c. Birth plan	P3-"Being induced was already a step in the wrong direction to a unmedicated birth" P5- "I got an epidural- which I didn't want originally- but the pain with the Pitocin hit so I took it" P6-"I was not prepared at all for a natural childbirth- not my cup of tea- I was accepting all medication that they would legally give me" P9-"I vividly remember thinking if I push one more time this baby is going to come out-but my doctor agreed I needed to have a c/s – so I didn't want to push him out"
1d. Memory of birth	P4-"I felt very alone in there (the OR) before the birth" P5-"I pushed 4 times and she was born. It was very quick- she was just born" P7-"I had a really hard time focusing on pushing because I was so concerned about her" P9-"I am throwing up and shaking on the OR table while they are cutting me open trying to get him out" P10- "I realized I was having contractions at like 5am, got to the hospital at 7:50 and my son was born at 8:16 in triage" P10- "Oh my gosh! I really thought I was going to have him in the car. It was a lot of pain but it was over quick"

1e. Pregnancy and birth complications	P2-“Got an epidural and blood pressure went really low – then I had fetal distress P5-“it was 160/110, my OB said get to the hospital right away, and they decided to induce me three weeks early.” P6- “I would (…) have to put me to sleep because I would not legally sign or agree for them to do it while I am awake at that point” P6-“they apparently ripped off the polyp which put me in the preterm labor” P6-“I was told and it was putting her in distress- her heart rate was dropping- I had 2 more pushes before they would have to remove her by force.” P6-“I tore a lot- I tore everywhere. The doctor said I had 23 stitches”
1f. Hospital stay	P3-“It was interesting because no one else were leaving their rooms” P8- “It was bizarre because you were like the only person- you didn’t see anybody. I never saw another mother- or another pregnant woman” P8-:I walked in on Friday and walked out on Saturday- 29 hours total with C/S number 5 because it was horrible” P5-“I was also worried about us having spent 4 days in the hospital – did we catch COVID- are we ok. It not what I ever imagined it would be” P5-“we got put in the ‘COVID room’ and I was like ‘Oh my gosh how well do they clean this room’. It was a little freaky”
1g. Visitors in the hospital and postpartum	P1-“I faced time them but that was it- its just not the same” P3-“I am going to make you change your clothes and shower when you get here because that is where my anxiety is” P4-“We had like 12 people in that tiny room and it was A LOT, but then this time it went to having no one” P5-“I always imagined my grandmother bring there and she didn’t understand why she was not able to come to the hospital- it was just a lot of drama” P5-“instead of my grandmother being excited to meet her on Facetime, she chewed me out and I had to hang” P6-“I put the ball in their court. They know just as much about COVID as I do- you understand exposure levels, if you feel like you have been exposed don’t come over” P7-“My mother and my husband were there for delivery and on the mother baby unit the siblings were able to come” P7- “people would bring food- and most people didn’t really ask to hold her- and I didn’t like pass her around” P8- “it was very uncaring- unforgiving- no bending- that is just how it is- no compassion- It was very routine and less socialization, compassion, interaction- severely different than my last children” P9- “Everyone kind of came in waves so they didn’t come all at once” P10- “My husband is a dentist and owns his own practice and had to see his patients-they would not switch out to someone else -so there were a lot of time I was there by myself” P10- “Let my mother’s side of the family visit at home because I know what they are doing and who they are coming in contact with- they are careful and safe”

Theme 2: Fear, Anxiety, and Isolation

Fear in pregnancy is experienced in an estimated 25% of individuals who report fear of pain in birth or fear of well-being of their infant under non-pandemic conditions (Giesbrecht et al., 2022). However, the COVID-19 pandemic has increased fear and psychological distress (Matvienko-Sikar et al., 2020). According to the current limited literature on birth during COVID-19, mothers who gave birth during the pandemic described feeling distressed, having fear and anxiety, and loneliness during birth which replaced previous feelings of safety, joy, and happiness reported before the pandemic (Lebel et al., 2020; Ravaldi et al., 2020; Yasa et al., 2020).

Another strong theme that participants described during the interviews was strong emotions of fear, anxiety and isolation that participants felt being pregnant and giving birth during the COVID-19 pandemic. The participants described a general sense of fear that COVID-19 may impact the well-being of themselves and their babies as well as a sense of anxiety about the threat of, and the unknowns of the virus. Many of the participants also described a sense of isolation and lack of social interaction during their pregnancy and after delivery due to the COVID-19 pandemic. There were 2 participants who experienced significant loss prior to their pregnancy and described that impact as well. When the themes of all participants were analyzed five subthemes emerged. The subthemes were (a) fear of COVID-19 during pregnancy, (b) anxiety being pregnant during COVID-19, (c) loss of social interaction during pregnancy, (d) isolation during postpartum, (e) pregnancy during COVID-19 after loss. Table 4 shows the subthemes and responses for Theme 2.

