THE UNIVERSITY OF HULL

Exploring the Barriers to Compassion for Postpartum Mothers and their Experiences during the COVID-19 Pandemic.

being a Thesis submitted in partial fulfilment

of the requirements for the degree of Doctor of Clinical Psychology

in the University of Hull

by

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BSc (Hons) Psychology, University of York

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This portfolio thesis is dedicated to my sister, Emily; you inspire me every day and I would be lost without you.

Overview

This portfolio thesis comprises of three parts:

Part One: Systematic Literature Review

The systematic literature review explored the psychological experiences of postpartum mothers during the COVID-19 pandemic. A systematic search of 5 electronic databases found twelve qualitative papers that met the inclusion criteria. The National Institute for Health and Care Excellence (NICE) Quality Appraisal Checklist for Qualitative Studies was used to evaluate the quality of the studies, whilst Thomas and Harden's (2008) Thematic Synthesis was used to configure the findings across the studies. Four superordinate themes were identified: relationships, psychological strengths, mental health difficulties, and emotional responses. The findings revealed a range of positive and negative psychological experiences, with some postpartum mothers experiencing psychological growth, and others emotional distress. Clinical implications and key areas for future research are discussed.

Part Two: Empirical Paper

The empirical paper explored the fears, blocks and resistances (FBRs) to the flows of compassion in first-time mothers. Nine women attended an online semi-structured interview with the researcher that were analysed using Reflexive Thematic Analysis (Braun & Clark, 2019). The study found three themes, with subthemes, that encompassed the FBRs that mothers experienced: 'Super Mum': the Unobtainable Ideal, the Exchange of Distress and Compassion, and Going Through it Alone. The FBRs identified within each theme are summarised, and a theme map illustrates the relationships between themes and how this maintains FBRs for first-time mothers. Clinical implications of the research and areas for future research are discussed.

Part Three: Appendices

Appendices relevant to the systematic literature review and empirical paper, including a reflective statement, epistemological statement, and all relevant documentation.

Total wordcount (including tables, figures, references and appendices): 41,637

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Part one- Systematic Literature Review

A Systematic Review of the Psychological Experiences of Postpartum Mothers during the COVID-19 Pandemic

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Conflicts of Interest
None declared.

Abstract

Problem: The literature exploring the experiences of postpartum mothers during the pandemic has identified a variety of different experiences, with postpartum mother's experiences often being reported alongside pregnant mothers. The challenges that postpartum mothers faced during the COVID-19 pandemic are distinct and understanding their psychological experiences during this time may facilitate important changes in perinatal and maternity services.

Background: the COVID-19 pandemic posed challenges for mothers, particularly, new mothers and pregnant women as governments imposed restrictions limited the prenatal groups and services they could access.

Aim: to synthesise qualitative literature around the psychological experiences of postpartum mothers during the COVID-19 pandemic.

Methods: A systematic literature search using five electronic databases was conducted, to investigate the psychological experiences of postpartum mothers during the COVID-19 pandemic. Twelve studies were identified and quality assessed. These studies were then included in a thematic synthesis.

Findings: The findings were organised into four groups with subordinate themes that reflected the psychological experiences of postpartum mothers and the areas of their lives most affected: relationships, psychological Strengths, mental health difficulties, emotional responses.

Discussion: Mothers had psychologically challenging experiences alongside opportunities for psychological growth and development. Relationships exist between the themes. These findings have clinical implications for health professionals working with mothers who gave birth during this pandemic. These findings should also be taken into account by health services worldwide should restrictions be re-introduced in the future for pandemics.

Conclusions: The psychological experiences of postpartum mothers during the COVID-19 gave rise to difficult emotions, relationship changes and positive psychological phenomena.

Key words: Postpartum Period, COVID-19, Pandemics, Mothers, Experiences

Introduction

Table 1

Statement of Significance

Problem	Lack of understanding of the psychological experiences of postpartum women worldwide during the COVID-19 pandemic. Much of the qualitative literature currently reports pregnant women's and postpartum mothers' experiences together, despite facing unique challenges.
What is already known	Quantitative research has shown that perinatal mothers experienced higher levels of depressive symptoms, generalized anxiety and loneliness during the pandemic.
What this Paper Adds	A qualitative synthesis of the lived psychological experiences of post-partum mothers worldwide during the pandemic.

The postpartum period is often a time for parents to adapt to their new roles, bond with their infant and enjoy special moments with family and friends. However, the postpartum period poses many challenges too, including transitions, contradictions, tensions and transformations [1]. Many parents experience stress, anxiety and fatigue during the postpartum period; and around one in five mothers experience a mental health problem within the first year [2,3]. During these challenging months, mothers often seek information, psychological and practical support, and to share their experience [4].

On March 11, 2020 the World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak a global pandemic, and many countries put in place restrictions to reduce the spread of the virus. Restrictions such as national 'lockdowns' and non-essential service closures dramatically affected the lives of millions of people worldwide and particularly affected how healthcare services were accessed. This pandemic has contributed to an increase in mental health problems in the general population. Research has shown an increase in levels of anxiety, depression, and traumatic stress in a representative UK sample when compared to previous population data. An estimated 27% of the population are experiencing clinically significant levels of mental distress compared to estimates of 13% and 17% for anxiety and depression pre-pandemic [5-7]. Restrictions introduced across many countries to limit the spread of COVID-19 included social distancing and 'stay at home' orders, which contributed to feelings of social isolation and loneliness for many [8].

Among perinatal women, isolation and reduced social support increase the risk of developing perinatal anxiety and mood disorders such as postpartum depression [4, 9]. Quantitative research has highlighted the pandemic's impact on perinatal mothers, with research showing higher levels of depressive symptoms and generalized anxiety among this population across five European countries [10]. Many mothers in the UK reported feeling down, lonely, irritable, and worried since the start of the national lockdown, with 30% of these mothers feeling unable to cope [11]. However, quantitative research provides only a snapshot of mothers' experiences during the pandemic, where responses are often limited by the language used within measures of mood and wellbeing. Quantitative research using measures of mood and wellbeing pose closed questions to participants, where their experiences are reduced down to numbers on a scale or words that do not always accurately capture or reflect their experiences.

This review uses qualitative research to explore the psychological experiences of postpartum mothers during the COVID-19 pandemic. No reviews of the psychological experiences of postpartum mothers could be found, therefore this review is novel. The review focuses on qualitative literature in order to explore the lived experiences of postpartum women across the world during the pandemic. This review also hopes to add to the qualitative literature that has examined the impact of the COVID-19 pandemic on postpartum mental health by bringing the existing research together. For the current review, psychological experiences were defined as encompassing all aspects of mental health and wellbeing including relationships and emotional responses.

The aim of this review is to explore the psychological experiences of postpartum mothers during the COVID-19 pandemic. This review is needed because there is no research at present that highlights the most prevalent psychological experiences of postpartum women worldwide. This review will inform clinical practice within perinatal mental health services by providing an insight into the lived experiences of postpartum mothers during the pandemic, which may have a long-lasting impact on their wellbeing and relationships.

Participants, Ethics and Methods

Search strategy

A systematic literature review was conducted between December 2021 and February 2022. Five electronic databases were searched through EBSCOhost search service: Academic Search Premier, APA PsycInfo, APA PsycArticles, CINAHL Complete, MEDLINE. The databases were chosen to ensure the relevant literature was found. Prior to the literature search, a scoping search was conducted to ensure that there were no existing reviews on this topic and to help identify key search terms.

Search terms

No previous reviews were identified, therefore search terms were derived through a number of methods. These included identifying search terms (and their synonyms) that had appeared in the abstracts and titles of papers in the scoping search and existing literature and through consultation with the second author . A search protocol was created which included the research question, inclusion and exclusion criteria and the agreed search terms, to ensure replicability and transparency. A further search using the search terms was run using two further electronic databases (MEDLINE and Web of Science).

The final search terms were:

experiences OR perceptions OR attitudes OR views OR feelings OR qualitative OR perspective*

AND

Mother* OR maternal OR mum* OR mom* OR postpartum OR postnatal

AND

COVID-19 OR coronavirus OR pandemic OR sars-cov-2 OR quarantine

Psychological and mental health related terms were not included in the search terms as this research was concerned with all psychological experiences of mothers during the pandemic, including positive psychological experiences (e.g. resilience) which may have been omitted by the search term ‘mental health’. The broader search terms ‘experiences’ and ‘perception’ allowed for research into both challenging and positive experiences to be found.

The final set of search terms regarding the context of COVID-19 did not include terms such as ‘lockdown’, ‘restrictions’ and ‘service closure’ as these was considered to not be universal as different words and language was useful worldwide to describe the events of the

pandemic, and not all countries had restrictions implemented. Additionally, it was thought that the search terms of ‘pandemic’, ‘COVID-19’ and ‘quarantine’ were sufficiently broad and universal to ensure research conducted during this context was included in the search results.

When searching the databases two limiters were applied to ensure that the articles were written in English and peer-reviewed. The peer review limiter was used to ensure that all articles had been through a formal review process. In order to ensure that the search revealed only the most relevant papers, the ‘Expanders-apply equivalent subjects’ was removed. The ‘Title’ limiter was applied for the second set of search terms (population-based search terms). The publication date limiter was also applied to ensure that only research written during and after the COVID-19 pandemic (from 01/01/2019 to 2022) was included.

Selection

Titles of all research papers generated by the final search were screened for relevance to the review and duplicates were removed. If it was unclear from the titles whether the paper was relevant to the question, the abstract, and in some cases the full article, was reviewed. The abstracts of the remaining papers identiied were reviewed and the inclusion and exclusion criteria were applied.

Table 2

Inclusion Criteria and Rationale

Inclusion criteria	**Rationale**
Population: individuals who identified as mothers and were in the post-partum period	The review aimed to investigate the psychological impact of the COVID-19 pandemic on post-partum mothers. Research where postpartum themes were reported separately from other populations (e.g. pregnant mothers) were included.
Context: Any person who was in the post-partum period during the COVID-19 pandemic (<12 months after birth).	The review aimed to investigate the psychological impact of the COVID-19 pandemic on post-partum mothers.
Language: English	English is the only language the researcher can read and understand fluently.
Study design: qualitative data from both qualitative and mixed method research	Qualitative data was included as this provided rich data on the psychological experiences of postpartum mothers during the pandemic and highlights themes in their wellbeing and mental health.
Study type: full text, primary research articles, published in an academic peer-reviewed journal.	The review aimed to explore empirical research which included research questions, collected data on psychological phenomena, and reported the findings.

