Maternal Voices in Times of Change: Centering Motherhood Discourses to Inform Tailored Postpartum Depression Interventions

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Abstract

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This thesis details a study examining the compounded impact of a global pandemic on mothers experiencing postpartum depression (PPD). In 2020, an online cross-sectional mixed-methods survey was conducted with 500 mothers who gave birth within the previous 12 months, with 317 participants meeting clinical criteria for PPD based on the Edinburgh Postnatal Depression Scale. Participants provided 452 responses to open-ended questions designed to capture the unique challenges of balancing motherhood and mental well-being during COVID-19. Thematic analysis revealed three emergent themes: experiencing fear, experiencing isolation, and lack of resource support. The themes illustrate how crisis contexts exacerbate existing vulnerabilities for new mothers that may hinder access to effective mental health support. Fishbein's (2009) Integrative Model of Behavioral Prediction (IMBP) is employed as a conceptual interpretive

framework when examining mothers' accounts to understand how their concerns may inform support-seeking behaviors during high-stress life events. The study's findings and discussion offer direction for the development of comprehensive interventions that more thoroughly address the multilevel mental health needs of new mothers.

Maternal Voices in Times of Change: Centering Motherhood Discourses to Inform Tailored Postpartum Depression Interventions

As the world suddenly stopped during the early days of the COVID-19 pandemic, new mothers faced a perfect storm of isolation, fear, and uncertainty. While the virus devastated communities, another silent crisis was potentially unfolding behind closed doors. In non-crisis times, postpartum depression (PPD) affects 13% to 19% of new mothers in the U.S. (Hutchens & Kearney, 2020). Stressful life events, such as giving birth during a global health crisis, can exacerbate the prevalence of PPD (Ding et al., 2023). As the healthcare community became overwhelmed, support networks vanished. Mothers were left to navigate the uncertain terrain of new parenthood in unprecedented isolation, and the prevalence rate of PPD swelled to an alarming 28% (Chen et al., 2022; Harrison et al., 2023; Safi‐Keykaleh et al., 2022). This study seeks to better understand the impact of a global pandemic on mothers experiencing PPD in order to inform mental health support and interventions tailored to mothers' unique needs. While the COVID-19 pandemic presented an extreme case, examining mothers' experiences during this period offers valuable insights into how major societal crises, such as natural disasters, economic downfalls, or public health emergencies, can affect maternal mental health and support-seeking behavior. The lessons learned about support systems, healthcare delivery, and resilience factors during the pandemic can inform more robust and responsive mental health services for mothers facing various types of challenges.

Further, treatments for postpartum depression are underutilized in the U.S. healthcare system (Manso-Córdoba et al., 2020; Pearlstein et al., 2009). This underutilization highlights the critical importance of understanding how and why mothers seek help in the first place. For the purposes of this study, support-seeking refers to the actions taken by individuals to obtain

emotional, informational, or active assistance to cope with challenges, stressors, or mental health concerns, which encompasses both formal clinical care and informal sources of support. This understanding of support-seeking is loosely based on MacGeorge and Zhou's (2021) assertion that "support-seeking behavior influences the quality of support provided to groups with stigmatized health conditions" (p. 143).

The most prevalent mental health treatments for PPD, interpersonal psychotherapy (which focuses on relationship conflicts and life transitions over a series of scheduled visits) and cognitive behavioral therapy (which helps patients identify and modify negative thought patterns through multiple structured sessions), present a host of accessibility barriers. The in-person requirements of such therapies is particularly challenging for individuals during the postpartum period (Huang et al., 2018; Stuart, 2012). The adoption of PPD treatments is also impeded due to sociocultural and structural barriers, including stigma, physical and technological access, insurance and affordability, and material and emotional support, among others (Canty et al., 2019). Additionally, the pandemic inspired a greater need for distanced care, such as telehealth modalities, echoing access and literacy disparities related to technology.

This study analyzes qualitative accounts from new mothers experiencing postpartum depression symptoms during the early COVID-19 lockdown period (July-August 2020), examining their support-seeking behaviors through thematic analysis and later applying the Integrated Model of Behavioral Prediction as an interpretive lens to further understand the thematic findings. Prior work within this larger research study has explicitly focused on barriers to virtual therapy and opportunities for co-designing digital mental health interventions (Gonzalez et al., 2021; 2022). This current exploration aims to focus more intentionally on how

written accounts related to motherhood, as reported within the survey, can help us better understand future support-seeking behaviors and proactively design tailored health interventions.

The manuscript includes a literature review of previous relevant scholarship in this area, a rationale for the theoretical framework that guided this work, and a description of the study's methodology. Additionally, results highlight thematic categories that emerged during analysis that best capture the perspectives shared by new mothers experiencing postpartum depression during this period. Findings from this study offer future directions for the development of comprehensive messaging and interventions that more thoroughly address the multifaceted mental health needs of new mothers, with robust considerations for complex identities and crisis contexts. For example, interventions should be designed to honor mothers as whole people rather than just parental caregivers, while addressing not only their clinical depression symptoms, but also their expressed needs for social connection, financial support, and opportunities to experience joy in motherhood, particularly during crisis situations when support networks are disrupted. Because identities of motherhood are constructed, performed, questioned, and reified through communication (DeGroot & Vik, 2021), the written accounts of mothers trying to balance caregiving responsibilities and their own mental health needs during a crisis should directly inform interventions and programs. This study thus addresses a gap in theoretical and practical understandings of support seeking behaviors among a population that is often disproportionately impacted by health disparities.

Literature Review

PPD Research in Communication Studies

Although PPD has received limited attention in health communication research, communication scholars have increasingly recognized PPD as a critical area of study (e.g.,

Gonzalez et al., 2022; Scharp & Thomas, 2017; Wang & Pavelko, 2024), examining how language and communication patterns shape both societal understandings of maternal mental health and the lived experiences of mothers navigating this condition. One method that allows for an unobtrusive understanding of PPD is utilizing online platforms to explore the self-reported accounts of new mothers experiencing PPD (Miller & Stana, 2024; Thomas et al., 2014; Scharp & Thomas, 2017). The studies conducted by Miller and Stana (2024), Thomas et al. (2014), and Scharp and Thomas (2017) utilized publicly available online forums to analyze the written narratives of mothers with PPD who sought support in online support-group settings. Further, Miller and Stana's (2024) study found that informational support was the most frequently sought type of support in online PPD forums, and identified two key themes in online PPD support groups: the social construction of motherhood and social barriers to treatment. Analysis of these digital narratives revealed patterns in mothers' experiences and needs, leading to recommendations for more targeted health promotion campaigns and improved healthcare provider responses. Central to these projects were the discursive practices, that is, the structured ways of writing and interacting that shape how knowledge is constructed and shared, which led to the sense-making of mothers' lived experiences. Sense-making here describes the cognitive and emotional process through which mothers interpret and assign meaning to their experiences with PPD through a reconciliation of their experiences and an integration of these understandings into their personal identities (Gabriel et al., 2023). These practices highlight the crucial role of health narratives in both understanding and coping with PPD.