Table 4

Subthemes and Responses for Theme 2: Fear, Anxiety, and Isolation

Subthemes	Quotes
1a. Fear about COVID during pregnancy	P1:"I was scared I would get sick or would do something that would eventually hurt my baby" P6- " I was admitted through the ER and I was nervous about being in ER- I did not want to catch COVID" P7-"I remember from the moment I took the pregnancy test and I just sobbed out of fear- I could not even be excited- I just thought is this going to end in heartbreak" P7:"Pregnancy was not a normal one because it was on the heels of all that trauma- the whole time I was just terrified" P8- Your bringing a new life into the world and it should not be based in fear P8- "You are already afraid anyway- I mean you are going in to have your baby cut out of you- to have all these other unknowns was definitely more stressful P8-"Not knowing what to expect- you hear these horror stories of women not being able to hold their baby if they test positive" P9-"people are scared and their fear and anxiety was put on me during my pregnancy" P10- "I got COVID during pregnancy- I was afraid, I was really scared – in a panic initially"
1b. Anxiety about COVID during pregnancy	P1: "Getting pregnant I was a little nervous because of COVID and I didn't know what it was going to be like" P3- "kind of constant threat over my head of- what if this gets bad again" P5:"it brought a level of anxiety out in me that I did not know that I had" P5- "had to basically screen people before they came over- and we made sure they wore a mask, we tried to sit outside" P7: "Terrified being pregnant and getting COVID after reading the negative impact COVID was having on pregnancy and babies" P9- "I remember being worried people were not going to come when there was another wave" P10- "I was more anxious in the pregnancy because of COVID" P-10- "A lot of people who struggle with anxiety and depression struggled really hard being more isolated"
1c. Loss of social interaction during pregnancy	P1: "people did not want to come to my baby shower because of COVID- so I didn't really get to be around people" P2: "social separation o– people - not seeing people on a social level- just sad at the loss of the way things had been" P2- "changing the way we worship the way we shop, the way that we interact with each other" P8- "You have people over and find out someone had COVID and then you stop letting people over again" P10-" Alienated my from my family and friends- having to stay away from each other during that time"

1d. Isolation during postpartum	P2: "People brought food- dropped it and run- have a nice day- send me a picture" P3: "Once the new baby excitement was gone- it is back to being very isolated." P3: "struggled harder in postpartum than I thought I would- part of that is how isolated things still are" P4: "it was when there was that spike after Christmas and we just waited to mid to end of January" P5: "very hard time not being able to have as many friends over as I wanted- really having to limit people" P10- "Living an hour away from my family and with COVID, I had no idea how dependent I was on the social interactions of my friends, family and the city of Philadelphia that I lived in for 39 years" P10-"Not being able to interact with people the way we used to and have fun and not be fearful- feel robbed of summer"
1e. Pregnancy after loss	P2- "we had a pregnancy loss and I didn't want to give myself anything to question- you question every decision you make" P7- "I never really let myself believe that she was going to be healthy or be able to come home" P7-"It was hard to let myself get my hopes up that she would be ok, It was a very hard pregnancy mentally" P7- "The overall feeling of that day was anxiety and fear of what was going to happen"

Theme 3: Support From Spouse and Others

The birth experience is a unique experience that will stay with a woman for life. Current literature identifies the relationship between a positive perception of the birth experience and favorable attitudes to motherhood and a favorable relationship with her infant (Barker et al., 2017; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019). There have been several factors identified as influencing a positive birth experience, one of which is having support during pregnancy and birth. Zeynep (2020) found that adequate support during pregnancy and birth was a key factor that led to an increase in reporting a positive birth experience. Mercer's MRAT highlights that having support was an important aspect of successfully attaining the maternal role. In the 4 stages described in the MRAT, one of the stages is the formal stage, also called "acquaintance, learning and physical restoration". During the formal stage, a woman

meets her infant at birth and relies on the guidance and instructions on mothering from family and the nurses. With time a woman begins to learn her own style of motherhood and successfully transitions to attaining the maternal role (Mercer, 1981; Mercer, 1985; Noseff, 2014). The COVID-19 pandemic limited any visitors in the hospital, and also impacted family visiting after delivery due to shelter in place orders and travel restrictions. Some of the participants interviewed identified support from spouse and family as impacting their pregnancy and birth experience. When the themes of the participants were analyzed two subthemes emerged. The subthemes were (a) support from spouse and (b) additional support during labor. Table 5 shows the subthemes and responses for Theme 3.

Table 5

Subthemes and Responses for Theme 3: Support of Spouse/Family

Subthemes	Quotes
1a. Support from spouse	P6-"I was allowed 2 people with no changing out and my husband and my doula were my 2." P6- "Even though he is not on paternity leave, if there is an emergency he is right in the other room" P7- "I don't know how I would have functioned without his support" P8- I didn't really know what I was walking into. I didn't know if my husband would be denied access" P9- My husband doesn't watch the baby- he is raising our son- it is perfect- our son does not know days without us
1b. Additional support during labor	P2-"my daughter was exposed to COVID and (..) was asked for 2 negative test before babysitter felt comfortable having her at the house" P4-"I would actually have help at home- family that would help me with the baby, help me clean- help ME. Help me recover" P6-"As curve balls got thrown at me, she (doula) was at least aware- she know the biggest thing was I wanted the epidural" P7-"My mother and my husband were there for delivery and on the mother baby unit the siblings were able to come"