Table 3

Exclusion Criteria and Rationale.

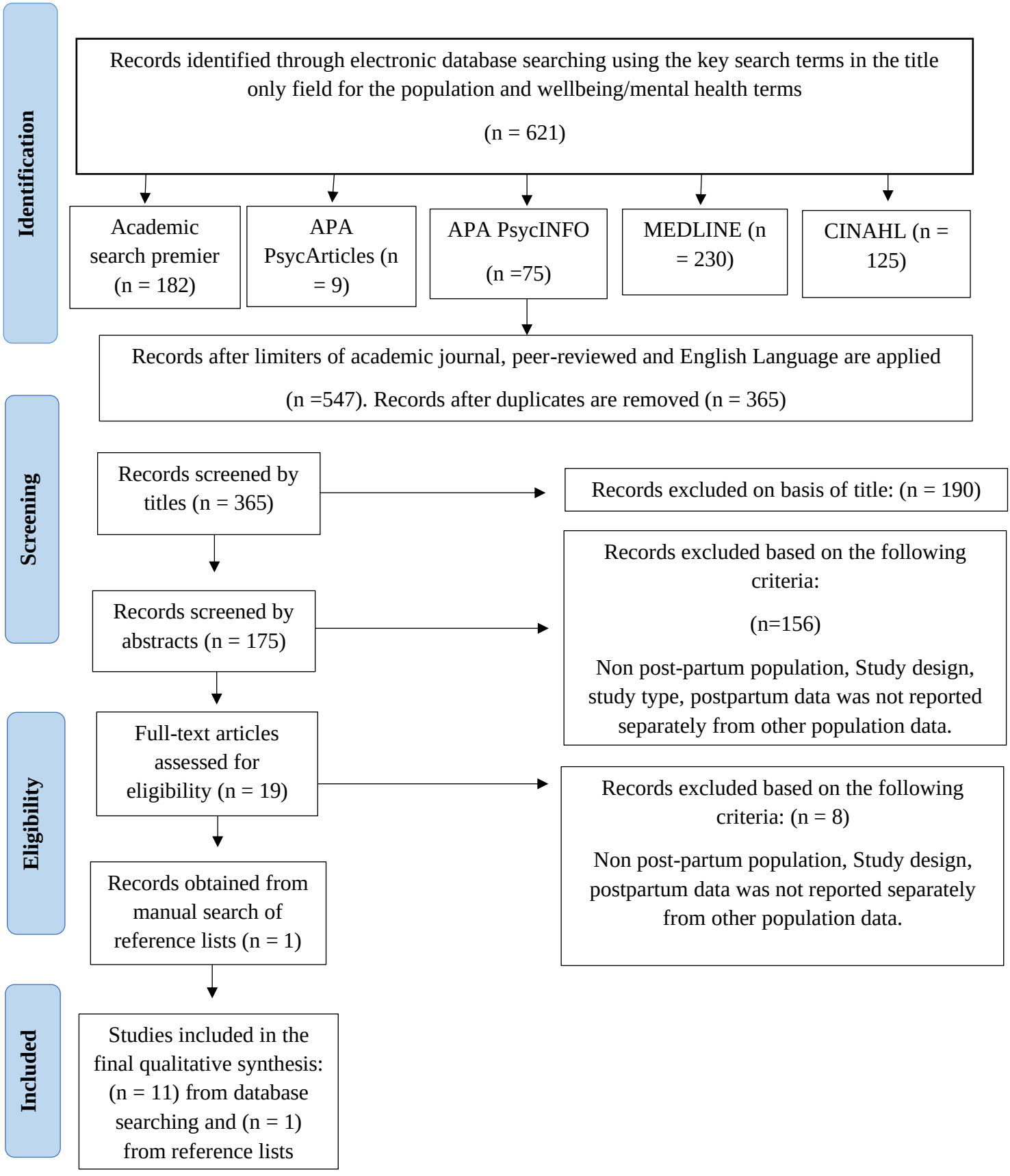
Exclusion criteria	**Rationale**
Population: individuals who were not mothers in the post-partum period (pregnant or >12 months after birth).	The review aimed to investigate the psychological impact of the COVID-19 pandemic on women in the post-partum period (defined as between birth and 12 months after; Joint Commissioning Panel for Mental Health, 2012). Therefore research that focused solely on parents/caregivers who were > 12 months post-partum or pregnant were excluded. Research where postpartum themes were reported separately from other populations (e.g. pregnant mothers) were excluded.
Context: any person who did not experience the post-partum period during the COVID-19 pandemic.	The review aimed to investigate the psychological impact of the COVID-19 pandemic on post-partum mothers.
Study design: quantitative data	Quantitative data was excluded as this research was concerned with the psychological experiences of post-partum mothers during the COVID-19 pandemic.
Language: Any non-English	Translating papers was not possible.

Study type: Secondary research articles, studies not published in peer-reviewed journals. Papers that are abstracts, literature reviews, meta-analyses, commentaries, letters, editorials, reports, conferences, grey literature, case reports, opinion articles and book chapters	The review aimed to explore original and primary research.

Papers that met these criteria underwent further screening. Some papers were excluded at this stage. Of the final sample of included papers, a hand search of the reference list was completed to identify other relevant papers. The same inclusion and exclusion criteria were applied to papers identified in this way. Figure 1 summarises this process.

Figure 1

Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) diagram of search strategy (12).



Data Extraction and Quality Assessment

Following article selection, key data were extracted from each paper using a bespoke data extraction form (See Appendix D). This included research aim(s), study design and analysis, participant characteristics, study timeline, and key qualitative findings as outlined by the study. A summary of the characteristics of the studies and their quality rating can be found in Appendix D.

The National Institute for Health and Care Excellence (NICE [31]; See Appendix E) quality appraisal checklist was used to assess the quality of each of the studies selected. This checklist is designed for assessing qualitative studies and includes questions that are applicable to a range of qualitative research methodologies. The NICE quality appraisal checklist for qualitative studies was selected because it is well-established and adequately addresses all relevant aspects of methodological quality.

Two research papers were randomly selected and rated by another researcher in order to establish inter-rater reliability. Any discrepancies in quality assessment were discussed until an agreement was formed.

A summary table of the results of the quality assessment can be found in Appendix F. As a limited number of studies were selected for this review, quality assessment was not used as a method to exclude studies from the analysis. Quality assessment did however provide important information considered within the synthesis.

Data Analysis

Thomas and Harden's method of thematic synthesis was chosen for the analysis and synthesis of mothers' psychological experiences of the pandemic evident in the selected studies.[13]. This method enabled the researcher to synthesise the data across multiple qualitative papers whilst staying 'close' to the primary findings, thus minimising the researcher's influence on

the review's findings. The researcher completed line-by-line coding by reading and re-reading the results sections of the studies to become familiar with the data and identify psychological experiences of mothers. During this process the researcher considered how each of the codes related to one another across the studies, and also how it related to mothers' psychological experiences during the pandemic. Themes and quotations from each of the papers were interpreted and coded into descriptive themes. Descriptive themes were then interpreted further and links were made between them to generate analytical themes concerning the specific aspects of mothers' psychological experience. The descriptive themes within each of the analytical themes highlight the range of psychological experiences that mothers encountered.

Results

The 12 papers included in this review were published between 2020-2022. Research took place in a range of countries: four were from the United States [14-17] , three were from the United Kingdom [18-20], three were from Canada [21-23], and one study each from Germany [24] and Brazil [25]. Data collection for seven studies took place between the March and June 2020 which were the first few months following the WHO's declaration of the COVID-19 pandemic. Four studies collected data in the later months of 2020 and the beginning of 2021, and only one study collected data exclusively in 2021.

Three of the studies used a mixed-methods design and nine studies used qualitative methodology only. Three studies used a sample of both pregnant and post-partum women whereas nine studies used a sample of only post-partum mothers. One study included partners (n=5) in the interviews with mothers [24]. This research paper was included as interview data from partners was reported separately, and only 5 of the 25 mothers interviews had their partners present during the interview. Therefore the impact of partners' presence on the findings would have been small. Across the studies, there was a total of 1,619 postpartum mothers. Sample sizes ranged from 10 to 1,219. Only one study did not report data on participant age [21]. Seven papers reported mean participant age, but did not report mean age for pregnant and postpartum mothers separately [15, 16, 17, 18, 20, 23, 24] . Mean participant age across the seven papers was 32 years. Four papers reported on data on age ranges (e.g. 25-35 years-old) [14, 19, 22, 25].

Four studies used questionnaires [15, 18, 21, 22]. The remaining eight studies used semi-structured interviews, one of which used photo-elicitation alongside interviews [17]. Five studies used Thematic Analysis [18-20, 23, 25], three used Content Analysis [15, 17, 24], one used Interpretative Phenomenological Analysis [16], two used Feminist Poststructuralist

Discourse Analysis [21, 22]. One study did not report their method of analysis but presented themes within their results section [14]. With regards to quality assessment, all studies were rated as ++ (n= 10) and + (n= 2), which means that all (++) or some (+) of the NICE quality appraisal criteria have been fulfilled, and where they have not been fulfilled the conclusions are very unlikely (++) or unlikely (+) to alter.

Synthesis of Findings

Findings were synthesised into superordinate and subordinate themes as shown in Table 4.

Table 4

Superordinate and subordinate themes.

Superordinate theme (Analytical themes)	**Relationships**	**Psychological Strengths**	**Mental health difficulties**	**Emotional responses**
Subordinate themes(descriptive themes)	Challenges and changes to family life Strengthened relationships: connected and bonded	Gratitude Care for and preservation of the self Confidence and agency	Trauma Anxiety and Intolerance of Uncertainty Stress and feeling overwhelmed	Lost at Sea: Feeling abandoned and unsupported 'Like I was in jail': Disconnected and Isolated Fearful Loss and disappointment Relaxed and less pressure

Relationships

Mothers experienced changes in their relationships and household dynamics, for some, this was a positive change and for others this was more challenging.

Subtheme: Challenges and changes to family life

Many postpartum mothers described having increased demands during the pandemic due to school closures and partners working from home. Mothers reported having to balance taking care of their infant alongside caring for their older children, home-schooling, managing

household responsibilities, and work [17, 18, 20, 25]. Partners working from home added to mothers' chores, stress, and led to more arguments [21]. Mothers reported that these challenges impacted their breastfeeding experiences and the amount of time they had to spend with their infant. This highlights how the COVID-19 pandemic contributed to some mothers experiencing relationship difficulties with their partners, which in turn affected their relationship with their infant.