Other areas of related communication inquiry include research into PPD-related media messaging and its influences on postpartum depression policies (Chung & Kim, 2019), PPD support groups (Gillis & Parish, 2019), and patient-provider communication (Mukherjee et al.,

2018; Sword et al., 2008). Research in communication studies has enhanced the recognition of postpartum depression as more than just a clinical diagnosis by illuminating its social and identity dimensions. These studies have revealed how PPD exists not only as a medical condition requiring professional intervention but also as a complex experience embedded within social relationships, community contexts, and the evolving identity of motherhood. Additionally, digital media representations of motherhood and mental health have helped normalize and destigmatize the experiences of individuals affected by PPD (Shannon, 2022). Similarly, research efforts into the support-seeking behaviors of mothers with PPD have led to increased awareness about the marginalization of women and their experiences navigating their identities among support networks and the broader society (Anderson, 2013). Lastly, other studies have highlighted the differences in experiences faced by women of color in healthcare systems related to having their concerns heard and their mental health needs sufficiently met (Mukherjee et al., 2018). Studies conducted during COVID-19 have identified prominent pandemic-related stressors, including fear of contracting the virus, meeting basic necessities for day-to-day life, accessing timely healthcare, and job distress (American Psychological Association, 2020; Fitzpatrick, 2020; Said, 2021). The American Psychological Association found that all of these stressors were higher in people of color in 2020 amid the pandemic (American Psychological Association, 2020), suggesting that mothers of color may have experienced compounded vulnerabilities during this period that potentially exacerbated their risk for PPD while simultaneously facing more significant barriers to receiving appropriate care and support.

Support-Seeking for PPD

Support-seeking among mothers with postpartum depression has been well-documented in relevant literature (see Sahoroy et al., 2023). Yet, the unprecedented constraints and stressors

brought on by the COVID-19 pandemic fundamentally hindered both the availability of and access to traditional support systems, creating unique challenges that warrant careful examination (Gonzalez et al., 2022). As described by Lim et al. (2013), support-seeking involves actively soliciting various informational, instrumental, or emotional resources from others, with conceptual similarities to related behaviors such as feedback, information, and help-seeking (Lim et al., 2013). The documented barriers and costs associated with these related help-seeking behaviors can likewise be applied to understanding the challenges associated with the support-seeking processes (Lim et al., 2013).

Early support from partners and loved ones during the perinatal period significantly influences whether new mothers seek help for postpartum depression, both through professional healthcare services and informal support networks (Fonseca & Canavarro, 2017). Research has also shown that a mother's attachment style strongly predicts how, or whether, she will seek help for postpartum depression, with different attachment patterns (secure, anxious, avoidant, or disorganized) creating specific barriers to accessing both professional care and informal support (Cacciola & Psouni, 2020). However, many women with secure attachments also experience PPD without seeking help, often due to unrealistic expectations about motherhood causing shame and withdrawal (Cacciola & Psouni, 2020). Along with these existing dynamics potentially hindering one's ability to seek effective support, mothers who were directly impacted by the COVID-19 virus, through infection or infection of loved ones, were more likely to experience increased anxiety and depression as a result of these compounded factors without avenues to seek effective mental healthcare (Usmani et al., 2021). Collectively, these findings highlight the critical need for a more nuanced understanding of how various contextual factors interact to create barriers to support-seeking in postpartum depression.

Successful Interventions for New Mothers

As attention towards maternal mental health has increased over the last two decades, PPD interventions have continued to evolve, with research demonstrating the effectiveness of various therapeutic approaches in supporting mothers during the postpartum period. Methods such as talk therapy, cognitive behavioral therapy, and other relevant interventions, such as phone-based support and family counseling, have proven beneficial in reducing PPD (Huang, 2018; Leight et al., 2010). Additionally, a combination of medication-based treatments and monitoring and adapting mothers' nutrient intakes has also warranted promising results in PPD symptom reduction (Werner et al., 2016).

An increase in accessible interventions has been proposed to remove access barriers for those who may encounter more challenges navigating in-person clinical appointments (Gonzalez et al., 2022). Dol et al. (2020) discussed the utilization of mobile mental health applications (mHealth) as a factor in reducing depression symptoms and increasing maternal social support in mobile app users. Similarly, virtual, app-based therapy, though less studied than other forms of PPD intervention, has been found to reduce barriers to postpartum treatments, especially for mothers from minoritized backgrounds (Bina, 2020). Additionally, holistic therapies, which recognize individuals as complete entities whose well-being depends on the integration of multiple dimensions (Papathanasiou et al., 2013), have shown promise in reducing negative psychosocial symptoms related to PPD (Ainur & Widyawati, 2020; Zauderer & Davis, 2012). These approaches, including mindfulness exercises, massage therapy, and aromatherapy, have been particularly beneficial for breastfeeding mothers concerned about medication use (Kobliska, 2018). This suggests that a comprehensive approach combining multiple forms of therapy may provide more accessible options for new mothers.

Theoretical Framework

Although previous studies have examined PPD through various interpersonal, media-based, and technological frameworks, this study sought to employ a theoretical model that centers a more thorough understanding of future health-related behaviors as it relates to mothers seeking adequate postpartum care and support. The Integrative Model of Behavioral Prediction (IMBP) is derived from two earlier behavioral theories: the Theory of Reasoned Action (TRA; Fishbein & Ajzen, 1975) and the Theory of Planned Behavior (TPB; Ajzen, 1985). TRA was originally designed by Fishbein and Ajzen to identify the key distinctions between attitudes and behavior (Glanz et al., 2008). TRA asserts that behavioral intentions, shaped by attitudes toward the behavior and subjective norms– a person's perception of social pressure to perform or not perform a specific behavior based on what others think they should do– are the primary predictors of behavior. TPB, presented by Ajzen in 1985, further enhanced this framework by adding perceived behavioral control as a third determinant of intentions, which recognizes that people's perceptions of their ability to perform a behavior significantly influence their actions. These theories, like many other models of health behavior change (e.g., Health Belief Model, Social Cognitive Theory), have provided health promotion researchers systematic frameworks for understanding why people engage in specific health behaviors and which psychological factors influence certain health decisions (Coleman & Pasternak, 2012; Paul et al., 2023).

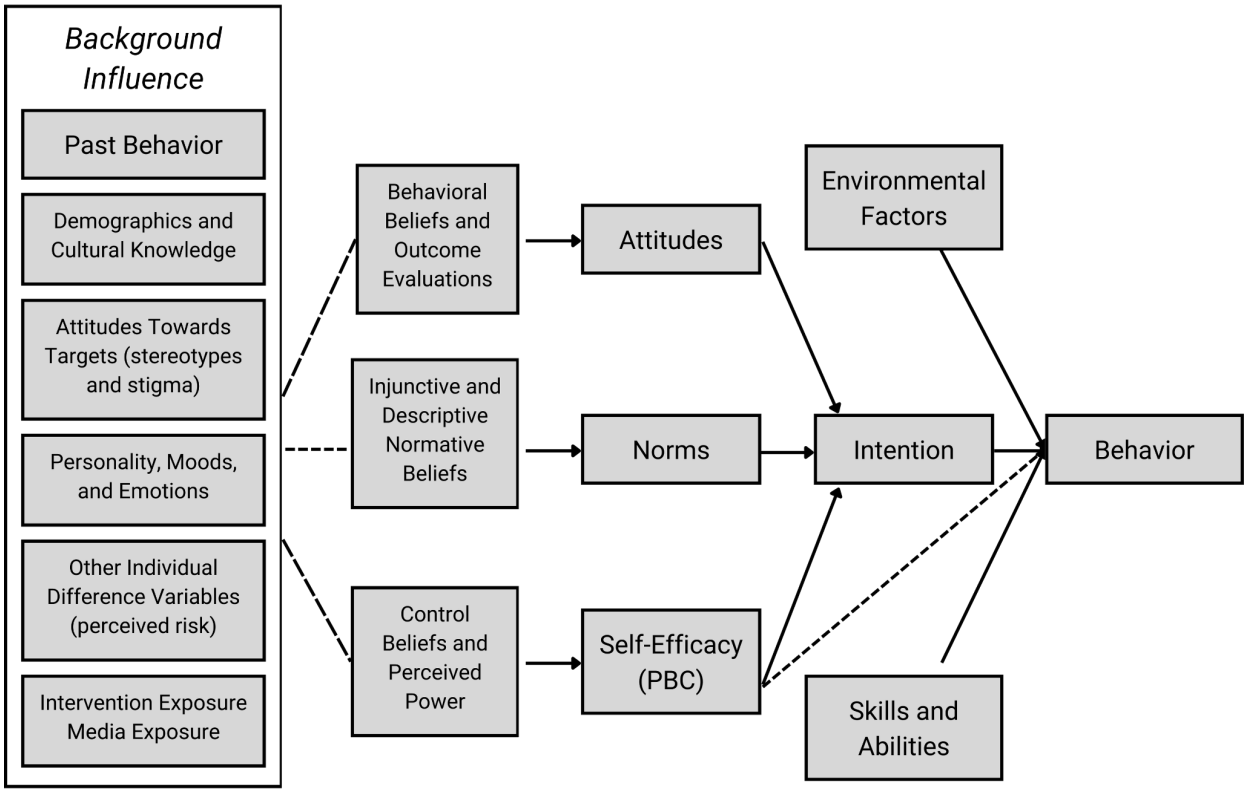
Building on these foundational theories, the IMBP, also referred to as the Integrated Behavioral Model or simply the Integrative Model, was developed by Fishbein (2009) as a comprehensive framework to understand and predict human behavior, particularly in the context of health-related actions. The IMBP framework asserts that while many variables might influence behavior, effective prediction and intervention require focusing on just a few key