Theme 4: Relationship With the Health Care Team

The healthcare team plays a vital role in a woman's birth experience and has been identified as key to a positive birth experience in literature (Pereda-Goikoetxea et al., 2019). Mothers placed a high value on the connection with family and healthcare team members who were trusted to care for them (Hall et al., 2018; Hemberg & Kock, 2018). Connection with the healthcare team made women more likely to feel positive about the birth experience. A positive connection with the healthcare team made mothers more likely to report a positive birth experience when they felt listened to and supported by the healthcare team. The relationship with the healthcare team was another strong theme that emerged during the analysis of the participants' interviews. Communication with the healthcare provider was identified throughout many of the interviews as being impactful. Most participants reported feeling supported during labor and birth. There were mixed experiences with nurses on the postpartum unit once the delivery was done. Many participants did not have a good experience after delivering, commenting that they felt unsupported and not a priority. Several participants described feeling like they did not see nurses as much after they delivered and that it felt like nurses were just taking vital signs and checking boxes. When the themes of all participants were analyzed 6 sub themes emerged. The subthemes were (a) feeling supported, (b) communication, (c) feeling judged, (d) not feeling heard, (e) nursing care on postpartum, (f) relationship and trust with physician (see Table 6).

Table 6

Subthemes and Responses for Theme 4: Relationship With Health Care Team

Subthemes	Quotes
1a. Feeling supported	P1: "He learn through the nurse what was making me feel better- making him know what to say and making him more comfortable" P4-"They were great at talking me though everything and checked to make sure I was OK" P5-"I could not have asked for any better nurses" P6- "My relationship with the nurses was phenomenal" P8- "Nurses were great. No one really talked about COVID- they were focused on the baby and what I needed" P9- "They (nurses) were really supportive. I honestly felt like I had a cheerleading squad in there for me. Everybody was like you got this- you're doing amazing!" P10- "My nurses were really nice. The night nurses were all the same the nights I was there"
1b. Communication	P1- "she actually broke it down for him and that helped him to calm down because she caught on to his nerves and tried to really validate to him that everything is good" P2-"My nurse was great- she was very communicative – she was like ok this is what the plan is" P2-"I like when a nurse came on shift, they (..)would tell each other my vital signs in front of me, and what was going on with me" P3-"he was so good about being able to talk through anything I was worried about" P7-"I was so anxious- I was shaking so bad and I could not calm myself down. My nurse was diffusing essential oils" P7-"She was talking to me about anxiety- and she struggled with it and was very good at taking me out of the thoughts that something bad happening" P10- "They (nurses) had phones and I could text the nurses directly if I needed them. I really liked that and thought that was great communication"
1c. Feeling judged	P2-"sometimes I felt judged- like oh you have been here 4 times so your exposing yourself unnecessarily" P3-"she was very hung up on my weight -no other factors –she was going to call me high risk and make me miserable no matter what"
1d. Not Feeling Heard	P2-"so they discharge me 12 hours later- and I just cried- I was like what do you mean" P3-"I was sobbing in my room holding my baby- because I just wanted to go home (tears up) that was probably the worst part" P8- I don't think you understand the kind of pain I am and you say you gonna give me water?
1e. Nursing Care on Postpartum	P2-"It was different – the nurses would come in once and try to get everything done- even though I tested negative" P4-"That first night was definitely the hardest by far. I didn't see any nurses" P4-""I just felt very unimportant – like nurses were just there to check the boxes" P4- "I don't feel like I got a lot of help- other than checking my vitals every 4 hours- I just felt very alone" P4- "I remember feeling like I don't matter- like I wasn't a priority-everyone was so busy P6- "It was constant feeling like you're not getting good attention- I absolutely hated that"

1f. Relationship and trust w/ physician	P2-"My provider was very hands off-she only came in at the delivery that is the only time I saw her" P5-"My doctor went out of her way to come over and check on me- I could not have asked for anything–better" P6 -"doctors were nice but I had lost so much trust from previous issues-the whole thing with the polyp was handled way wrong, P7-"After my loss I had an ectopic pregnancy and my doctor was really good with me though that- he would call me at home to give me results- he was awesome" P8- "No appointment was set up – no one wants to see you anymore. I have not seen a doctor since I delivered" P9-" The doctor that delivered, she understood my pain and encouraged me to slow down my breathing because my blood pressure was spiking-stark difference from the guy the day before P9- "She (doctor) never tried to give me any anxiety. She would always be like- this is perfectly normal, you're doing great" P10- "I really enjoyed working with him. He (doctor) was responsive to my messages and phone calls" P10- "He was paying attention to everything going on in my history- I did not have to remind him- about my hypertension and to monitor that"

Theme 5: Education and Understanding

Mothers who reported a negative birth experience identified three major themes: low-quality relationship with the healthcare team, lack of physical and emotional support during labor, and lack of information to make decisions (Aktas & Aydin, 2018; Baxter, 2020). Education to make informed decisions is important to mothers during pregnancy and birth, but particularly during a pandemic. It is recommended that mothers be part of the decision with education on options and the risk and benefits of decisions (Mullins et al., 2020; Ryan et al., 2020). Another theme that emerged during analysis of the interviews was the concept of the importance of education and knowledge through pregnancy and birth during COVID-19. Many mothers discussed confusion and mixed messages around the COVID-19 vaccine and the inability to get childbirth education due to the pandemic. After comparing themes of participants 2 subthemes emerged. The subthemes were (a) vaccine and (b) education on birth (see Table 7).