"I am at home with an energetic 5-year-old who would normally be in school. I do not have time to express in between feeds or sometimes breastfeed at all because I feel I need to meet my daughters demands and run the house and basically be a single parent most of the time. Before lockdown I was able to have my mum and sisters come and stay and help out. I could also have friends to help me or my older daughter could go for play dates to allow me to focus on the baby."

*[18] page 10*Subtheme: Strengthened relationships: connected and bonded

Isolation, school closures, and working from home guidance meant that families spent increasing amounts of time together, and for some, this strengthened family connections. Many postpartum mothers reported closer relationships with their infant and older children, described being a stronger family unit overall, and had more time to adapt to their new parenting role [14, 18-21]. For those mothers where there were fewer competing demands during the pandemic, some mothers were able to spend more time with their infants without disruption from visitors or pressures to go out. This meant that many mothers felt a greater bond with their infant, which had a positive impact on their breastfeeding experiences.

Many mothers reported feeling supported by their partners both emotionally and practically, as they were often working from home [14, 16-18, 20, 21]. Some mothers reported feeling more connected with family and friends as virtual communication via social media became

the norm. Some mothers formed new connections with fellow mums on social media pages, giving them an opportunity to share their experiences and advice with one another. .

"My husband is home full-time and that has been so helpful just to not be alone. I can really focus on her and my husband and our family time."

*[14] page 5**Mental Health Difficulties***

This superordinate theme examines how the COVID-19 pandemic impacted on mothers' mental health and psychological wellbeing.

Subtheme: Trauma

Some mothers described having difficult birth experiences which were exacerbated by having to be separated from their partners and feeling unsupported by hospital staff [23, 24]: One mother who tested positive for COVID-19 whilst in hospital described how she was traumatised by her experience of being isolated from hospital staff and her partner, and could not imagine having another child. The restrictions on partner presence during births, social distancing measures, and reduced staff numbers appear to have contributed to the traumatic birth experiences of some mothers during the COVID-19 pandemic:

"I had a second-degree tear, and I was trying to breastfeed and all that ... just doing that alone was really traumatic, to be honest. There [were] a couple of times where I just really felt like I was at my breaking point because my daughter was crying so much and I just didn't know what to do"

[23] Page E559

Subtheme: Anxiety and intolerance of uncertainty

Mothers reported experiencing postnatal anxiety, with particular concerns about their infant's ability to socialise with other adults and infants and the impact this may have on their development, attachments and mental health in later life [21, 22]. Other mothers

reported having anxiety about being away from their infant when they tested positive for COVID-19 and reported overthinking [20]. The implications of infants contracting COVID-19 was also a significant worry for mothers, which was often exacerbated by unclear, or a lack of, information [21, 22]. Breastfeeding was also a cause of anxiety in mothers who felt they had little information and support with it, and were worried about their babies' weight which resulted in one mother seeking reassurance from professionals [20]. The uncertainty associated with the pandemic contributed to many mothers' anxieties, particularly about 'the new world' their infant will grow up in, and when the pandemic will end [15, 22].

"I never had anxiety before…I never, I've never suffered with it. But even if I like, if I see [baby]- if I go to like if I pop to the supermarket now, I get all like panicky. I feel like I've got to rush in and rush out as quickly as I can. I dunno if it's 'cause it's just odd when you go in there now and the one-way systems and all like being a bit weird or I don't know if I would've been like that anyway because I'm away from the baby, but I suppose I wouldn't've overthought it before."

[20] Page 11

Subtheme: Stress and feeling overwhelmed

Many postpartum mothers reported experiencing high levels of stress as a result of the pandemic. The most prevalent source of stress were finances, with many mothers reporting difficulties with finding work, childcare, experiencing job loss and maternity pay issues [15, 17, 20, 25]. Other sources of stress included the lack of help with caring for their children, and the overwhelming responsibility to care for, protect and breastfeed their infant [17-19, 25]. Mothers reported being overwhelmed by the amount of information surrounding

COVID-19 and the postpartum experience, and found that mothers sharing their birth experiences on social media led them to feel stressed about their forthcoming birth [19, 22].

"[If] my job would've told me they didn't have an overnight position, I would've lost my job. And I would've had to, because I can't put [my new-born] in day care with all this going on…oh God, it was so scary, 'cause like at this point, what are we gonna do, how're we gonna live, how're we gonna pay rent, how're we even gonna get groceries. We have no back up plan, we don't have anything..."

[17] page 248

Psychological Strengths

This superordinate theme examines how the pandemic provided opportunities for mothers to develop and experience positive emotional responses and skills.

Subtheme: Gratitude

Across the research, mothers were found to be grateful for various aspects of their lives during the pandemic, including the support they have received from partners and friends. Many mothers expressed gratitude for being able to spend time with their infant and family during the lockdown [14, 17, 19, 24]. This family time was often considered 'special' and 'important' to participants [14, 18, 21, 22]. Gratitude for supportive partners during the lockdown was also expressed by mothers [17]. Some mothers expressed feeling 'lucky' and grateful to have been able to access online groups where they could connect with other mothers, which was not possible to access through face-to-face groups [18]. Others had friends provide practical support by providing cooked meals, however, gratitude for these altruistic acts was sometimes met with feelings of guilt when having to set boundaries on social distancing to friends [17]. In expressing gratitude, some mothers acknowledged their

privileges and reported feeling ‘lucky’ for not having it as ‘bad’ as others during the lockdown [17, 19]:

“I’m feeling grateful for all this special time with my kids and we started a garden and have all this intense family time”[14], page 4

Subtheme: Care for, and preservation of, the self

Many of the studies highlighted how mothers had engaged in various cognitive and behavioural strategies to protect themselves from the difficult experiences that the pandemic had created. Some mothers reported using coping strategies such as exercise, faith, being outdoors, creating routine, and setting up online support groups to connect with other mothers [14, 22]. Mothers also cited sharing household and caring responsibilities with their partner as important for maintaining their health and wellbeing, for some this involved managing the guilt associated with asking for help [14, 20]. At times, mothers felt that it was important to break social distancing rules in order to connect with family and friends when feeling particularly isolated and distressed. This was often associated with mothers undertaking their own risk assessments and doing what felt ‘right’ for them [19, 20]. Other mothers chose not to engage in information-seeking behaviours as this was a source of anxiety and confusion [22]. Cognitive strategies used to maintain psychological health included not comparing one’s current postpartum experiences to their previous ones nor other mothers, and engaging in self-kindness [17, 20].

Many mothers reported having adjusted their expectations about their postpartum experiences whilst focusing on the good, which had enabled them to developing resilience [14]. *“My two best friends and I as well, have been very naughty and met and gone for walks together, because none of us are coping very well mentally…so that has helped tremendously [laughter] erm and I[Voice wavering] I feel terrible er because I obviously am not trying to*

*do the wrong thing but I think the problem with the way the Government's handled this is they haven't been very…I don't know. It just sounds like they haven't thought it through very well, which I'm sure they have, but I don't know. It doesn't feel like it. It feels like they've just done all the wrong things [laughter]."[20] page 6.*Subtheme: Confidence and agency

Agency refers to the sense of control that mothers felt they had and the capacity for them to influence their emotions and behaviours. It is clear that many post-partum mothers utilised agency to manage their own wellbeing and solve their difficulties, which at times contributed to mothers feeling proud of themselves and more confident in their ability to breastfeed [22]. Breastfeeding mothers reported that the pandemic's stay at home orders allowed them to become more confident with breastfeeding, giving them the opportunity to practice without disruption from visitors or pressure to do so in public spaces. However, this confidence in breastfeeding at home, meant that some mothers did not feel confident about doing so in public [18]:

"Not being able to go out has allowed me to gain more confidence in bf. I still do not feel confident enough to feed in public and feel I need support with positioning to be able to do this. Not having lots of visitors also has allowed me to be able to feed how it works for us without having to worry about people coming round."

[18] page 8

Emotional Responses

This superordinate theme examines the affective reactions of mothers during the COVID-19 pandemic, of both positive and negative valence.

Subtheme: 'Lost at Sea': Feeling abandoned and unsupported

Across all 12 papers, a theme emerged of mothers feeling abandoned and unsupported by others, including healthcare services and family. Many postpartum mothers reported feeling unsupported during their hospital stay, as policies meant that partners were not allowed to be

present during labour and the period shortly after birth [20, 23, 24]. Other times mothers felt unsupported and abandoned included when their perinatal nurse was reassigned to the COVID-19 ward, and when a trying to visit their infant in intensive care on a different floor of the hospital [22, 23]. Mothers who tested positive for COVID-19 had particularly strong feelings of abandonment whilst in maternity care, as hospital policy meant that staff members isolated infected mothers, kept their distance, wore Personal Protective Equipment which led some mothers to have difficulty hearing what their care staff were saying and were unsure with whom they were talking [23, 24]. Additional barriers to accessing resources and support and poorer quality of care was cited as contributing factors to mothers feeling abandoned [17, 24]

During the postpartum period many mothers felt unsupported with their breastfeeding journeys, and felt that they really needed access to face-to-face breastfeeding support during the lockdowns [16, 18, 20, 21, 24]. Many mothers reported a lack of face-to-face healthcare which included not having home visits, 6-week check-ups, and difficulties accessing mental health services [15, 19, 20, 22, 24, 25]. As a result, some mothers reported being left in pain, having further health difficulties, and the lack of support ultimately led to the cessation of breastfeeding for some.

Additionally, mothers struggled without the face-to-face support of family, as this meant they were not able to access emotional support or help with childcare which was particularly challenging for mothers who had older children [14, 15, 20, 23, 25]. Mothers also felt abandoned and unsupported due to the forced closure of parenting support groups and baby classes, and felt that online parenting groups were not the same [20, 22].

"[My partner] had to leave 4 hours after [I delivered]. It was terrifying. I'd never had a baby before, and I had the whole night and then the whole next day to take care of a newborn by

myself after having a hard labour and delivery. I was there alone, I was on pain medication. It was not set up to help women at all. It was more helpful for the staff than it was for the parent. I felt — not by [my partner], but by our health care system during this time ...

— abandoned and forgotten about."

[23] page E559

Subtheme: 'Like I was in jail': Disconnected and Isolated

Social connection with friends and family was missed dearly by many mothers, who were saddened at not being able to connect and share their infant with loved ones and many reported feeling lonely throughout the pandemic [18-25]. Many mothers reported missing the opportunity to connect and build friendships with other new mums and the feelings of community that accompany being part of a mum and baby group [18, 20-22]. These feelings of loneliness were conflicted with mothers' drive to keep their infant safe from COVID-19, which then led many mothers to worry about the impact that social isolation would have on their infant's development [14, 17, 21]. Many mothers mentioned that they were able to connect virtually with loved ones and fellow mums online, but felt that these online interactions were not the same [17, 18, 22].