determinants that most significantly shape behavioral outcomes in specific populations. This streamlined approach allows researchers and practitioners to identify the most impactful factors when designing interventions for particular behavioral changes (Yzer, 2012). Therefore, the application of the IMBP in a health communication context specifically offers new perspectives on how health messages and related interventions can be tailored to address the unique communication needs and support barriers that mothers face.

The IMBP (Figure 1) contains various components that interact to predict behavior, including attitudes, norms, self-efficacy (which refers to a person's confidence in their own capability to successfully execute a specific behavior or task), and the critical mediating role of intention.

Figure 1

The Integrative Model of Behavioral Prediction



While more frequently utilized in quantitative research, the IMBP has also found application in qualitative studies. For instance, the IMBP was adopted to examine a mixed-method survey regarding college students' exercise intentions (Chen, 2018). The survey included an open-ended questionnaire in which the IMBP was used to identify the most salient health behavior beliefs, including students' beliefs about the health benefits of exercise and release of stress. Chen's study concluded that health communication should focus on enhancing students' affective attitudes, norms, and levels of confidence to increase future exercise intention. Further, a group of community psychologists employed the IMBP to interpret the findings from focus group discussions to design effective occupational health interventions for Christian Methodist pastors (LeGrand et al., 2013). LeGrand et al.'s study provides a successful example of the IMBP's application in a qualitative research setting, where rather than adopting the model deductively to produce structured interview guides based on IMBP's constructs, the research team opted for an inductive approach, applying the framework retrospectively to interpret emergent themes and inform intervention design. This methodological approach aligns with the current study's design, where the IMBP serves as an interpretive lens to understand open-ended survey responses rather than as the initial framework.

A qualitative study conducted in 2014 by communication scholars, Thomas, Scharp, and Paxman, applied derived behavioral constructs from the IMBP, such as cues to action, facilitators to help-seeking, and self-efficacy, to explore new mothers' online discourses of experiences with postpartum depression (Thomas et al., 2014). In their analytical approach, researchers began with inductive open coding to identify five primary modified health behavior constructs aligned with the IMBP framework. These constructs–severity (derived from "attitude"), social norms, barriers to help-seeking, facilitators/cues to action, and self-efficacy–were then used to close-code 30

women's narratives. The researchers adapted Fishbein's original constructs to better fit their qualitative data, combining norms and normative beliefs, integrating control beliefs with self-efficacy, and dividing behavioral beliefs into separate "barriers" and "facilitators" categories. Elements of the IMBP utilized in Thomas et al.'s study revealed the most prevalent concerns of new mothers experiencing depression-related symptoms, with "severity" being the most prominent construct, as it appeared in 94% of women's accounts.

In the current study, components of the IMBP are applied to examine the thematic categories that emerged from open-ended survey responses, where mothers described their concerns regarding health, family, and COVID-19's impact on their daily lives and functions. Constructs of the IMBP provided guidance for understanding the complexities of respondents' behavior by considering cognitive, social, and other related factors, such as attitudes, intentions, perceived norms, self-efficacy, and environmental factors. Using an a posteriori approach, the IMBP was applied as an interpretive lens following primary thematic analysis rather than as a deductive coding framework. This allowed mothers' authentic voices and experiences to emerge organically through Braun and Clarke's (2021) thematic analysis methodology. Components of the IMBP, such as behavioral beliefs, normative beliefs, and perceived norms, were used to make sense of the thematic categories which arose from mothers' accounts, with the goal of understanding how their concerns and healthcare priorities may lead to future support-seeking behaviors for PPD care during a crisis or high-stress life event.

Previous applications of IMBP in both quantitative and qualitative studies have proven the model's versatility and effectiveness in health communication research. By applying the IMBP as an interpretive framework, this study aims to thoroughly understand mothers' self-reported accounts while systematically analyzing how attitudes, perceived norms,

self-efficacy, and environmental factors may shape their support-seeking intentions and behaviors amid global or national crises. In the following section, we discuss our data collection and analysis methodologies that contributed to our process of exploring the following research questions:

RQ 1: How did mothers experiencing postpartum depression narrate and make sense of their lived experiences during the COVID-19 pandemic?

RQ 2: What factors might influence support-seeking intentions and behaviors among mothers experiencing postpartum depression?

Methods

In July and August of 2020, shortly after shelter-in-place and social distancing orders were mandated across the U.S. in response to the emerging COVID-19 pandemic, a multidisciplinary research team administered an online cross-sectional mixed-methods survey (N=500) conducted via the platform Prolific.co. This period represented a unique time for new mothers who faced additional challenges beyond typical postpartum stressors, which directly informed the study's methodology. Existing studies have documented how pandemic restrictions during this time severely limited access to in-person support networks, childcare resources, and healthcare services that new mothers typically rely on (Abdul-Fatah et al., 2024; Jackson et al., 2022). Many mothers were isolated at home with young children while managing increased household responsibilities and heightened anxiety about potential virus exposure to their vulnerable infants. Given the widespread restrictions and rising public health concerns, conducting research via an online survey was not solely a methodological preference, but a practical necessity during the mandated shelter-in-place orders.

Eligibility criteria for the online survey included 1) having given birth in the last 12 months, 2) being a U.S. resident, and 3) being over the age of 18. The survey duration averaged 10 minutes, and responses were captured using Research Electronic Data Capture (REDCap), a secure web application developed to capture data for research that complies with HIPAA standards. Participants received $5 in financial compensation for their participation. Open- and closed-ended survey questions were designed to understand mothers' experiences in the postpartum period, including their access to mental health support during the pandemic. All survey participants provided written responses to open-ended questions. However, for the purpose of this study, which aims to highlight the written accounts of mothers with postpartum depression, only responses from women who were experiencing PPD symptoms, as indicated through a survey measure, were included in the analysis.

Of the 500 survey respondents who participated in the study, 317 met the diagnostic criteria for postpartum depression based on the Edinburgh Postnatal Depression Scale (EPDS) administered during the survey. The EPDS is a 10-item questionnaire that assesses PPD risk by measuring the frequency of symptoms experienced by respondents (Cox et al., 1987). The 317 participants who indicated symptoms of PPD provided a total of 452 written responses to two open-ended survey prompts. These prompts include: "Do you have any concerns about your child's health as a result of the COVID-19 outbreak?" and "Please take a moment to describe any other challenges you are facing as a new mother due to the COVID-19 pandemic." The responses were exported from REDCap and sorted into a Microsoft Excel sheet, where response totals were calculated and underwent review using thematic analysis. The average length of a written response was 25 words. 135 respondents answered the first prompt ("child health concerns"),

and all 317 respondents responded to the second and final prompt of the survey ("general concerns").