Table 7

Subthemes and Responses for Theme 5: Education and Understanding

Subthemes	Quotes
1a- Vaccine	P1: "I did get a little mixed message- but if they were so behind the vaccine, they didn't bring it up that much" P3-"first it was-if your pregnant this is probably not the best idea-then it was to have a discussion with your doctor about your own risk and benefit" P5-"I got a lot of unknowns- we know you need this but we don't know what its going to do" P6-"So my OB basically did not recommend not to but did not recommend to either" P6- "It went from pregnant women should not get the vaccine under any circumstances – to pregnant women should get the vaccine no matter what"
1 b- Education on birth	P1-"I really wanted to take a Lamaze childbirth class, like they show in the movies that explain what it is like and there are none you can go to face-to face" P3-"it was important to us was that we wanted the education on what are things that could happen" P3-"I think that I value education even more heavily that I did before pregnancy."

Theme 6: Bright Side and Lessons Learned

The final theme that emerged was the bright side and lessons learned described by the participants after their experience of delivering a baby during the COVID-19 pandemic. There were many participants who expressed things that were bright sides of the COVID-19 pandemic, such as finding strength through challenges faced during COVID-19. Despite the loss of having family support most participants highlighted the bright side of having uninterrupted time as a new family. There were also some reflection from the participants on lessons learned from having the experience of delivering a baby during the COVID-19 pandemic. Some participants described how it was to adjust to life after delivery during the pandemic and some described a kind of new normal that has resulted from the pandemic. Then some participants had thoughts on unintended consequences and ripple effects that had taken place due to the COVID-19 pandemic. During analysis there were 7 subthemes that emerged. The subthemes were (a) bright side of no visitors, (b) becoming stronger through challenges, (c) working from home, (d)

lessons learned, (e) adjusting to life after delivery, (f) new normal, and (g) ripple effect/unintended consequences (see Table 8).

Table 8

Subthemes and Responses for Theme 6: Bright Side and Lessons Learned

Subthemes	Quotes
1a. Bight side of no visitors	P 1: "Bittersweet that once the baby was born no one was allowed to visit- but it was just me and him and we truly got to hold our baby and didn't have to share" P2- "there were no visitors allowed- but it was actually kind of nice. There were no interruptions" P4-"as much as it was challenging being alone in the hospital- it was time that we got- my husband and the baby" P5- "at the same time- that time we got to spend together alone was very good" P6- "So the COVID lock down of not letting people in- I really liked. It saved me from having to be mean."
1b. Becoming stronger through challenges	P1-"It's ok to not know everything and learn as you go. Its ok to feel stressed- its ok to cry- its ok to ask for help." P2- "We are stronger than we think- we get through what needs to be done- we are kinda bad ass" P7-"God is in control- but you just have to trust in Him and trusting in the doctors and nurses that they know what they are doing and they are doing their best"
1c. Working from home	P5- "Working from home has given me a lot more time with my child then I would have had the pandemic not happened" P6- "working remote ever since COVID was a good thing - working from home was a stepping stone for us to make a big transition" P7-"my husband work was closed and he ended up he was home with me 6 weeks after (..)we lost our baby" P9- my prayer was Lord I don't want to have to rush back to work because my husband was an engineer at the time and he only got 3 days of to mourn
1d. Lesson Learned	P2--"I forgot how much I enjoyed just having conversations with someone that I don't live 24 hours- just the ability to have that" P3- "Education and advocacy for yourself- and from practitioners for your patients is important." P4- "I learned how to be a better advocate for myself in the hospital. Which is not something that I thought I would have to do" P5-"motherhood is about going with the flow-if you think one thing something else is going to happen- so you just have to be ok with being fluid- being flexible" P6- "You are more impacted by hospitals being understaffed than anything COVID" P10- "I did not realize I was so dependent on being able to have the option of visiting and hanging it" P10- "You have to think about the chain of infection and every time you are around someone and you go around someone else- you can pass it"

1e. Adjust to life after delivery	P2 "it's been like a secret garden of life -we get to have our little time to figure out what we want and then from there we get to share how and when we want" P4- "no pressure for us to get back out in the world or see people. We kind of lived in a bubble for a month and get the toddler acclimated to the baby and us to our new life-which was really nice" P7-"the world is different but having the extra family time and being able to spend more time together. Forcing you to slow down and appreciate things more"
1f. New Normal	P2-"New normal is more distance, more interactions turned to online- it is so different before the pandemic" P7-"we don't even know normal anymore- just the new normal. Just the fear- if you are sick at all you are paranoid – is it COVID" P10- "I go to dinner or a baby shower- then I spend 7 days monitoring myself - I count the days to see if I need to go get tested. Talk about taking the fun out of things"
1g. Ripple effect of COVID-unintended consequences	P3- "needed more of a balance of safety and caution- while maintaining normalcy for moms and their birth experience" P3- "There is a deeper psychological impact in this than policy makers are accounting for" P6- "Hire more people and pay them what they are due" P8- We lost our rights, our choices were taken away-I didn't realize they were rights because it was just normal and all of a sudden normal is not ok anymore P8- People have lost compassion- no one cared. It was like a baby factory – you come in- give you pills and its like in and out P8- The whole journey was just almost robotic- where is the humanity in all this. I think people have become happy hiding behind masks - you don't have to interact or deal with people