"I felt like I'd been imprisoned. I was just, like, sick and tired of being in this living room. I think that was really hard."

[20] Page 8

Subtheme: Fearful

The most common fear amongst postpartum mothers during the pandemic was the prospect of their infant, themselves or their partner, contracting COVID-19 and one member of the family having to isolate from the others [14, 15,19, 25]. Some mothers feared infecting their infant or other family members, and the possibility of being exposed to the virus at work [17,

20]. The reality of having to care for an infant without support of their partner whilst in hospital, and without access to healthcare services in the community, was described as terrifying for some mothers [20, 23].

"I caught COVID already while I was, uh, 37 weeks pregnant. So um, I'm pretty, uh, scared.As long as I feel like, um, the kids go outside and come back, I feel like they have to have a mask on when they interact with [my newborn]."[17] Page 247

Subtheme: Loss and disappointment

Many postpartum mothers reported mourning the loss of special moments during their pregnancy and postpartum period. Memorable events such as obstetric appointments, baby showers, family photoshoots were cancelled for many mothers, and social isolation meant that parents were unable to introduce their new-born to family members and share their infant's milestones [15, 17, 20, 21]. Similarly, special moments and choice were taken away from mothers as some were not able to have the birth they had planned for due to limits on the number of birthing partners and staffing constraints [19]. Some mothers were disappointed by and mourned the parental leave that they had imagined for themselves as social distancing and closures left many mothers isolated [20, 22].

"it was so heart-breaking because they were on the other side of the glass. And his mum, this is her first grandchild and she's propped up against the glass like tears streaming down her eyes, because obviously the first thing you want to do is hold them.. . it was awful to watch them have to stay outside."

[19] page 9

Subtheme: Relaxed and less pressure

In contrast to the negative impact illustrated by the previous four themes, many mothers found that they felt relaxed during the postpartum period whilst in a pandemic as it allowed them to have more time to spend as a family, adapt to their new role as parent, focus on breastfeeding, and focus on their post-birth recovery [18-21, 23, 24]. A large contributor to this relaxed state was that mothers felt less pressure to go out, meet people and had fewer social obligations [18-21]. Furthermore, social distancing guidance meant that postpartum mothers had fewer visitors which led them to feel less internal and external pressure to keep the house tidy, be a 'Super Mum', and to parent in certain ways [18-21, 23, 24].

"During lock down I have had more time to focus on feeding my baby on demand and not feel rushed because I need to be anywhere."

[18] page 8

Discussion

This review aimed to explore the psychological experiences of postpartum mothers during the COVID-19 pandemic. Thematic synthesis indicated four themes across the 12 studies that revealed different aspects of mothers' experiences. The results indicated that mothers had both psychologically challenging experiences, as well as opportunities for psychological growth and development. Relationships exist between themes, for example, many of the psychological strengths developed during the pandemic were related to mothers' mental health difficulties, emotional responses and changes in relationships.

These findings support quantitative research that has shown that many perinatal women during the pandemic scored above the clinical cut-off on a range of measures of psychological well-being, and therefore had particularly distressing experiences [11, 26]. Other qualitative research into the experiences of postpartum mothers that did not meet the

inclusion criteria support these findings also, with many mothers experiencing mental health concerns and reporting ‘silver linings’ of the pandemic [27, 28].

Assessment of strength of review

Quality assessment indicated that most of the included studies were high quality. The quality score for some studies was affected due to a lack of detail in reporting the role of the researcher and ethical considerations. Two of the studies shared the same sample of 68 mothers. As all papers were considered to be of a high quality, quality scores did not have an impact on the researcher’s interpretation of the findings

The review is based on samples of parents from the UK, USA, Canada, Germany and Brazil. Each of these countries has different legislation in place for maternity rights and access to healthcare, which will likely have had an impact on postpartum mothers' experiences during the pandemic. The majority of the research papers in this review conducted their research in countries where mothers had maternity rights. Eight of the studies took place in countries where mothers are legally entitled to paid leave and have access to healthcare services which are free at the point of use. Four of the papers included in this review used US samples, where employers are not legally required to provide paid maternity leave and healthcare is not free at point of use. The findings of this review may not completely reflect the experiences of US mothers as they have fewer maternity rights and increased financial stressors associated with becoming a mother. Furthermore, many of the studies collected data within the first few months of the pandemic, however, the variation in the number of COVID-19 cases and restrictions across nations means that findings cannot be grouped reliably based on their study timeline. However, common themes were identified across studies, suggesting that there were shared experiences across different samples and timelines.

One sample included mothers of infants who were born prematurely and therefore had an additional stressor during the postpartum period. Two samples included only breastfeeding mothers who experienced barriers to accessing support with breastfeeding and juggling this alongside other care and work demands.

Future research recommendations

Further research should examine mothers' perceptions of how giving birth during the COVID-19 pandemic has affected them in the long-term as many mothers reported difficult experiences that may have lasting effects on their mental health e.g. trauma. Additionally, future research should explore the impact that the pandemic had on the cognitive and emotional development of children born during this time. The increased time that families spent together at home may have supported infant development and familial relationships, or was perhaps negatively impacted by the additional demands that mothers faced during this time. Understanding how this pandemic affected the COVID-19 generation may provide important information on child development during times of uncertainty.

Wider Implications

These findings demonstrate the many psychological challenges that postpartum mothers experienced during the COVID-19 pandemic, and highlight the psychological strengths that some mothers were able to harness and develop. At the time of writing, the WHO has not yet declared the novel coronavirus pandemic over. Should new variants arise and infection rates increase, restrictions may be reintroduced and these findings should be taken into consideration by perinatal services worldwide in order to support mothers effectively. Additionally, these findings highlight the potential for psychological growth and strengths to be developed during adversities such as pandemics, which are important factors that mental health professionals should draw on when working with individuals clinically [29].

Additionally, clinicians should consider these findings when working with women, who were in the postpartum period during the pandemic and families and young people who were born during this time.

These findings highlight the need for health professionals and policy makers to not make assumptions about the experiences of mothers during the pandemic, as some mothers felt disconnected and alone whilst others felt more connected to their family and relaxed. Therefore, it would be important for health professionals working with mothers to carry out thorough assessments to understand how they were affected by the pandemic, and understand any trauma or fears that may impact on their future experiences. Additionally, these findings should be taken into consideration when working with families and young people who were born during the pandemic as these findings suggest that some mothers had increased opportunity for bonding with their infant, thus impacting attachment styles and relationships within families [30].

Conclusion

This study demonstrates the emotional challenges and opportunities for psychological growth that postpartum mothers experienced during the COVID-19 pandemic. This research demonstrates that a range of mental health concerns as well as emotional responses were experienced, which resulted from a range of factors during the lockdown including additional barriers to healthcare support and limited childcare.

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PART TWO: EMPIRICAL PAPER

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Fears, Blocks and Resistances to the Flows of Compassion in First-Time Mothers

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Abstract

Purpose

Compassion-based interventions have been used to support mothers with their mental health and psychological wellbeing, although with varied success and, at times, high attrition rates. Literature has reported that some mothers experienced barriers to engaging with these compassion-based interventions. No research has explored what barriers to the flows of compassion exist for mothers. This research aims to understand the fears, blocks and resistances (FBRs) to the flows of compassion for first-time mothers.

Methods

A sample of nine first-time mothers attended semi-structured interviews. Interviews were transcribed and then analysed using a contextualist approach to reflexive thematic analysis.

Results

Three themes and six subthemes were discovered. 'Super Mum': the Unobtainable Ideal' highlighted how societal narratives and pressures placed on mothers contributed to many of their FBRs. 'The Exchange of Distress and Compassion' describes the negative outcomes that mothers associated with the direction of the flows of compassion. 'Going Through it Alone' highlights some of the isolating experiences of motherhood that contributed to many of the FBRs mothers experienced.

Conclusions

Many fears, blocks and resistances to compassion exist for first-time mothers which are captured in the themes and subthemes. Relationships exist between themes and subthemes. a theme map illustrates how FBRs may be maintained in this sample. These themes have

implications for perinatal mental health services and how compassion-based therapeutic approaches are used with this population.

Keywords

Compassion; Mothers; Fears, blocks and resistances; Qualitative; Empirical research

Fears, Blocks and Resistances to the Flows of Compassion in First-Time Mothers

Becoming a parent can be challenging for some, with many parents dealing with stress, anxiety, and fatigue (Vismara et al., 2016). The physical, relational, and biological changes that arise after becoming a parent can affect a person's wellbeing. For example, the number of British women who experience mental health difficulties during pregnancy or the postnatal period is estimated to be 10-20% (Bauer et al., 2014). Postnatal depression (PND) is the most prevalent mental health difficulty in perinatal women, affecting 11.9% (Woody et al., 2017). Postpartum psychosis, Obsessive Compulsive Disorder and Post-Traumatic Stress Disorder can also affect many women during the perinatal period (Bauer et al., 2014).

Postnatal depression is a difficult illness that has a widespread effect on the family. Research estimates that 19.3% of mothers worldwide with postnatal depression have self-harm ideation, and that suicide is the second most common cause of mortality in postpartum women (Lindahl et al., 2005; Wisner et al., 2013). These researchers also noted that women in cultures that stigmatize motherhood among unmarried women were at greater risk of death by suicide, with rates of suicidality in postpartum women in North America and Europe being lower than their counterparts in South America or Asia. These findings perhaps highlight the importance of social support and compassion during the perinatal period. This research also illustrates the potentially devastating consequences of postnatal depression if left untreated. Furthermore, partners of mothers with postnatal depression are themselves more likely to experience mental health difficulties (Goodman, 2004; Matthey et al., 2004).

Postnatal depression has also been shown to affect infant development. Specifically, infants of depressed mothers tend to perform worse on object concept tasks, are more insecurely attached to their mothers, and demonstrate mild behavioural difficulties (Murray,

1992). Interestingly, infants of postnatally depressed mothers were also more vulnerable to the adverse effects of lower social class.