Participant Characteristics

The survey attracted initial interest from 2,416 individuals. Of these, 500 met the eligibility criteria and began the survey and 479 women submitted completed responses. The 479 respondents had a mean age of 30.3 years. The sample was predominantly White (72%), with women of color comprising 135 individuals (28%). 12% of respondents identified as Black/African American, 5% identified as Asian or Pacific Islander, 5% identified as Hispanic or Latino/x, 5% reported having multiple ethnic identities, and 4 respondents (<1%) ethnically identified as "other." 74% of respondents were married, 17% indicated they have never been married, 4% indicated they were currently divorced or separated, 2 respondents (0.4%) were widowed, and 4.6% did not provide a marital status. Upon taking the survey, 58% of participants indicated that they did not have current access to childcare, whereas 37% had current childcare. 39% of respondents held a Bachelor's degree, 22% held some form of postgraduate degree (e.g., Master's, Doctorate, Juris Doctorate, etc.), 10% had a high school diploma or GED as their highest level of education, 6% held an Associate's degree, 0.4% had less than a high school diploma, and the remaining 5.6% declined to answer. 23% of respondents indicated they were not in paid work (e.g., homemaker, retired, or disabled), 20% were reported part-time employment, 9% were employed full-time at the time of the survey, 7% were unemployed and/or looking for work, 2% marked other, and 9% of participants declined to answer. When asked to self-evaluate their English proficiency, 97% of participants rated their English as "very well." The geographic distribution of respondents spanned across the United States, with higher representation from more heavily-populated states including California, Florida, and New York.

Data Analysis

After the survey data was extracted from REDCap, a multidisciplinary coding team began reviewing the dataset to identify relevant information provided by mothers who indicated symptoms of PPD. A quantitative coder generated a formula that filtered the survey responses from the 317 participants who scored higher than a nine on the EPDS scale. A score above nine on the EPDS scale indicates the presence of depressive symptoms that warrant further monitoring, with scores of 10-12 suggesting significant distress and scores of 13 or higher indicating a high likelihood of postpartum depression requiring further clinical intervention (Cox et al., 1987). After identifying the study subsample, an independent qualitative coder conducted an initial review of the 452 written accounts and reported early insights from the review process to the research team for feedback.

The open-ended survey responses were then coded using Braun and Clarke's (2021) reflexive thematic analysis framework. Braun and Clarke's six-step approach to thematic data analysis includes: 1) researcher familiarizes themselves with the data, 2) initial code generation, 3) search for relevant themes, 4) reviewing themes, 5) naming and defining themes, and 6) writing the analysis report. The data was organized in Microsoft Excel sheets, where early codes were generated, categorically organized on separate spreadsheets, and finalized into broader themes after multiple review processes.

The coding process began with a thorough content familiarization phase, yielding eight high-level codes that encompassed between 13 and 100 responses in each. The initial codes include, "Worry," "Feeling isolation," "Physically isolated," "Worry for child," "Fear/terrified/scared/afraid," "Concerns for finances," "no social support," and "not sharing baby joy." Some codes had more rigid inclusion criteria than others. For example, the "fear"

category required explicit mentions of the keywords: “fear,” “terrified,” “scared,” and “afraid.” Likewise, responses coded under “Feeling isolation” only captured the accounts that contained words such as, “lonely,” “loneliness,” or “feeling isolated.” Similarly, “Concerns for finances,” only encapsulated responses that discussed money, employment, or finances as an explicit concern. “Worry,” on the other hand, was a broader code, which included responses detailing fear, anxiety, stress, and the many mentions of “feeling worried” during the pandemic period. The criteria for “social support” and “baby joy” codes were also broadened to contain the many comments describing the lack of interpersonal support systems during this time and the missed opportunities to celebrate the birth of a new child. Relevant responses were then identified and coded across the various codes, appearing in multiple first-round coding categories. In subsequent analytical iterations, these codes were systematically consolidated into various thematic categories, which were ultimately refined into three distinct themes, each containing 2 to 3 subthemes to capture the multiplicity of responses within each theme. Themes and their respective codes were then defined and renamed using conceptually relevant titles. Each finalized theme contained a substantial number of responses (ranging from 86 to 143), providing rich data for interpretive analysis. Rather than claiming traditional thematic saturation, the research team made what Braun and Clarke (2021) describe as “an interpretative judgement related to the purpose and goals of the analysis” (p. 210). Therefore, the team determined that the data provided was sufficient enough to develop meaningful, multifaceted themes that addressed our research questions with suitable depth and comprehension.

Findings and Interpretation

Through iterative thematic analysis of participants’ written accounts, several patterns emerged that inform our understanding of mothers’ support-seeking behavior during the early

pandemic period. Emergent thematic categories include increased fear ("Experiencing Fear"), primarily fears of illness and concern for a child's health and development; experiencing both physical isolation and feelings of loneliness ("Experiencing Isolation"); and lack of support resources ("Lack of Resource Support"), such as social support, financial support, and happiness.

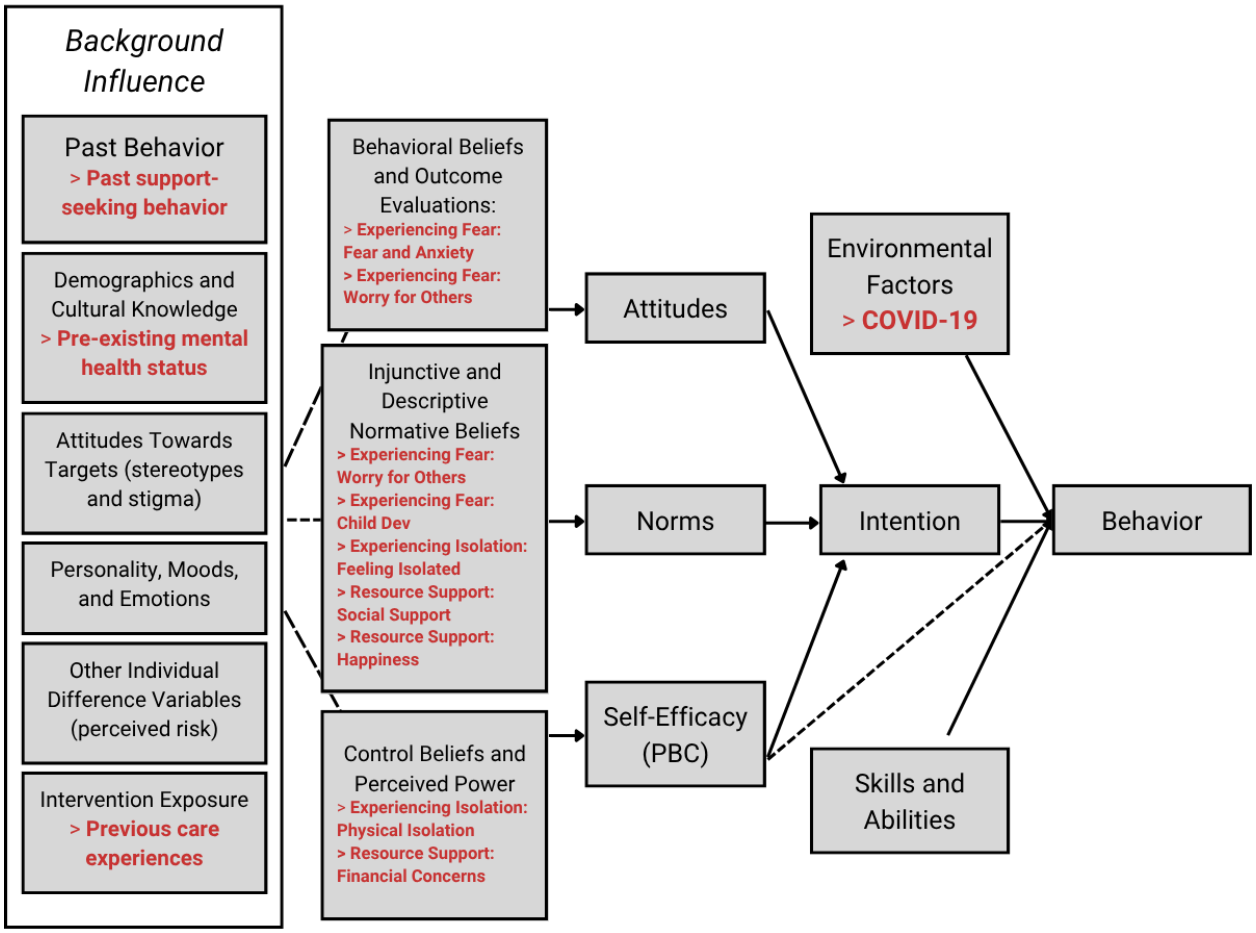
We used the IMBP not to code data deductively, but as a lens for identifying potential behavioral influences within emergent themes. The choice to employ IMBP as an interpretive lens following thematic analysis was notably essential given the original questionnaire was not explicitly designed using the IMBP framework. The three emergent themes overlap with various constructs found in Fishbein's IMBP, including attitudes, normative beliefs, self-efficacy beliefs, perceived norms, and, more crucially, the environmental factors that the COVID-19 pandemic accounts for. The themes represent various aspects of human behavior (such as through attitudes and perceived norms) and other related factors that could impact a mother's ability to access mental health support, such as how resource constraints reshaped behavioral beliefs during this time. These factors related to behavioral determinants include an inability to access timely care and/or support due to demanding parenting responsibilities, or in the context of a public health emergency, due to fears of illness and virus transmission. Such constraints were revealed in mothers' written responses and account for the environmental factors highlighted within this construct of the IMBP model.