Outliers

There were three interviews that I identified that had elements that were outliers as I completed the analysis. Two of the participants had experienced a significant infant loss, but had dramatically different responses, attitudes, and feelings going into their subsequent pregnancy. The third outlier had some profound and somewhat unique experiences when compared to the rest of the participants interviewed that was not fully captured in the studies themes. The 3 cases are highlighted to describe their unique experience that was not adequately captured in the overarching themes of the study.

Participant 7 was an ICU nurse working at the onset and height of COVID-19. When asked how COVID impacted her she responded that she "worked in the hospital as a nurse so COVID has had a big impact on me- unfortunately it has become a normal part of life". She went on to share that she had a late fetal demise during COVID and "when

we lost the baby and I could not go back to that setting with so many people dying and my going through what I was going through". The pregnancy and birth she had following her loss was the birth experience that she was interviewed about, but there was so much trauma brought into this pregnancy from her previous loss. She also talked about being a pregnant nurse during the pandemic. "There were protections for pregnant nurses caring for COVID patients in the beginning- but during my March 2021 pregnancy there was no protection". She talked about how the longer the pandemic went on the "caring and concern factor has dwindled". Her subsequent pregnancy was difficult mentally as she struggled with her emotions. "It was hard to let myself get my hopes up that she would be ok, it was a very hard pregnancy mentally". The pregnancy was filled with fear and anxiety and the belief that this baby would not live. She said, "I never really let myself believe that she was going to be healthy or be able to come home".

Participant 9 was a teacher and had a baby at 33 weeks that passed away 3 months later. She was so committed to keeping a positive attitude about the health and safety of this baby despite COVID- "this baby is going to be healthy, this baby is going to be full term this baby is going to be here and live a long life and we are not going to let COVID rain on our parade". This participant had a deep belief that this baby would be protected and healthy. "The Lord promised us – this is our rainbow baby- the Lord promised us a healthy baby". She was able to voice the struggle she had losing her previous baby and how she was so intentional about celebrating this pregnancy and birth. "I needed people to see our baby- to see his little personality- the last baby a lot of family did not get to see him before he passed because he was in the NICU." She was strong in her beliefs and

found unique ways, through social media, to make sure she was able to share her pregnancy despite the restrictions of the pandemic. “Because we knew we could not be physically together, (social media) was a pseudo reality that we had all these peoples support and it was safe- that helped us keep that little bit of normality” She also shared how she had pregnancy photo shoots and made sure to cherish every moment. She had an online community that she shared that “people were celebrating with us and every week we chose a different character trait that we wanted our baby to have and write on my stomach- declare certain things over his life-he is going to be a joyful baby, he is loved, he is safe, he is revolutionary, he is greater than all these things”

Participant 8 was a stay-at-home mother who had strong and emotional feelings on the pandemic and how it was handled. She said, “I think it (COVID) was more blown up then it should have been- people die all the time anyway- I mean the economy, the children- I don’t think they ever will be normal”. The participant expressed concerns about the things that she saw happen during the pandemic, feeling like personal freedoms were violated with all the restrictions. “It was like everyone just drank the Kool-Aid. People were just complaisant- like that’s the rules so you have to do it”. She reflected on her concerns about how social isolation and lock downs have impacted society. “Our world is already so focused on the phones and devices and then take away the real actual socialization and what do you have left”. She also added her concern about the long-term impacts that the social isolation of COVID could have. “I always heard that the number one cause of mental retardation is an impoverished environment and we are keeping kids stuck at home and not going out and everyone out are like zombies”.

Summary

The purpose of the study was to explore the lived experience of mothers who gave birth in the healthcare setting during the COVID-19 pandemic. The study provided a much-needed insight into the mother's perceptions of their birth experience during the COVID-19 pandemic. Understanding the mother's personal perspective provided insight into the aspects of the birth experience that most impacted during the pandemic. The overarching themes of the participants that emerged were (a) birth experience versus reality, (b) fear and isolation, (c) support from spouse/family, (d) relationship with the healthcare team, (e) education/understanding, and (f) bright side/lessons learned. The themes and subthemes that were identified can be used to develop policies and procedures that will help improve the care provided during pandemics such as COVID-19. Women and children are some of the most vulnerable populations, thus it is imperative to focus on mothers' and infants' emotional and physiologic wellness, both while they are in the hospital and after discharge home. Looking beyond the statistics and listening to the stories of mothers and their perceptions of their birth during the COVID-19 pandemic can create positive social change by empowering their voices in leading change. Chapter 5 will look closer at the results of the study and how the information learned can aid in the current understanding of birth under the stressful conditions of a pandemic and can help guide practices that include complex decision-making and care that can still create a positive birth experience during this challenging time.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