Several psychological and psychosocial approaches have proved effective in reducing the symptoms of postpartum depression, including peer support and cognitive behavioural therapy (Dennis & Hodnett, 2007). However, in the last decade third-wave psychological therapies have become increasingly available within mental health services as the evidence base for their efficacy continues to grow (Dimidjian et al., 2016). Compassion-focused therapy (CFT) is part of the 'third wave' of psychological therapies with one of the aims of this approach being to help clients develop greater compassion for themselves. The concept of self-compassion and compassion more broadly may have the potential to improve wellbeing and mental health in new mothers, with research highlighting its psychological and physical health benefits for adults (Pace et al., 2009).

Compassion and Self-Compassion

Within the literature, the CFT definition of compassion reflects a widely-accepted understanding of compassion as "a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (p. 94). CFT posits that compassion can flow in three directions , i.e. compassion can be shown to others, received from others, and expressed to the self (Gilbert & Choden, 2014). Research has shown that, on average, individuals tend to score highly on compassion for others, but poorly on measures of self-compassion (López et al., 2018).

Compassion: a CFT Perspective

Compassion is thought to have evolutionary origins from mammalian caregiving, as parents attended to their infants (and others) distress and took action to relieve it (Brown & Brown, 2015; Gilbert, 1989, 2005, 2017).

CFT proposes that three emotion regulation systems exist, these are the drive, soothing and threat systems (Gilbert, 2005). These three systems have different functions: the threat system works to detect and select responses to threat; the drive system works to motivate and excite; the soothing system is linked to managing distress and promote bonding. CFT proposes that when there is an imbalance amongst these systems, distress arises, e.g. people with heightened sensitivity and overactivity of the threat or drive system often experience high levels of shame and self-criticism. A key goal of CFT is to rebalance the three systems which often involves strengthening the soothing system by gaining skills of compassion.

Having a baby for the first time can bring about feelings of happiness, affection and protectiveness. But this is often accompanied by many threats related to hormonal changes, exhaustion, birth difficulties, lack of support, and fears of being inadequate. These feelings emerge from an overactivation of the threat system, which suppresses the soothing system. This imbalance in a caregiver's regulation systems may result in postnatal distress, and a threat orientation to the flow of compassion.

Self-Compassion

As discussed, developing a compassionate self is a key part of CFT that can improve psychological health (Pace et al., 2009). Gilbert understands self-compassion as being an important part of CFT, and states it involves developing a compassionate self-identity that possesses the following qualities: wisdom, strength and courage, caring-commitment (Irons & Beaumont, 2017). Key skills involved in developing a compassionate self-include having genuine concern for one's wellbeing, being sensitive to one's distress, becoming distress tolerant, and showing empathy and understanding to one's distress without judgement (Gilbert & Irons, 2004).

Kristin Neff's research into self-compassion conceptualises it as expressing non-judgemental understanding towards oneself and seeing one's actions within the context of shared human fallibility (Neff, 2003). Self-compassion may play an important part in becoming a mother, as it involves being understanding of the mistakes and struggles one may face when the inevitable challenges of motherhood arise.

Neff's research suggests that self-compassion comprises three components: self-kindness, common humanity and mindfulness. Self-kindness involves being understanding about one's own difficulties; common humanity is apparent when an individual perceives their experiences as part of being human rather than viewing them as discrete and isolated events; mindfulness is the ability to be aware of one's negative thoughts and feelings, not suppressing or exaggerating them (Neff, 2003). The effects of self-compassion on wellbeing is becoming increasingly understood, with evidence suggesting that it is as effective as cognitive reappraisal and acceptance strategies in regulating mood in depression (Diedrich et al., 2014).

Additionally, self-compassion is associated with well-being in adolescents and adults, with reports of less depression and anxiety and a greater sense of social connectedness in those rated more highly on measures of self-compassion(Neely et al., 2009; Neff & McGehee, 2010). Although these findings cannot prove direct cause, they suggest that being compassionate to the self is correlated with psychological well-being, and that it could enhance new mothers' sense of social connectedness during the postnatal period where finding the time to meet with friends can be difficult.

Receiving Compassion From Others

Receiving compassion from others requires individuals to allow others to notice their distress, and being open to the care and kindness of others. 'Social safeness' is associated

with receiving compassion from others as it refers to the calming and warm experience of feeling cared about, being connected, and reassured by others (Gilbert, 2009). Receiving compassion from others may involve social support, feelings of connectedness and belonging. Receiving acts of compassion such as social support has been shown to protect us from disease and improve longevity in individuals living with illnesses such as cancer (Broadhead et al., 1983; Cassileth et al., 1988).

Our early life experiences can shape how receptive of compassion we are, as individuals who can recall many experiences of parental warmth tend to have a greater capacity for receiving compassion than those who can recall fewer experiences of parental warmth (Kelly & Dupasquier, 2016).

Giving Compassion to Others

Compassion for others requires individuals to be aware of and sensitive to others' suffering, wanting to alleviate it, and taking steps to do so. Compassion for others is thought to have evolved as a caregiving response to vulnerable offspring, as well as promoting cooperation amongst individuals (Goetz et al., 2010). Becoming a mother demands this flow of compassion, frequently, between infant and parent, as mothers must notice and act to relieve their infants distress e.g. when they need comfort.

Research has highlighted the benefits of being compassionate towards others, as a sample of community adults had increased self-reported happiness after spending 1-week performing a daily compassionate action towards others, compared to a control group (Mongrain et al., 2011). Additionally, compassion for others is related to improved psychological wellbeing, positive connectedness and improved positive mood (Brown et al., 2003; Hutcherson et al., 2008; Sheldon & Cooper, 2008). At present, there is little research

exploring parenting and giving compassion to others, despite the evolutionary underpinnings of caregiving for this flow of compassion.

From the research discussed, it is clear that compassion can ameliorate poor psychological wellbeing, enhance our sensitivity to other's distress, and improve interpersonal relationships for adults. It is likely that these benefits extend to parents too, with much research highlighting the role of compassion in parenting. Although becoming a mother can bring joy and happiness for many, it can also be difficult, with approximately 10-20% of mothers experiencing mental health difficulties during the perinatal period (Bauer et al., 2014). Exhaustion, limited support and fears of inadequacy are just some of the threats a new mother may face, activating the threat system Gilbert proposed (Gilbert et al., 2014). For some new mothers, this threat system can become overactive and suppress the soothing system. It is proposed that these changes in the systems disrupts the feelings of bonding between mother and infant (Cree, 2010). This is key to understanding how compassion relates to parenthood, and how its absence may affect attachment, relationships and the wellbeing of families.

Compassion and Parental Wellbeing

The importance of the flow of compassion is further supported by research examining the effects of compassion on parenting and parental wellbeing. Research has shown that many pregnant and postpartum women with current, or a history of, anxiety or depression symptoms have low self-compassion, self-kindness, and common humanity, even when current symptoms were controlled for (Felder et al., 2016). This study had 189 pregnant or postpartum women (less than 1 year) complete self-report measures of depression and anxiety, as well as the Self-Compassion Scale. These findings highlight the relationship between perinatal depression, anxiety, and self-compassion, but fail to explore what is

contributing to their low self-compassion, self-kindness and common humanity. This warrants further research into the development and maintenance of poor self-compassion in perinatal women.

Additionally, it has been shown that self-compassion is important for parents of children living with Autistic Spectrum Disorder. Self-compassion was found to universally predict parental wellbeing, and was positively associated with life satisfaction, hope, and goal reengagement (Neff & Faso, 2015). Self-compassion in this sample was also negatively associated with depression and parental stress. This highlights the benefits of self-compassion for parents, and these results may also extend to parents with children who display challenging behaviour.

Compassion-based Interventions for Mothers

The literature presented thus far has established the importance of compassion for healthy psychological functioning in new parents. Consequently, several compassion-based interventions for parents have been developed. Many compassion-based interventions aimed at supporting the well-being of first-time mothers have considered the demands of becoming a parent and recognised that attending face-to-face interventions may be challenging. As a result, many online, compassion-based self-help interventions have been trialled with new mothers, as they offer the flexibility that many women require when caring for an infant.

Online Interventions

Kindness for Mums Online (KFMO), is an online, compassion-based intervention, aimed at improving maternal psychological well-being in the first year postpartum (Gammer et al., 2020). The program draws on aspects of mindfulness and self-compassion, with exercises designed to fit around parenting tasks. The KFMO intervention, showed that mothers who followed the program had significantly greater increases in well-being than

controls, post-intervention. However, the effect size was small, and changes in wellbeing were not observable at the 6-week follow-up. This study had high attrition with 48.6% of mothers in the intervention group failing to complete any post-intervention measures, and 46.7% failed to engage in the 6-week follow-up. Attrition was higher among women in the intervention group compared to the control group, which perhaps may be related to practical obstacles, such as lack of time to engage in the program, or psychological barriers, such as fears and resistances to compassion. This data would suggest that there are barriers to accessing compassion-based interventions for many mothers, but the nature of these barriers are unclear (Gammer et al., 2020).

A second online, compassion-based intervention for new mothers is *Mindful with your baby*, an 8-week mindful parenting group intervention designed for mothers and their babies. This intervention uses elements of face-to-face training, where mothers can practice new skills with their baby in the moment (Potharst et al., 2017). The foundations of the program are similar to those of Mindfulness-based cognitive therapy and uses similar meditation exercises, however, it is adapted to the presence of infants and the key themes that play a role for most new mothers. The *Mindful with your Baby* training led to a significant improvement in mindfulness, self-compassion, and mindful parenting at the end of the program, at eight-week's post intervention and at one year follow-up. Well-being, psychopathology, parental confidence, and responsivity also improved, with small to large effects. This demonstrates the effectiveness of mindfulness and compassion-based interventions on new mothers. However, for ethical reasons, a large proportion of participants (61%) received other forms of psychological support during the training and/or in the follow-up period. Therefore, it is unclear how much of these changes are a result of the mindfulness intervention itself. Furthermore, 7% of participants dropped out of the study, suggesting that this intervention was not appropriate or accessible for all mothers.

Two brief, internet-based versions of Compassionate Mind Training (CMT) and Cognitive Behavioural Therapy (CBT) have also been developed for women during the perinatal period. A sample of pregnant women, postpartum women and women who intend to become pregnant in the future, were recruited to engage in one of the training courses. Both interventions were found to have similar effects in improving mood, self-reassurance, self-criticism and self-compassion, however CMT was found to be superior to CBT in reducing depression and anxiety symptoms (Kelman et al., 2018). These findings indicate that CMT may be the most appropriate intervention for new mothers who experience negative affect. However, CMT also had issues with mothers fully engaging in the training, as 48 of the 137 mothers in the sample did not complete the follow up items (CBT exercises and CMT audio meditations). Across both interventions, 14 mothers completed the 45 minute didactic course in less than 10 minutes, suggesting that they did not meaningfully engage with the intervention (Kelman et al., 2018).