As outlined in the IMBP model, environmental factors include the physical and social restrictions caused by COVID-19 that directly impact behavior regardless of intentions. Lockdowns, social distancing requirements, and facility closures prevented many people from engaging in certain preventive and treatment behaviors. Findings from this study cannot be adequately situated within the IMBP framework without first understanding the influence of

COVID-19 as an environmental factor and constraint. The COVID-19 context as a global health crisis acted as a crucial external factor. New mothers faced particular challenges accessing traditional support systems, such as help from family members and friends, and healthcare services that were unavailable during shelter-in-place orders. The following figure (Figure 2) displays the emergent themes and related topics as they fall under each relevant IMBP construct.

Figure 2

Themes, Sub-Themes, and Related Topics Affiliated with IMBP Constructs



The background influences that precede the IMBP model must also warrant consideration prior to further engagement with IMBP's constructs. An individual's previous experiences with healthcare systems or providers, for example, could facilitate or inhibit their willingness to seek

help during this time. Furthermore, any pre-existing mental health status of mothers, such as those who were already experiencing anxiety or depression before giving birth, creates varying levels of vulnerability and affects their capacity to actively seek out support for mental health. The following sections describe the thematic categories and provide new insights into how these recounted experiences may influence future support-seeking behaviors related to formal and informal mental healthcare for PPD.

Experiencing Fear

The first theme, "Experiencing Fear," was characterized in several ways that illustrate the unfortunate and unique circumstances of this moment in time. For example, mothers explicitly wrote about feeling terrified in response to prompts about the wellbeing of their children. More generally, mothers also expressed worries and fears regarding COVID-19 as a health crisis impacting their families and concerns about members of their family missing out on vital opportunities for socialization and development.

Fears and anxiety. Many mothers used words like "worried," "fear," "afraid," and "terrified" to describe their mental state during this stage of the pandemic. They spoke to the uncertainty of the world around them and, more specifically, about the fear of an illness they had limited information on. Nearly all of the written accounts in this theme communicated mothers' fear of their children contracting an illness. One mother wrote, "I live in fear of my children getting sick. I think about it constantly." This statement illustrates the fear encroaching on these mothers' daily lives, where concern for their children's well-being was all-consuming. This type of fear was particularly pronounced among mothers who had experienced previous health traumas with their children, as another mother shared:

> It is fear and anxiety about my child getting coronavirus. [...] My middle child passed away from a terminal illness and heart defect, but ultimately, it was the flu which made him weak enough and caused heart and organ failure. This will forever cause me stress and anxiety in regard to my children's health.

This account demonstrates how past traumatic experiences with childhood illness intensified fears surrounding COVID-19, creating a heightened sense of vulnerability regarding health matters during this time. This account also details a potential priority-shift that mothers faced in order to protect their children from the harmful effects of illness and virus transmission.

Worry For Others. Beyond personal concerns, mothers expressed their worries about the well-being of close family members and their communities during the pandemic. This reported apprehension encompassed both COVID-related and non-COVID concerns. One respondent explained:

> I am always very worried any time we leave to get essentials, and I am worried my partner will bring the virus or another disease such as whooping cough or measles home from his workplace. I am also worried that my child will get sick from non-virus related issues (ear infections, skin issues, strep, etc.) and will not get as good of care due to virtual visits [versus] in-person care or will have to go to the hospital and be at more risk of contracting COVID-19.

The pandemic also created additional worries about relationship health and emotional well-being. One mother highlighted how confinement measures strained her marriage: "It is harder to reach out for help because of quarantine and distancing restrictions, which has, in turn, put more stress on my marriage since we have no alone time to be a couple." This reflection reveals how mothers worried not only about physical health risks but also about the stability of

their most important relationships during an extended period of stress and isolation. Their inability to seek external help or support may have caused in-home challenges to feel more insurmountable.

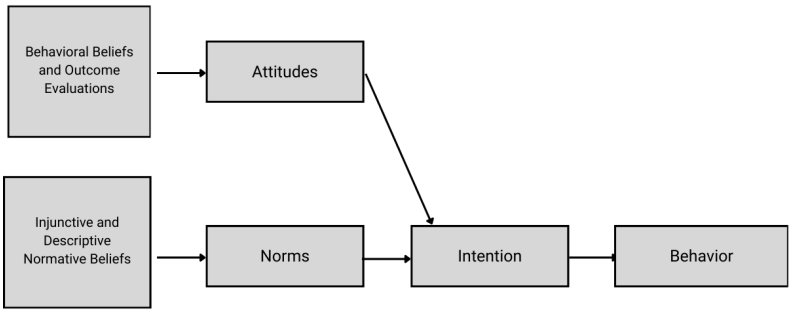
Child Growth and Social Development. Throughout the responses, there were increasingly notable concerns stated for children's social and developmental well being. The levels of uncertainty and anxiety mothers faced when considering the impacts of isolation were heightened. These concerns were echoed throughout the accounts, with mothers writing, "Socializing my daughter has been nonexistent. I'm afraid it will impact her growth." Similar reflections discussed the negative impact of the lockdown orders on children's ability to connect with friends and family members: "I am unable to take my kid to play dates. I feel her social skills might get impacted since I am keeping her at home due to lockdown. She might miss her interaction with other kids and extended family." Another mother wrote, "I worry that my children will lack social skills due to isolation because of COVID-19. I also worry that we will be unable to build or maintain relationships with family and friends."

Play dates, family time, leaving the house, activities that were once considered normal were now an exception. Mothers continually wrote about how this impacted their ability to provide their children with much-needed social interactions. Respondents discussed how these disrupted routines and spaces their children used to occupy were abruptly taken away, "They were in daycare, and now they are not. I worry about the impact this isolation will have on their social development." These persistent concerns highlight how the pandemic fundamentally altered childhood socialization, leaving new mothers to navigate unprecedented challenges in supporting their children's developmental needs.