The purpose of the qualitative phenomenological study was to explore the lived experience of mothers who gave birth in the health care setting during the COVID-19 pandemic. The birth experience is a phenomenon that is well researched in the current literature (Bringedal & Aune, 2019; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Ravaldi et al., 2020). There is limited research from other countries on the perception of the birth experience of women who have delivered in healthcare settings during the COVID-19 pandemic, but none in the United States, according to my review of the literature. The research was important to look beyond prevalence and statistics and learn more about the lived experiences of women who delivered during the COVID-19 pandemic. The research question was: What is the lived experience of women who delivered a baby in a healthcare setting during the COVID-19 pandemic?

Summary of Findings

The COVID-19 pandemic has significantly impacted the birth experience for women who delivered a baby in the healthcare setting. The findings of the research study highlight participants' experience of feeling fear, anxiety, and isolation throughout their pregnancy, birth and postpartum. Participants described their lived experience as mothers who delivered a baby during the COVID-19 pandemic. With this knowledge, I was able to determine the impact of the changes to isolation practices and customary obstetrical care practices during COVID-19 on their birth experience. Participants highlighted the desire for education on birth to feel prepared. Having family support is an important part

of feeling positive about your pregnancy and birth experience and emerged as a shared theme in the study as well. Despite the restrictions and emotional stress of the COVID-19 pandemic, most participants were able to reflect on some bright sides, such as quality time with family and a renewed appreciation for socialization and human connection.

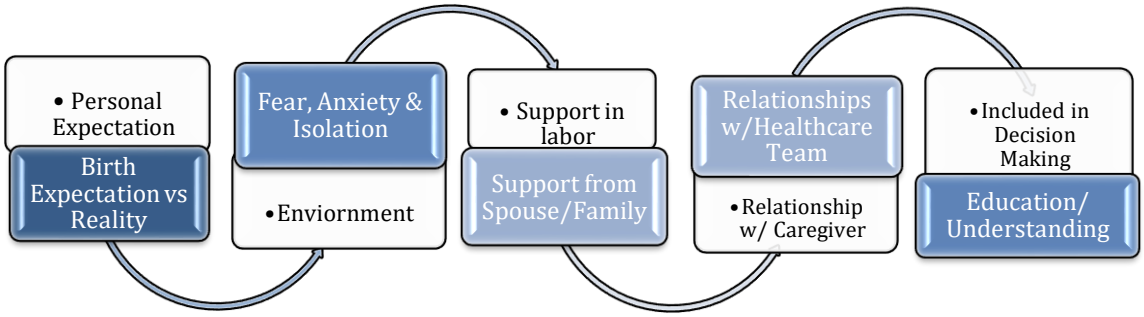
Interpretation of Findings

Amid the COVID-19 pandemic, health care organizational leaders made decisions to balance the risk of transmission between COVID-19 positive mothers and their infants. Recommendations and guidelines for the care of pregnant women and infants in the health care setting developed rapidly and changed through the pandemic as more information was learned about the COVID-19 virus (Chen, 2020; Davis-Floyd, 2020). There is a significant amount of literature on COVID related to prevalence, risk assessment, transmission, treatment, and clinical outcomes, but very limited research exists, according to my review of the literature, on how the changes impacted a woman's perception of her birth experience. It is known that a mother's perception of her birth experience can impact the bonding and well-being of both mothers and infants. Current research has found that a mother's birth experience is influenced by factors including environment, support during labor, inclusion in decision-making, expectations of birth, and the relationship with care takers (Barker et al., 2017; Bringedal & Aune, 2019; Chabbert et al., 2021; Hall et al., 2018; Pereda-Goikoetxea et al., 2019; Zeynep, 2020). The findings of the research confirm that COVID-19 has impacted the birth experience. The overreaching themes identified by the research participants were (a) birth experience versus reality, (b) fear and isolation, (c) support from spouse and family, (d) relationship

with the health care team, (e) education and understanding, and (f) bright side and lessons learned. The themes confirm the factors described in the literature as influential to the perception of the birth experience. Figure 2 compares what is identified in the literature as being impactful on the birth experience compared to the themes that emerged from this research.

Figure 2

Themes of Study vs Themes in Literature



The MRAT describes the stages that a woman experiences as she successfully obtains the maternal role. The MRAT includes the pregnancy, birth, and postpartum period as part of that role attainment (Mercer, 2004) . The COVID-19 pandemic impacted all stages of pregnancy, birth and postpartum as mothers have been denied support in doctors visit, been filled with fear and anxiety about COVID during pregnancy, and were discharged home without having the support of family and friends that is common when new mothers come home from the hospital due to social distancing and shelter in place orders. The MRAT highlights the importance of having support in successfully attaining the maternal role. In the Formal stage of the MRAT, also called “acquaintance, learning