A brief CFT self-compassion intervention has also been created for mothers up to 24-months postpartum. This intervention involves having access to a set of online resources that outline simple techniques for increasing self-compassion.. This study found that the online compassion-focused resources were not being accessed by 50.2% of the postpartum women it was available to, with many reporting that they did not have the time to do so (Mitchell et al., 2018). Other barriers to accessing the resources included mothers thinking it would not be useful, discomfort with doing self-compassion exercises, forgetting, fatigue, or technical difficulties. This suggests that more flexible interventions are required to increase mothers' participation.

However, the findings did highlight that accessing and engaging in online compassion-focused resources were effective in increasing self-compassion and decreasing

post-traumatic stress symptoms following childbirth. Mothers also reported improved subjective breastfeeding experiences following this intervention, although there was no change in participant's psychological flexibility, shame, or satisfaction with infant feeding. This research has highlighted that many barriers to compassion exist for new mothers and suggests a need for research to explore these barriers further in order improve accessibility and uptake of similar interventions.

Various preventative interventions have also been developed for pregnant women, including a 6-week Internet-based Mindful Self-Compassion Program for women identified as at-risk of developing postnatal depression (Guo et al., 2020). Participants completed several measures at baseline, 3 months, and 1 year postpartum to assess their depressive and anxiety symptoms, mindfulness, self-compassion, and mother and infant wellbeing. The intervention group showed a significant improvement in their depressive and anxiety symptoms and demonstrated more mindful and self-compassionate behaviours in the postpartum period than the control group. This highlights the effectiveness of mindful self-compassion interventions for postpartum women with symptoms of anxiety and depression. However, this study had a dropout rate of 8.2%.

Further online research has shown that prompting parents to engage in self-compassion is effective in lowering their feelings of guilt or shame (Sirois et al., 2019). One hundred sixty-seven parents of children (<12 years old) were recruited and randomly assigned to recall a guilt versus shame provoking parenting event, and then randomly allocated to either a self-compassion prompt versus a control condition. Parents in the self-compassion condition were encouraged write about a difficult parenting event of theirs, to re-read what they had wrote, and then were prompted to respond in writing with self-kindness, common humanity, and mindfulness. When compared to control conditions (no prompts), parents greatly benefited from self-compassion, and reported reduced feelings of guilt and

shame. This further supports the notion that self-compassion is important for parents and can improve parental well-being when facing the challenges of parenting. Differences between the conditions were maintained even when controlling for dispositional self-compassion, and baseline guilt and shame. These findings, taken alongside those discussed previously, highlight how self-compassion can benefit parental wellbeing throughout the child-rearing years, from pregnancy to adolescence. These findings also suggest that supporting mothers to minimise barriers to compassion in the perinatal period may equip them with the skills needed to manage parental guilt and shame throughout their child's lifetime. However, it is important to note that this research recruited a convenience sample, therefore the findings may not be representative of parents more generally. Participants were predominantly female, therefore increasing the applicability of these findings to mothers.

Face-to-Face Intervention

The Australian 8-week parenting program 'Caring for Body and Mind in Pregnancy' (CBMP) has also been developed as a preventative measure for PND (Townshend et al., 2018). This intervention is based on Mindfulness-Based Cognitive Therapy and has been modified for pregnancy, with implicit teachings on attachment theory, reflective functioning and transition to motherhood through class discussions. One-hundred and nine pregnant women at-risk for perinatal depression and anxiety were recruited and completed pre and post intervention measures. Findings demonstrate that the CBMP program significantly reduced perinatal depression and anxiety and general stress scores, while significantly increasing self-compassion and mindfulness. Researchers also found that self-compassion had a stronger influence in reducing perinatal depression than mindfulness, thus supporting the need for interventions for this population to be more compassion-focused, with elements of mindfulness included. However, no control condition was used in this research, therefore it is unclear whether these findings are result of placebo as participants had invested time into the

intervention and therefore may be biased to report improvements in self-report measures post-intervention. This study reported 'high' attrition rates, and noted a significant increase in attrition after the mother's gave birth. This highlights how the demands of motherhood may act as a barrier to mothers engaging in compassion and mindfulness based interventions. This study required mothers to attend CMBP sessions in person on a weeknight for 8 weeks. As exact attrition rate were not reported it is difficult to understand what impact the modality (online vs. face-to-face) of the intervention had on completion of the program.

In summary, there have been several studies investigating the effectiveness of compassion-based interventions for mothers. Drop-out rates varied across the interventions, with one study reporting that 50% of participants did not access the intervention materials provided (Mitchell et al., 2018). Multiple barriers to accessing the compassion-based interventions exist, with lack of time being a common barrier. These studies highlight the potential benefits of compassion-based interventions for mothers, but also illustrate the need for such programs to consider the barriers to accessing and engaging with compassion-focused resources.

Compassion: Fears, Blocks and Resistances

It has been established that the flow of compassion is important in parenting and that interventions can be designed to improve this, however, the evidence also suggests that there may be significant obstacles to parents engaging in these interventions, with online programs experience attrition rates ranging from 7-50% (Mitchell et al., 2018; Potharst et al., 2017). It is therefore important to understand what prevents or stops women from engaging in compassion-based interventions, and indeed compassion more generally. Understanding these barriers may help to inform how these interventions are designed and delivered. Similarly, by

understanding these barriers it may aid the development of preventive interventions to address such barriers in parents-to-be.

Within CFT these barriers can be understood in three ways where individuals may fear some flows of compassion, they may block it out or resist it. This is indicative of a 'threat' orientation in their inner and outer world, and may contribute to poor emotional wellbeing (Gilbert, 2019).

Fears of Compassion

Fears of compassion can present as an avoidance or a fear response to experiencing compassion from all three directions (from the self, from others and to others). Some examples of fears of compassion include the belief that 'compassion is a weakness', or that it will be rejected by others.

For some people, receiving compassion and developing self-compassion can be difficult, with some perceiving it as a sign of weakness and opportunity to be taken advantage of (McLaughlin, 2003). The concept of compassion may also be frightening; a sample of chronic mental health patients resisted compassion as they felt that they were undeserving of it, or were unfamiliar with the concept (Gilbert & Procter, 2006). For some of these patients compassion revealed unresolved grief of wanting love and kindness but actually feeling rejected and alone.

Fears of compassion for the self appears to be linked to fearing compassion from others, which means that individuals who fear compassion from others may also fear it from themselves (Gilbert et al., 2011). This research suggests that multiple flows of compassion can be feared by an individual, and these fears were associated with insecure attachments, self-criticism, self-coldness, depression, anxiety and stress. Gilbert and colleagues also found self-criticism to be a strong predictor of depression in these participants. These findings

highlight the psychological consequences of fearing compassion and the factors that may contribute to these fears.

Blocks to Compassion

A second barrier to compassion are blocks, and this is typically when an individual is unable to be compassionate due to environmental constraints, such as time or lack of insight. Mitchell and colleagues highlighted how lack of time contributed to a significant proportion of mothers not engaging with a brief CFT intervention. Lack of time may be related to the number of demands that mothers face when caring for their infant, including caring for their other children, running a household, and returning to work. Other blocks to the flows of compassion may include environmental constraints such as a lack of social support, distance from family and friends, and difficulties accessing online compassion-based exercises (Lee et al., 2019; Mitchell et al., 2018). The impact of blocks, such as care demands, on the flows of compassion is highlighted in the increased attrition rates that Townshend and colleagues noted after mothers in their sample gave birth (Townshend et al., 2018).

Internal factors, such as mental health, can also act as a block to the flows of compassion. Self-compassion has been found to be a useful tool in times of distress, however, research with depressed individuals has revealed that many find self-compassion to be difficult to develop, despite recognising its value (Diedrich et al., 2014; Pauley & McPherson, 2010). Many of these participants reported that the impact of depression was one factor that made self-compassion challenging. This research suggests that blocks to compassion may be out of our conscious control.

Resistances to Compassion

Resistances to compassion are observed when a person could be compassionate but chooses not to be. This may be due to a belief that there is no point to compassion, or that

they are perhaps focused on competitive self-advantage and so decide not to share their resources (compassion) with to others. Resistances such as these are commonly associated with increased power or persons with narcissistic tendencies (Basran et al., 2019; Keltner, 2016). Resistances to compassion were reported by Mitchell and colleagues, with 5.9% of participants not engaging with the program as they thought it would not be useful, and 4.8% finding compassion exercises uncomfortable (Mitchell et al., 2018). Guilt and shame may also act as resistances to the flows of compassion, as mothers may feel guilty about being compassionate to themselves or others and may feel that they should instead attend to their infant's needs (Rotkirch & Janhunen, 2010).

The Impact of FBRs

Fears, blocks and resistances (FBRs) to compassion may result in a person's distress going unnoticed, and there may be no attempts by themselves or others to alleviate their distress. This can have a negative impact on a person's wellbeing, with fears of compassion being associated with self-criticism, stress, depression and anxiety (Gilbert & Choden, 2014; Gilbert et al., 2014). Meta-analyses have examined the relationship between fears of compassion and mental health and has found strong associations between fears of compassion and depression, shame, and self-criticism (Kirby et al., 2019). These associations were largest for clinical samples, and some of the strongest associations were found for fears of being compassionate to oneself and fears of receiving compassion from others, with the factors of shame, self-criticism, and depression. In relation to the 'flow' of compassion, these findings would suggest that fearing self-compassion and fears of receiving compassion have the greatest impact on mental health.

In addition to this, functional magnetic resonance imaging (fMRI) research has demonstrated that human fears, blocks and resistances to self-compassion have neurological

underpinnings. Individuals who score highly on measures of self-criticism show a threat response in the amygdala when attempting to be self-reassuring to set-back events and find it more difficult to self-reassure (Longe et al., 2010).

This research highlights the negative consequences of fearing and resisting compassion, whilst illustrating that accepting compassion from others and developing compassion for the self is challenging. However, evidence from compassionate mind training and compassion-based interventions has shown that improving self-compassion and the ability to accept compassion from others is achievable (Gilbert & Irons, 2004; Gilbert et al., 2014; Gilbert & Procter, 2006).

Measuring Fears, Blocks and Resistances

In response to clinical observations that some individuals may fear self-compassion and receiving compassion from others, Gilbert and colleagues developed the Fear of Compassion Scale (Gilbert et al., 2011)). This measure consists of subscales that assesses a person's fear of: compassion for others ('Being too compassionate makes people soft and easy to take advantage of')., compassion from others (e.g., 'I try to keep my distance from others even if I know they are kind'), and compassion for self (e.g., 'I worry that if I start to develop compassion for myself I will become dependent on it'). Items are rated on a five-point Likert scale (0 = Don't agree at all, 4 = Completely agree).