Relevant IMBP constructs evident in "Experiencing Fear" include mothers' behavioral and normative beliefs during the pandemic. Displayed below (Figure 3) is the relevant extracted section from the complete IMBP model.

Figure 3

IMBP Constructs Identified in Theme 1



Behavioral beliefs centered on fear, about the pandemic and potential health risks to loved ones, can influence attitudes toward seeking support (Yonemoto & Kawashima, 2023). For some, the perceived risks of in-person care may outweigh the benefits of seeking PPD treatment unless virtual options are available and technology is easily accessible. Or mothers with heightened concerns for their children's health may be less inclined to prioritize their own during this high-stress period. Normative beliefs manifested through mothers' heightened awareness of societal expectations regarding COVID-19 safety protocols and through their concerns about children's development. The pandemic created new public health norms that mothers reported feeling obligated to follow, balancing adherence to certain protocols, such as distancing and hygiene guidelines, with their children's needs for normal early life experiences. The developmental concerns frequently mentioned in the open-ended responses reflected mothers' understanding of typical childhood milestones and their worry that pandemic restrictions might

interfere with their children meeting these normative expectations for socialization, growth, and development.

Experiencing Isolation

Isolation was prevalent among respondents in two ways. Mothers reported experiencing feelings of isolation, primarily loneliness, due to separation from family, social support systems, and the broader community. Additionally, they described the physical isolation they experienced during this time, both from their social circles and outside resources such as childcare, and how it impacted their overall well-being. While the pandemic created widespread isolation for all new mothers and families, this experience was particularly consequential for women experiencing postpartum depression symptoms, as emphasized throughout the responses. For these mothers, pandemic-related isolation compounded existing feelings of disconnection often characteristic of PPD. The combination of PPD and pandemic isolation created a uniquely challenging circumstance that warrants specific attention in understanding maternal mental health.

Feeling Isolated. Feelings of isolation were described as "feeling alone," "loneliness," or "feeling like missing out." One mother wrote, "I am so lonely. I have no friends, no one to talk to. I sit inside with my son and stepdaughters, and that's all I ever do day in and day out," while another stated, "Just general loneliness. I never expected to be so alone with a small baby," and a third reflected, "It just feels so isolating. I have my family here, but it's much different than I thought it would be." These quotes exemplify the mental state of mothers during a highly stressful, yet highly isolating time. The isolation they write about was not simply detailing the act of being physically confined to their homes. Rather, respondents described an altering form of disconnection from their previously expected social networks, jobs, families, and community. One mother noted her feeling of hopelessness as a result of her isolation, "My biggest challenge

is a sharp decrease in social support, particularly being cut off from regular church services. Being isolated makes it harder to not feel hopeless." The feelings of hopelessness and lack of social support that emerged became a significant contributor to maternal distress. These types of responses highlight how a public health emergency not only changed the external physical circumstances of families but also fundamentally altered the emotional components of early parenting experiences.

Physical Isolation. The act of physical confinement that mothers experienced with their young children was also detailed in numerous written accounts. Respondents wrote explicitly about how the choice to stay away from loved ones impacted their mental state:

> Loneliness. I can't see anyone, and that's been hard. At the same time, I'm facing a lot of backlash from friends and family for choosing not to allow visitors. My son is less than a month old and his pediatrician has said we should allow no visitors for at least eight weeks. We are being criticized for taking this advice to heart, and it's been rough. This [isn't] what I want, but I have to do what's best for him, and no one seems to get that.

The conflict detailed in this account between protecting a newborn during a health crisis and the act of maintaining in-person social connections emerged as a particularly challenging aspect of parenting and protection during the pandemic. The physical isolation added new emotional burdens, and mothers were additionally tasked with taking on labor of various forms. During this time, more than half of the 479 survey respondents (58%) indicated they did not presently have access to childcare. One response articulated the added burden of taking on multiple professional roles alongside parenting responsibilities during the pandemic:

> It's hard watching the months go by and see my 9-month-old grow but miss out on all of the baby classes (music, etc.) I did when my older child was a baby. Also, both of my

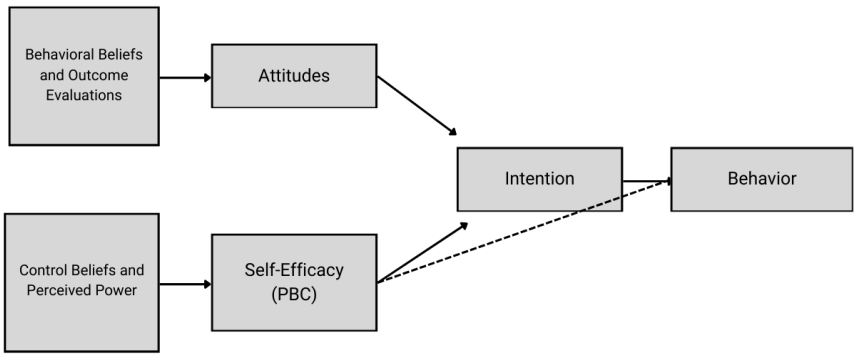
> kids receive Early Intervention services (speech for my 2-year-old and [physical therapy] for the baby) and it has all been telehealth which basically means in addition to being the mom and head of the household I have taken on the role of PT and [a speech and language therapist]. It's HARD.

The multifaceted challenges of parenting in isolation required parents to assume new roles that were highly specialized and took more time away from their duties simply as new parents. This mother's emphasis on how hard the parenting duties have become underscores the difficulty and overwhelming feelings of responsibility that extended beyond the traditional caregiving roles during this unexpected period.

The IMBP constructs that align with this theme, as seen in Figure 4, include mothers' behavioral beliefs and perceived control beliefs.

Figure 4

IMBP Constructs Identified in Theme 2



As outlined by the IMBP, behavioral beliefs are personal beliefs about the outcomes of performing a specific behavior that also influence a person's overall attitude toward the behavior (Ajzen, 2020). Consequently, the act of physical isolation, as well as pervasive feelings of isolation becoming an everyday norm around this time, may influence mothers' beliefs about the value of seeking formal support and the potentially adverse consequences of remaining in

isolation. Similarly, efficacy beliefs focus more on perceptions about one's ability to perform a specific behavior and their control over that behavior (Alyafei & Easton-Carr, 2024). Multiple forms of isolation, such as physical and social, which are often thought of as one in the same, can directly impact one's beliefs about their ability to access appropriate care (Holt‐Lunstad, 2024). Physical and social isolation present concrete barriers to support that serve as a crucial environmental factor for many mothers, where social isolation, in particular, may alter perceptions of what support-seeking behaviors are "normal," contributing directly to the perceived norms construct of the IMBP.

Lack of Resource Support

The third and final emergent theme details mothers' accounts of the financial stressors that arose amid the COVID-19 lockdown. This category also characterized social support and joy as crucial resources during the postpartum period, which mothers reported lacking during prolonged isolation. Survey respondents explicitly described their inability to experience the joy or celebration of sharing their newborn baby with their families and friends.

Financial Concerns and Restraints. Due to the pandemic, families across the United States suffered job and income losses. Families that recently experienced childbirth and lost nearly all of their income were seven times more likely to have trouble paying bills during the COVID-19 pandemic (California Department of Public Health, 2023). At the time this survey was administered, 30% of respondents indicated they were unemployed or not in paid work. This devastation felt from financial constraints, specifically due to medical expenses, was captured throughout the survey. One mother wrote, "My [insurance] plan does not cover counseling/therapy, although I wish I could afford it. The [labor and] delivery bills are rolling in, and those are a priority." Many mothers spoke more generally about their once stable income

being negatively impacted, “My salary has been cut and I am struggling financially,” which speaks directly to the harsh realities many faced in the wake of the public health crisis harming typical job and economic operations. The financial hardships described by these mothers reflect the broader realization of economic inequality exacerbated during the pandemic. While some families experienced temporary setbacks, others were in more dire situations with fewer support systems and secure options. This period of fear and economic uncertainty, particularly faced by new mothers, was illustrated in the following account:

> I am absolutely broke. I wasn’t able to pay my rent after my job laid me off. I can’t get ahold of unemployment. I'm living at my partner’s mother’s house, and she has a granddaughter who comes and goes as she pleases[...] I don’t feel safe. There is no help for me. This country only cares about rich people. [...] I can’t do this. I wish I lived in some other country.