and physical restoration", a woman meets her infant at birth and relies on the guidance and instructions for mothering from family and the nurses. With time, the woman begins to learn her own style of motherhood and successfully transitions to attaining the maternal role (Mercer, 1981; Mercer, 1985; Noseff, 2014). The COVID-19 pandemic limited any visitors in the hospital, and also impacted family and friends visiting after delivery due to shelter in place orders, travel restrictions and fear of the virus transmission. The MRAT also highlights the importance of the nursing care provided to mothers and infants during the birth and postpartum period. The nursing care plays a critical role in both the birth experience, and the mother's successful acquisition of the maternal role. The study found that the nursing care provided during the birth experience has also been impacted during the COVID-19 pandemic as well. Participants in the study shared mixed experiences with nurses on the postpartum unit once the delivery was done. Many participants did not have a good experience after delivering, commenting that they felt unsupported and not a priority. A number of participants described feeling like they did not see nurses as much after they delivered and that it felt like nurses were just taking vital signs and checking boxes.

Limitations of Study

The limitations of the study are those that are not within the control or design by the researcher. Credibility in qualitative research is most comparable to internal validity in quantitative research. Qualitative research designs rely on the researcher's credibility, who is the instrument used to collect data (Patton, 2015). There is an inherent risk of bias as the researcher brings her perceptions, knowledge, and life experience to the study.

Credibility was accomplished in the study through empathetic interviewing and awareness of personal bias by the researcher. There are also inherent limitations of qualitative research methodology which aims to explore the experiences from a small sample size, in contrast with quantitative research which aims to explain and predict numerical statistical significance. Purposeful sampling used to attain participants with the shared lived experience of delivering an infant during the COVID-19 pandemic creates a limitation in the transferability of understanding the birth experience outside the context of the COVID-19 pandemic. Additionally, transferability is limited as different acute healthcare settings across the United States may have established different isolation precautions and care practice changes at different times during the pandemic. The participants' lived experiences in the study will reflect the isolation precautions and obstetric care practice changes they experienced in the healthcare setting they gave birth in. There are also inherent limitations in the rigor of the data analysis process. While the analysis was systematically completed based on the guidelines of IPA, I maintained sensitivity to the context of the data and included quotes from participants to support themes and kept the participant's voice in focus (Smith et al., 2009). Additional steps were taken through peer review by my chair and committee for agreement throughout the analysis process, but the analysis and results are still limited to my interpretation and analysis.

Recommendations

The nurses' role is vital in facilitating maternal bonding and identifying barriers to bonding (Barker et al., 2017). The results of the research provided a greater

understanding of the mother's perception of the birth experience during the COVID-19 pandemic. The results can increase the awareness of the importance of providing support and targeted education during stressful times such as what was experienced during the COVID-19 pandemic. Obstetric (OB) nurses and care providers have the opportunity to engage with mothers who are delivering a baby and encourage discussion about mothers' concerns and encourage maternal-infant bonding in the context of the limitations with COVID-19 isolation precautions or other emergent situations. OB nurses can recognize warning signs of delay in maternal role attainment, identify early signs and symptoms of postpartum depression and anxiety and provide any needed resources of support (Noseff, 2014). Future research could focus more specifically on the role of the healthcare provider on promoting or hindering a positive birth experience. The information gained from this focused research could further guide practices of the bedside nurse in education and support of mothers during stressful times like the COVID-19 pandemic. Additionally, nurses caring for patients during the COVID-19 pandemic faced unprecedented challenges, Future research could focus on the lived experiences of nurses and healthcare providers that cared for mothers giving birth during the COVID-19 pandemic.

Implications

Social Change Implications

Women and children are vulnerable populations, and it is imperative to focus on their emotional and physiologic wellness. Pregnant women are at increased emotional stress as they face limitations and restrictions of support during the COVID-19 pandemic

(Matvienko-Sikar, 2020). Looking beyond the statistics and listening to the mothers who have given birth during the COVID-19 pandemic provided the opportunities to explore and understand how giving birth during the COVID-19 pandemic impacted perinatal mental health and the overall birth experience. The obstetric healthcare team plays a vital role in providing pregnant women education and support (Barker et al., 2017; Matvienko-Sikar, 2020). The insights gained from the study can create positive social change by empowering the voice of pregnant women in leading change. The themes identified in the study will aid in the current understanding of birth under the stressful conditions of a pandemic and help guide practices that will include shared decision-making, support during labor, and providing education that can decrease fear and anxiety and provide care that can create a positive birth experience during these challenging times.

Methodological, Theoretical, and Empirical Implications

The methodology of qualitative research provided the ability to move beyond statistics and get rich, in depth description of what it means to individuals who have experienced the phenomenon of giving birth during the COVID-19 pandemic. The use of IPA allowed for the combination of the description of phenomenology, the interpretation of Hermeneutics, and the group level examination of Ideography across the participant's experience.

The study provider a deeper understanding of mothers' perception of the birth experience during the COVID-19 pandemic. The themes identified in the study were in agreement with the key variables identified in current literature as impacting a mother's perception of her birth experience. The study provided the novel understanding and

contributes new knowledge of how these key factors were impactful to women who gave birth during the COVID-19 pandemic.