This scale is well established in measuring fears of compassion, however, it does not assess blocks or resistances to compassion, such as lack of insight (block) or the belief that being compassionate is pointless (resistance).

Rationale

This research aims to explore the fears, blocks and resistances to the flow of compassion in first-time mothers using semi-structured interviews. Mothers can adapt to the

challenges of parenthood over the first few years. As the balance of the emotion regulation system changes in response to these challenges, experienced mothers adjust to, or learn skills in re-balancing the three systems and overcoming barriers to compassion. To understand what FBRs to compassion exist for new mothers it was considered important to interview women who were new to motherhood – with little experience of overcoming these FBRs. First-time mothers in the first 12 months postpartum have a good understanding of the FBRs to compassion that they face.

Reflexive Thematic analysis will enable the researcher to identify, analyse, and report patterns in the FBRs that new mothers experience across the three flows of compassion. This approach will also allow the researcher to examine how mothers' ideas of compassion might reflect the 'reality' of participants' lived experiences, the contexts in which they live, and those that limit or enable compassionate experiences.

It is important to explore what FBRs to compassion exist for new mothers, as this will allow compassion-based interventions to be adapted in a way that will enhance the participation in and completion of these interventions, e.g. by challenging fears of compassion as being weak. Additionally, identifying the barriers (FBRs) to compassion in new mothers will allow for new interventions to be developed that will address these inhibitors, before a mother goes on to participate in further compassion-based therapies. Addressing these FBRs should result in enhanced therapeutic outcomes if the mother goes on to engage in with interventions, as well as improved mental health (Kirby et al., 2019). To explore these, the following research questions were developed:

Research Questions

- How might first-time mothers fear, block, or resist compassion from others?
- How might first-time mothers fear, block, or resist self-compassion?

- How might first-time mothers fear, block, or resist compassion for others?

Method

Design

This research explores the barriers to compassion in first time mothers using qualitative semi-structured interviews and reflexive Thematic Analysis to produce results. The current absence of measures to assess all three barriers (FBRs) necessitates the qualitative methods chosen. Additionally, a qualitative methodology allowed for the research to obtain an rich understanding of mothers' experiences with the flows of compassion.

Recruitment and Participants

Ethical approval was granted by the Faculty of Health Sciences Ethics Committee (University of Hull, see Appendix G). Recruitment took place via social media platforms such as Mumsnet, parenting Facebook groups and a worldwide Facebook advert. Recruitment took place from December 2021 to March 2022. Using the same social media platform, the researcher contacted individuals who responded to the social media posts and adverts to provide them with the information sheet, a copy of the consent form, and to confirm whether they meet the inclusion/exclusion criteria. Twelve individuals who reported to be eligible to participate signed the consent form and agreed to participate. The sample size was deemed sufficient and appropriate for reflexive Thematic Analysis for a professional doctorate (Braun & Clarke, 2013).

Inclusion Criteria:

- Identify as female
- Aged 18+ years
- Identifies as a first-time mother (biological, adoptive, or full-time foster carer) of a child aged < 12 months-old.

- Have been a mother for ≥ 1-month (to allow for the opportunity to have experienced the flow of compassion since becoming a mother)
- English-speaking

Exclusion Criteria:

- Lack of sufficient fluency in English
- Mothers who are not a primary caregiver of their infant
- Have been a mother for < 1-month
- Mothers who had children prior to their recent infant.
- To minimise risk, mothers who report thoughts about self-harm or suicide in the 1-month preceding enrolment.

Procedure

A pilot interview with a mother who met the inclusion criteria was conducted initially to check the suitability of the interview schedule, this data was not included in the results. Interviews were arranged directly with participants who met the inclusion criteria and gave informed consent; and took place via videocall. Interviews took place in a quiet and private area of the researcher's home where the content of the interview remained confidential. Participants were offered a further explanation of the research and an opportunity to ask questions. Participants were made aware of their right to withdraw up until the point of data analysis.

Following each interview participants were emailed a sources of support sheet should they require help with anything that was discussed during the interview. Interviews were transcribed, transcripts were anonymised and any given names were replaced with randomly generated pseudonyms.

Analysis

Fears, blocks and resistances to the flows of compassion in first-time mothers were identified using reflexive Thematic Analysis (TA). Reflexive Thematic analysis is a method used for identifying, analysing, and reporting patterns (themes) within the data (Braun & Clarke, 2006, 2019). Reflexive Thematic analysis was chosen for this study because it enabled the researcher to examine mothers' experiences of the barriers to compassion from a data-driven perspective and one that is based on coding in an inductive way. Additionally, the reflexive version of TA was chosen due the importance of the researcher using reflexivity to consider their role as a researcher and its impact on their research practice and process. Braun and Clarke's Reflexive Thematic Analysis can be conducted from different epistemological positions, and therefore was suited to the researcher's critical realist ontology and contextualist epistemology (Braun & Clarke, 2019). As there is a lack of research into first-time mother's experiences of the flows of compassion and FBRs, this research was exploratory. A deductive approach to TA was undertaken where analysis was shaped by the construct of FBRs, which provided the lens through which the researcher coded and developed themes. Interpretative Phenomenological Analysis was considered as a method of analysis, however, as this research was concerned with the identifying patterns of FBRs across the data set and was not concerned with the unique characteristics of each individual participant, reflexive TA was deemed the most appropriate method of analysis (Smith & Shinebourne, 2012). Thematic Analysis was completed using Braun and Clark's six phases approach (Braun & Clarke, 2006):

Familiarisation: the researcher established an in-depth knowledge of the data set by reading and re-reading transcripts, listening to audio-recordings, and making notes on any initial analytic observations.

Coding: this step involved grouping similar data segments and labelling relevant features of the data to begin identifying patterns.

'Searching' for themes: codes were clustered together to highlight key patterns (themes) in the data.

Reviewing themes: themes were reviewed to check whether they have a good 'fit' with the coded data and with the data set as a whole. Each theme has a distinct organising concept. This may lead to changes in the themes and revisiting the 'searching' phase.

Defining and naming themes: Themes were given clear definitions and a name to ensure conceptual clarity.

Write up: the themes provided a framework for the analysis and analytic conclusions are drawn across them.

Twelve signed consent forms were returned, however, three participants requested to withdraw from the research due to a change in personal circumstances and COVID-19, see Table 1.

Table 1

Participant information with pseudonym, country of residence, and interview length.

Pseudonym	**Country**	**Length of interview (minutes)**
Maxine	India	62
Helena	India	50
Lily	United Kingdom	41.5
Jodie	United Kingdom	55
Hannah	United Kingdom	71
Gemma	United Kingdom	47
Victoria	United Kingdom	54
Maria	United States of America	19
Louise	United States of America	51
10	United Kingdom	Withdrawn
11	New Zealand	Withdrawn
12	New Zealand	Withdrawn

Nine interviews were completed with participants from the United Kingdom, United States, and India. Interviews lasted between 19 – 71 minutes ($\bar{x}$ = 50). Only one interview took longer than expected due to internet connection difficulties.

Researcher Influence

The primary researcher (HC) was a 25-year-old, White-British, feminist, female trainee clinical psychologist. The researcher is not a mother but has close family members who became mothers for the first-time during the course of the research. The researcher has no clinical experience of working with new mothers but has a particular interest in perinatal mental health which could influence the analysis of interview data. Following each interview, the researcher recorded their thoughts, feelings and comments on the process and content of the interviews. Throughout the research process, the primary researcher had regular research supervision with a qualified and research-experienced clinical psychologist and participated in a qualitative research reflective practice group with fellow trainee psychologists. Appendix B contains a reflective statement with further reflections on the primary researcher's position and influence on the research.

Results

Three overarching themes with subthemes were identified and are presented in Table 2. A summary of the fears, blocks and resistances to the flows compassion within each theme are summarised in Table 3.

Table 2

Summary of themes and subthemes discovered.

Themes	***'Super Mum': the Unobtainable Ideal***	***The Exchange of Distress and Compassion***	***Going Through it Alone***
Subthemes	Competing Demands Limit Compassion	Contagion of Distress	
	Fear of Judgment, Judging the Self, and the Accompanying Guilt	Suspicion, Ammunition & Self-Defence	
		Consent to Compassion	
		Reciprocity	

Theme: 'Super Mum': the Unobtainable Ideal

The 'Super Mum' is a term commonly used within western societies to refer to an archetypal mother who successfully manages her career, care demands and household tasks (Ussher et al., 2000). The 'Super Mum' was an archetype that many of the mothers idealised and aspired to be, but acknowledged that this is somewhat unobtainable or too difficult to

maintain. Aspiring to be the 'Super Mum' contributed to many of the fears, blocks and resistances to the flows of compassion that first-time mothers experienced. 'Competing Demands Limit Compassion' explores how this archetype has impacted on mothers' day-to-day functioning and their ability to engage with the flows of compassion. 'Fear of Judgement, Judging the Self, and the Accompanying Guilt' explores how mothers compare themselves to this ideal and experience guilt for not living up to it, despite reporting that it is not realistic or helpful to do so. These two subthemes interact and ultimately stem from mothers striving to meet the 'Super Mum' ideal. Mothers fear being judged for not managing all of their demands (household chores, child care etc.), a skill associated with this unobtainable ideal. Additionally, mothers judge themselves and feel a great sense of guilt when they put their need for compassion above their competing demands. Mothers prioritise their competing demands over their own wellbeing and needs for compassion, due to fears that they would be judged if they put their needs first, or would judge themselves and feel guilty for doing so.

Subtheme: Competing Demands Limit Compassion

The notion of a mother who can successfully spin the many plates of her family, career and home is not too far from the reality that many mothers described, albeit, at the cost of being able to engage with the flows of compassion. Mother described being the primary caregiver of their infants, whilst attempting to manage household and work demands alongside this. Mothers admitted that it is not always possible to keep on top of it all, thus keeping the 'Super Mum' ideal out of reach.

<u>FBRs to self-compassion</u>

Many first-time mothers reported being unable to engage with self-compassion due to blocks including care demands, fatigue and lack of time. Mothers juggled the responsibility

of work and household tasks, which resulted in first-time mothers having little time, energy, and patience to notice their distress and to respond compassionately to themselves.