Respondents’ repeated feelings of financial insecurity and lack of peace of mind during this period showcased the bleak circumstances for mothers following childbirth. Heightened fear for their safety and feeling left behind by the systems meant to protect them was particularly evident in quotes like the one above. The respondent’s experience highlights the intersection of economic vulnerability, housing instability, and emotional distress many faced when safety nets failed, underscoring how financial restraints impacted not only material conditions but an overall sense of well-being.

Lack of Social Support. Mothers reported their lack of social support as an essential care resource during this time period. This emerged as a particularly devastating challenge for mothers with PPD during the early pandemic days, as traditional support networks were severed by lockdown measures and fears of virus transmission. One mother described this challenge in

addition to her inability to identify helpful online resources, writing, "[Lack of] access to the best and verifiable information on taking care of my kid. Also lack of assistance from family members due to lockdown laws and [virus] transmission fears." Her experience highlights how multiple essential resources were simultaneously stripped away during a critical period when she needed them most. Not only was she unable to find trustworthy information about childcare, but she also lost the family support network she would normally have relied upon.

Similarly, the public health crisis with no definitive end in sight dismantled many previous community-based support networks. The stark contrast between pre-pandemic and COVID-era motherhood was captured by another mother who explained, "With my older children, I had a lot of support through moms groups and church nurseries in the family, but with this baby, she's never with anybody but me, and it's hard even to get groceries sometimes." This response illustrates the depths of mothers' isolation, transforming what was once a community-supported experience into a lonely endeavor where even basic necessities became challenging for many to obtain. The fears and grief felt by individuals, families, and communities, leading to the sudden closures of community spaces in efforts to prevent illness and death, created a devastating reality where mothers were forced to face their emotional struggles alone. As one mother expressed, "I have to grieve without my extended family." A simple yet heartfelt statement captures the trauma of motherhood during crisis times. Mothers mourned the loss of expected support and joy while being denied the very social connections that would normally help process such grief.

Restricted Happiness. The lack of happiness or feelings of joy mothers reported experiencing denotes a stark shift in changing circumstances surrounding the birth of their children during the pandemic. What was once known to be a joyous occasion, celebrated by

family and friends coming together to offer support and well wishes, was now removed from the everyday norms of families. Throughout the survey, respondents reported on the loss of joy, happiness, and celebration that traditionally comes with the birth of a new child. “Happiness” is categorized here as a resource because it is a psychological buffer that creates resilience (Cohn et al., 2009) and can help mothers withstand the challenges of early parenthood. Without the joy-inducing interactions with friends and family, mothers were deprived of both the emotional benefits and social affirmation that typically help sustain them through the demanding postpartum period, which may potentially deepen their vulnerability to depression. One mother shared:

> I cannot get support to care for my child or get the joy part of sharing her with my parents and siblings. I don’t get to show her off– in that good way. The baby is happy and funny, and I don’t get to give that joy to anyone outside the house. I also relied on preschool for her older sister, which is only just reopening with a few days a week, that puts stress on my ability to recover from pregnancy and care for the new baby.

Being unable to “get the joy part” of sharing the new baby with loved ones highlights an essential missing resource from day-to-day life. What is missing goes beyond familial support; it also extends itself to the broader community of fellow mothers who typically provide both practical support and emotional understanding. The absence of these networks, categorized by one respondent as “mama tribes,” led to a more profound sense of disconnection and lack of joy. One mother described this loss:

> I have a very close-knit mama tribe from after my [first child’s] birth.[...] I’m sad that my [second child] hasn’t been able to be a part of my tribe’s lives. We haven’t had visitors; none of my [daughter’s] friends have been able to see him/hold him in months. It’s very

> lonely not being able to just get together, let the kids play, let other mamas love on my son and hold him and give me a break.

Letting other mothers provide love, joy, and comfort to one another's children was an important element of maintaining a "mama tribe," as detailed above. This respondent's sense of normal involved the concept of collective or community mothering, which had practical and emotional components that were beneficial to their well-being. The pandemic disrupted the rituals themselves and the enjoyment these rituals created for mothers. While not all accounts explicitly mention "joy," many respondents wrote about not being able to welcome family into their home to spend time with the new baby, particularly those family members who enjoy being around children. One respondent wrote specifically about their parent, stating:

> I feel so sad [my dad] is missing my little baby grow up. My mom passed away several years ago and my dad is alone now. He loves his grandson so much and loves babies and has wanted a grandbaby forever but can't even be with him. This is messing with my mental health the most. Just extreme sadness. Also the lack of support. [...] I am unable to do the things I used to to cope with stress and anxiety because I have a baby. My baby is particularly needy and I can't find the time to do all the things I used to do to cope like exercise, dance, yoga, and meditation. If I could have help with someone to watch him, it would be easier, but with COVID no one can help so it's like double the stress. Stress of being a new parent and stress of COVID with no way to cope.

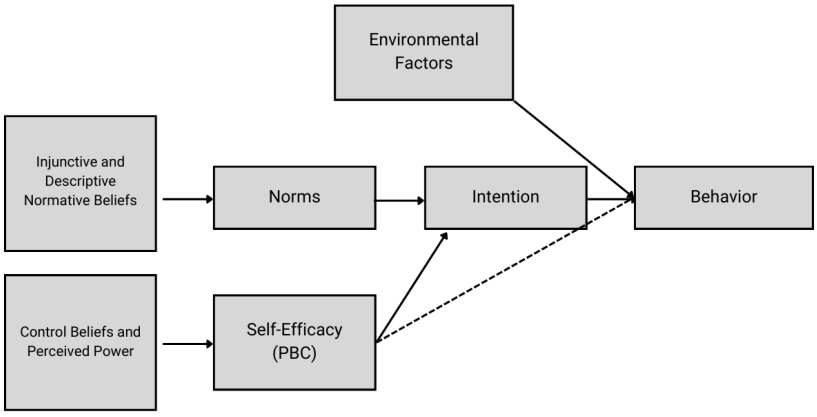
This final account illustrates the absence of intergenerational connections and support, like a grandfather's loving presence in his grandchild's life. This experience reveals how deeply intertwined joy in early parenthood is with familial and community connections. This suggests that the well-being of new mothers depends on the emotional ecosystem surrounding them and

their infants. As was captured, the pandemic didn't just postpone joyous celebrations, it also fundamentally altered the experience of becoming a mother.

Figure 5 details these sub-themes related to lacking resource support as they relate to constructs in the IMBP.

Figure 5

IMBP Constructs Identified in Theme 3



The distinct form of isolation that involved an absence of happiness reflects mothers' societal expectations about early motherhood, which the IMBP captures with the "normative beliefs" component. These beliefs reflect their expectations to exist in community with trusted members who offer additional support and care during more vulnerable times, such as the postpartum period. Their prolonged isolation from trusted members of their circles may have altered mothers' understanding of what is normal during this period, potentially changing their perceptions about whether seeking help was socially acceptable. The financial limitations discussed in this section may have directly restricted respondents' ability to seek help or support for themselves and their children, as was explicitly detailed by the account of a mother who had to prioritize medical expenses over counseling and therapy. This perceived powerlessness was evident in mothers' responses, which reflected limited access to social and financial resources.