Recommendations for Practice

Nurses and clinicians caring for obstetrical patients are uniquely positioned to promote maternal-infant bonding and maternal role attainment. The changes set forth during the COVID-19 pandemic created unforeseen barriers to customary obstetric care practices, visitation, and PPE requirements. The results of the study highlighted the impact of visitor limitations both in the office and during delivery and the postpartum period. Practice implications of the study focus on the ability to decrease fear and anxiety, decrease long-lasting psychological effects, and promote ideal outcomes for mothers and infants despite the stress of the pandemic (Cabrera, 2018). Some of the fear and anxiety expressed by participants could be alleviated with better education on the COVID-19 virus and the implication it has on pregnancy, as well as clear communication on hospital policies around PPE and visitation. The more education and information mothers are provided, the more they are empowered and in control of their birth experience. The healthcare team is uniquely positioned to connect many of the themes that emerged in this study. The following are clinical recommendations based on the results of the study:

- Discuss birth expectations and details of individual birth plans at office visits prior to birth.
- Ask mothers about their fear and anxiety and provide information and education to help address their concerns.

- Make sure that staffing ratios are adequate to care for and support mothers during and after birth.
- Address the physical changes and healing of mothers who give birth as well as their emotional well-being.
- Follow up with mothers who deliver under stressful conditions and be prepared to provide resources as needed.

Conclusion

As the numbers of cases of COVID-19 have decreased, travel bands have lifted, and mask mandates have been discontinued, it is important to understand there are still thousands of women all over the world who will forever be impacted by their birth experience during the pandemic. The research study allowed the voices of the participants to be heard, and the unique experience of mothers who delivered a baby during the COVID-19 pandemic to be shared. The study captured the feelings of fear, anxiety, and isolation experienced by many women who were pregnant and experienced the many changes made in the hospital setting due to the COVID-19 pandemic impacted their birth experience. The study highlighted the importance of having adequate support from spouses, family and the healthcare team on a woman's birth experience. While the many changes made in the healthcare setting and communities were made with the best intention of protecting mothers and infants, the study revealed many unintended consequences and the emergence of what participants described as a 'new normal'. Despite the challenges faced, participants also described personal resilience and some

bright sides of extra quality time as a family, and a new appreciation for social connections and relationships that may have been taken for granted prior to the COVID-19 pandemic.

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Appendix A: Recruitment Flyer for Facebook

HAVE YOU GIVEN BIRTH IN HEALTHCARE SETTING DURING THE COVID-19 PANDEMIC?

You are invited to take part in an interview for a Doctoral research study

- The purpose of the study is to explore the lived experience of mothers who have given birth in the healthcare setting during the COVID-19 pandemic

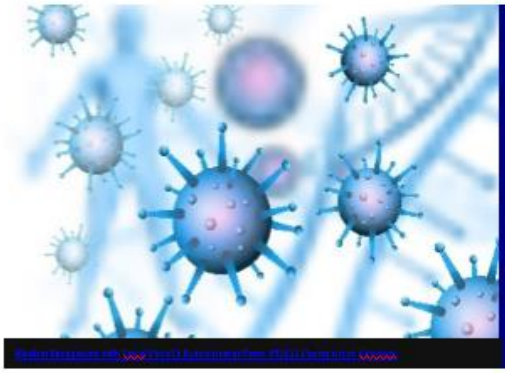
Location
Individual interviews will be conducted through Zoom and will last 30-60 minutes.

Are you eligible?

- 18 years old
- English speaking
- Delivered a live infant in the healthcare setting anytime after October 2020

If you're interested in participating:

Direct message me, call or email me.



If you are unsure if you meet the requirements, direct message, call or email me:

Bridgette Schulman, MSNEd, RNC-OB, C-EFM, CPPS
PhD Candidate at Walden University

Appendix B: Interview Guideline

Introduction: My name is Bridgette Schulman, and I will be conducting the interview today. As mentioned in our email communication, I am a Ph.D. candidate at Walden University. I am exploring the lived experiences of mothers who have given birth in the healthcare setting during the COVID-19 pandemic. I want to review the informed consent that was previously emailed to you. I am requesting that you permit me to conduct this recorded interview via Zoom that will last no longer than 60 minutes. Transcriptions of interviews will be completed and analyzed by me. Transcripts will not have any identifying information and will be shared with my university faculty and included in my analysis. This interview is voluntary. If at any time you don't feel comfortable answering any of the questions or decide to take part now, you can just let me know. Do you consent to participate?

1. I would like to get some basic demographic information. Could you tell me your age, if you are married, what your race/ethnicity is, how many times you have given birth previously to this delivery (if any), and what month and year delivered?
2. Can you tell me what it was like to give birth in a health care setting during COVID-19?
    - Can you tell me about your expectations about your birth experience, if any?
    - What were your impressions of the hospital environment during your birth?
    - Describe your relationship with the healthcare team that cared for you during your birth.

- What was your experience once you were discharged from the hospital?
- Tell me what you learned from your birth experience.
- What is your most vivid memory of your birth experience?
- How impactful has COVID-19 been to you personally?

3. Is there anything you would like to share about your birth experience?

Thank you so much for sharing this special life moment with me. I want to remind you that you have my contact in the email I sent you. If you have any questions feel free to contact me.