Mothers consistently described having no choice regarding their social and financial support situation. This lack of options directly impacted their self-efficacy beliefs, hindering their ability to advocate for themselves or pursue sufficient mental health support if and when needed.

Discussion

Prior family communication research on motherhood has revealed that framing mothers as whole people rather than self-sacrificing caregivers can provide a more nuanced understanding of the postpartum experience (Scharp & Thomas, 2017). This study sought to expand on this discourse, illuminating the difficulties encountered by new mothers in the context of stressful life events, to inform tailored health messaging related to PPD support and accessible interventions. Such interventions should prioritize and honor mothers in their entirety, framing messages and subsequent interventions that recognize the complex identities encompassed in caregiving and motherhood. The language and communication strategies employed within these interventions should reflect a more holistic understanding that moves beyond symptom-focused messaging to acknowledge mothers as multidimensional individuals with varied roles and identities. The written accounts that these new mothers provided in the survey emphasize the various facets of motherhood, in addition to their identities as women, family members, romantic partners, friends, and community members.

The three identified themes—experiencing fear, experiencing isolation, and lack of resource support—reveal how mothers with PPD symptoms narrated and made sense of their experiences during the COVID-19 pandemic through complex emotions, social disconnections, and resource constraints. The three themes further illuminate the critical factors potentially influencing and hindering support-seeking behaviors among mothers. Fear-based beliefs created additional challenges to seeking in-person support, the experience of isolation fundamentally

altered perceptions of what support options were available or considered safe, and resource limitations created new barriers that prevented mothers from pursuing mental health support even when they recognized its value. The findings revealed how crisis situations exacerbate the existing vulnerabilities of new mothers and create additional barriers to mental health support. The application of the IMBP framework provided valuable insights into how and why these experiences may influence mothers' support-seeking behavior and their communicated need for additional help, offering direction for developing more effective interventions. By understanding the complex interplay of behavioral beliefs, normative expectations, self-efficacy, and environmental factors, healthcare providers and policymakers can design support systems and support-related communication that better address the multifaceted needs of mothers experiencing PPD.

Of the findings, some of the most compelling were many mothers' reiterated concerns about their children's socialization and development during the early days of COVID-19. The pandemic created unique and unpredictable circumstances where normal childhood social interactions, such as playdates, family gatherings, and daycare, were abruptly halted, leaving mothers to worry more about the potential long-term developmental impacts. The intensity of these concerns suggests that future PPD interventions should explicitly address mothers' expressed anxieties about child development during crisis situations, framing support in ways that actively acknowledge the legitimate worries rather than focusing solely on PPD symptomology. Communication in future interventions should validate these developmental concerns through explicit messaging that normalizes these worries while providing evidence-based reassurance. This can offer a foundation of trust that encourages continued engagement with support resources.

The experience of isolation emerged as a complex challenge that went beyond physical confinement to homes for prolonged and uncertain lengths of time. Mothers described both the emotional state of feeling alone and the practical realities of being physically separated from their support networks. A notable characteristic of this theme was how this isolation transformed the experience of motherhood. Additionally, as pandemic restrictions removed access to joy-inducing social interactions, mothers lost both the emotional benefits and the social affirmation that typically help buffer against PPD. These findings suggest that effective interventions should include elements specifically designed to cultivate moments of joy and celebration, even in high-stress or crisis contexts. The communicative framing of these interventions is crucial. Support-based messages should acknowledge the reality of the isolation mothers face during the postpartum period while emphasizing possibilities for new connections. Messages should use intentional language that validates mothers' experiences while inviting them into supportive communities, whether through telehealth mediums or in-person support.

Financial constraints further compounded these challenges, as revealed in mothers' accounts of having to prioritize essential medical expenses over mental healthcare. The quote "My insurance plan does not cover counseling/therapy, although I wish I could afford it. The labor and delivery bills are rolling in, and those are a priority" provided a clear illustration of how structural barriers directly impact support-seeking behaviors. Utilizing the IMBP framework, we can better understand how these financial limitations influence control beliefs and perceived power, fundamentally restricting one's ability to seek help even when the need for it is actively recognized. This particular finding underscores the importance of developing low-cost mental health resources specifically for postpartum mothers, particularly during crisis situations when economic instability is exacerbated.

Beyond this, to offer comprehensive support to mothers, mental health care programs and services must also address systemic barriers that prevent many from accessing needed resources. Financial feasibility remains an obstacle, as many mental healthcare services involve out-of-pocket expenses that place them out of reach for families already facing financial strain from medical bills and other potential lost income. Time constraints represent another critical barrier, as scheduling additional counseling or support services may conflict with the unpredictability of caring for children and other family responsibilities. Cultural and language barriers may additionally prevent mothers from varied backgrounds from engaging with available resources, highlighting the demand for culturally responsive care that acknowledges varied lived experiences, values, beliefs, and family structures.

Limitations

This study has some important limitations that warrant acknowledgement. The analysis focused on responses to two open-ended survey questions, which may not fully capture respondents' experiences when not situated within the context of more quantitative measures. These accounts from mothers are not long-form narratives, which further limits the depth of understanding that can be gained from the data. Additionally, the survey format itself may have shaped the types of responses received and subsequently analyzed. The use of Prolific.co as the platform for survey administration may have introduced selection bias, as participants were limited to those already registered on this platform.

The findings are specifically circumstantial and contextualized within the COVID-19 pandemic, potentially limiting generalizability to other high-stress events or crises, such as an economic recession occurring independently of a global health crisis. These findings also imply that women were experiencing depressive symptoms directly related to being in the postpartum

period. Without further inquiry, there is no way to know with certainty if depressive symptoms indicated through the EPDS scale were tied to PPD or depression related to the pandemic or other external factors.

This study employed a theoretical framework that includes behavior as a key component, yet no explicit behavioral data were analyzed along with the written responses, representing a significant limitation in the application of the chosen theoretical lens. Additionally, survey participation required computer and internet access, which would have excluded perspectives from mothers without these resources, particularly those from lower socioeconomic backgrounds or rural and remote areas. It is also possible that mothers experiencing severe postpartum depression may have been too depressed to participate in survey research, and that mothers with fewer resources may not have had the time available to complete the survey, further limiting the representativeness of the sample. Future studies, which will not be driven by pandemic-restricted circumstances, should prioritize various modes of data collection (e.g., community-based focus groups, telephone interviews, ethnography, etc.) to improve overall study accessibility and quality and capture a multitude of participant experiences.

Conclusion

In May of 2023, the World Health Organization (WHO) declared the official end of the COVID-19 pandemic after approximately three years, with U.S. President Joe Biden ending all national public health emergencies for COVID-19 (Northwestern Medicine, 2025; World Health Organization, 2023). As the public's attention continues to shift away from the immediate concerns of COVID-19, scholars and action researchers face a critical moment for reflection. Academics, policymakers, and healthcare professionals are uniquely positioned to assess the data capturing the multiplicity of human experiences from this unprecedented global crisis. By

examining the challenges for new mothers that emerged during COVID-19 and understanding the "lessons learned," we can extract valuable lessons from the collective trauma and resilience demonstrated during the largest public health emergency in a century. These insights will be crucial in shaping family readiness for accessible and reliable mental healthcare interventions amid future global challenges or high-stress events, ensuring an increase in emergency preparedness and support for those who require it the most.

As we continue to recover from this global crisis, what we now understand about maternal mental health during extraordinary circumstances can inform more robust, accessible, and responsive care systems, not just for future crises but for improving routine postpartum mental health support. By centering the voices of mothers themselves, we become better equipped to develop communication strategies and health messaging that genuinely reflects mothers' articulated needs and concerns rather than presumed ones, developing interventions that honor their experiences, respect their complex identities, and provide the comprehensive support they need during one of life's most challenging transitions.

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