"I just didn't have time like I have no time. I would wake up at you know 5-6 in the morning with my daughter get her up get her washed get her changed rush to lab finish up my work come home sit with my baby for her meals play with her give her a bath put her to bed and stay up late with my work on the computer I would fall asleep at 1:00 o'clock or two o'clock again to wake up at 5:00 or 6 and the same charade begins all over again. so it was a lack of time I just couldn't get my thoughts in order."

Helena

Lily described how managing competing demands resulted in fatigue, which limited her ability to engage in self-compassion.

"when you're tired everything seems so much worse, and you almost lose the ability to be able to self-talk and almost self soothe, like compared to when you're not tired it's so much easier to be able to bring yourself back down to reality and kind of look after yourself"

Lily

Mothers described being overwhelmed with the responsibilities they have as primary caregivers and often prioritized their infants' needs over their own needs. Additionally, mothers gave precedence to their competing demands (e.g., household tasks) over their own wellbeing. Mothers managing these demands single-handedly had little opportunity for self-care. There was a sense that mothers feared acts of self-compassion as they were concerned that putting oneself first would mean that one is not a perfect mother.

"As a mother you are… you are very much right down the bottom of your pecking order. If you know what I mean. In your mind, you're right down there and everything else comes first. And I think every single thing that you do on a daily basis probably does come before your self-care."

Hannah

Furthermore, due to their many competing demands, mothers felt that taking time to engage in self-care and self-compassion was unrealistic. Care demands were also a block to mothers noticing their distress and acting with self-compassion because their attention was often focused on others and their infants' wellbeing. Jodie described feeling stuck between the want to be compassionate to herself, but feeling like it was not possible to do alongside her care demands.

"like do you not understand how unrealistic that is right now you've kind of got this thing which is like I'm looking after an infant who literally cannot look after himself like I feel like I have to put him first in every situation and so to some extent when people say if people say put yourself first well that's a lovely sentiment but it's not realistic you know?"

Jodie

<u>FBRs to receiving compassion</u>

Mothers also reporting being unfamiliar and uncomfortable with receiving some acts of compassion from others, particularly, acts such as supporting with household tasks. This was linked to the fear of others thinking they were unable to manage the demands of motherhood. Additionally, there was a sense that mothers resisted compassionate acts from others as they felt that others would not do things 'properly' and then they would have to

correct their mistakes, thus increasing their number of tasks to do. Gemma explained how her friends acted compassionately by supporting her with tidying when she told them she was distressed, and said:

"Part of us was relieved but I just realised it was an uncomfortable situation because I'm not used to people doing that for me because I just do it myself."

Gemma

Furthermore, compassion from others was met with resistance due the fear that doing so many lead to a loss of control over the many demands mothers attempt to juggle. Mothers fear losing control will lead them to make mistakes and fail as mother. Mothers felt that receiving compassion from others would involve letting go of some of their demands or allowing others to take on some of the responsibilities. Many mothers feared that allowing others support and acts of compassion (e.g. caring for infant for a night) would take control away from them which was experienced as uncomfortable, frustrating and could potentially result in mothers having to 'pick up the pieces' if other's actions disrupted the infants routines.

"it was difficult on me to accept that I can't have everything under my control and to let go sometimes… I have always functioned in a certain order and I make sure I've got things done, Obviously having the baby was going to disrupt this in some ways, right? I think I wasn't letting myself accept that a lot so having the conversation with my husband actually helped me realise that yeah that it's OK to let go"

Maxine

Mothers also resisted compassionate acts like these as it contributed to them feeling frustrated with themselves for requiring support and not living up to their 'Super Mum'

aspirations. Jodie described how accepting acts of compassion was somewhat 'out of character' for her, as she was often the carer busy managing her many demands.

"When I was in pain I would feel guilty about the fact that I wasn't resting when really I should, but also very frustrated. More frustrated than anything else because for me it's just so out of character to just sit down and rest, so I just don't do that."

Jodie

FBRs to giving compassion

Care demands were also a block to first-time mothers giving compassion to others, as they were fatigued, exhausted, and short of time and patience. Mothers described these blocks as limiting their ability to notice others' distress and to respond compassionately.

"I think tiredness can make anyone be uncompassionate and the problem is tiredness goes hand in hand with having a baby… you are physically tired, it is physically tiring breastfeeding, it is physically tiring standing at the nappy changing table changing constantly, it's emotionally tiring constantly thinking about another human"

Jodie

Managing numerous demands contributed to mothers feeling stressed, which acted as a block for mothers noticing others' distress and responding compassionately.

"being stressed and tired and things can make you really short with people and not necessarily think about their feelings… it makes you just think about your own feelings"

Victoria

Similarly, many mothers tend to resist giving compassion to others as they felt that at times they have more important things to attend to, and that one's own struggles were greater.

There was a sense that compassion was a limited resource that should be given out thoughtfully.

"you can't really understand that they're going through a hard time when you're going through a hard time. When you're already going through the same thing it's hard to put yourself in their shoes when you're already feeling it yourself"

Lily

Compassion was something that mothers could only in engage in on rare occasions as a result of their many competing demands. Mothers tended to resist giving compassion to others if they felt that it was likely to be rejected. Mothers did not want to spend their time and energy on being compassionate towards someone who will likely reject it. Victoria explained why she resisted giving compassion to a relative who was struggling, after her previous offers of compassion had been rejected.

"there's only so many times you can ask someone, do you what know I mean? like ask if they need any help or anything"

Victoria

Subtheme: Fear of Judgement, Judging the Self, and the Accompanying Guilt

The desire to be, and appear as, a 'Super Mum' contributed to many mothers experiencing guilt and fears of judgement that stopped them from engaging with the flows of compassion. Fear of judgement was a strong concern of first-time mothers across the three flows of compassion – to the self, from others and to others. This fear of judgement was at times related to a fear of not being able to meet others expectations with regards to breastfeeding and parenting styles. Mothers reported experiencing guilt if they engaged with

self-compassion and compassion from others. There was a sense that mothers judged themselves and this contributed to feelings of guilt about not being the perfect mother.

FBRs to self-compassion

Self-judgement was an apparent resistance to compassion for first-time mothers. Mothers reported having high expectations and hopes for themselves, and a desire to be able to 'do it all' as per the 'Super Mum' ideal. These expectations and pressures placed on oneself often led mothers to ignore their distress and not engage with self-compassion. Mothers did not want to attend to their distress and be compassionate to themselves because they feared that this would mean that are failing to be the 'Super Mum' they had aspired to be.

"maybe I do actually need some help and I don't like to admit that to myself so. I find it much easier to exist in a world where I can do everything and I don't need to worry about that stuff because I am all capable and all doing so that's why I find it difficult."

Jodie

Furthermore, mothers fear that being compassionate to the self will prevent them from becoming the best mother possible and learning from their mistakes. Similarly, mothers seemed to fear that self-compassion would lower one's standards of mothering. This fear of self-compassion was strongly related to perfectionism in mothers and fearing the consequences to their infant's development if one is not a 'perfect' mother. Helena explained why she sometimes choses to not be compassionate and empathetic towards herself:

"[if you are empathetic to yourself] you will always have to push yourself to be the best, so it doesn't matter whatever you are doing, I think eventually it just becomes that you can be better, and you have to push yourself... so maybe that's me being a harsh on myself that I can be better…and I'm still at this stage and I'm not moving forward. I could have done better."

Helena

Furthermore, mothers feared self-compassion and attending to their own needs as it was accompanied by feelings of guilt and they often judged themselves to be selfish for doing so. Self-judgment is a block to the flow of self-compassion for first-time mums, and was strongly linked to the fear of feeling guilty when self-compassionate. Mothers judged themselves as selfish and undeserving of self-compassion due to their perceived failures, which led to mothers to feel guilty when they engaged in self-compassion or attempted to. Jodie described how judging herself as selfish is a significant barrier to her being compassionate towards herself, which is not something she encounters when being compassionate to others:

"I would not accept that kind of talk from a friend I'd be like 'no you need to take time for yourself you need to look after yourself' all of this stuff, but when it comes to you and yourself and it's your baby that's crying downstairs, it is like you can't stop feeling like I feel selfish"

Jodie

Helena referenced how cultural and societal expectations of mothers contributed to her feeling selfish and choosing to prioritise her infant's needs above her own:

"It's also like drilled into our heads that as a mother, your baby always comes first. It feels sort of selfish like how can I take care of myself first and then baby?"

Helena

Similarly, fearing judgement from others also acted as a barrier to self-compassion for mothers. Firstly, mothers feared that showing compassion to themselves would lead to others perceiving them as struggling, weak and incapable. Distress was also concealed by mothers

due to the fear of that others would think they were ‘not coping’. Mothers wanted to appear all-capable to family and friends, and keeping the ‘Super Mum’ image intact acted as a resistance to compassion from others.

“I did feel that people would think that I’m inefficient, I was afraid that my boss would think I was incapable of working the way I used to before, I was scared that my husband would think that I am not doing my job as a mother very effectively or very efficiently, those were my two biggest fears.”

Maxine

Louise explained that her fear of being perceived as a failure and others noticing her perceived inadequacies can contribute to her not acting compassionately towards herself.

“I guess that they might think I'm not good at it. That there's like some element of being seen as like a failure. 'cause people don't really talk about the hard parts”

Louise

Furthermore, some mothers did experience judgement from others, which they felt contributed to greater self-criticism and doubt of their abilities, thus making it harder for them to engage in self-compassion, as illustrated by the following quote from Victoria:

“People interfering or judging you or making comments, puts doubt in yourself sometimes and that makes you struggle to think ‘I'm doing a really good job’ or makes you...feel really rubbish about yourself, and you're not going to really look after yourself”

Victoria

Mothers associated self-compassion with self-appraisal which was an uncomfortable or alien experience for many and was accompanied by judgement. Mothers felt that being kinder to oneself and praising one's efforts was discouraged in society, and therefore judged themselves or feared judgement from others for engaging in self-compassion:

"I've never told that to myself that I'm doing a good job ever... about anything like that, so just.... it's not something that I would say to myself, but I would definitely tell it to other people, you know"

Helena

FBRs to receiving compassion

Judgements from the self and others also contributed to mothers not engaging with compassion from others. Mothers reported finding it difficult to engage with compassion from others due to high levels of self-judgment, criticism and doubt. Helena described how her self-criticism led her to resist compassion from her partner at first, however, when her self-criticism escalated into unbearable levels of distress she allowed herself to receive his compassion.

"*I think I should be doing this...Like whatever it is, I should be doing it better and I'm not giving my 100% or you know, somehow I'm not being as good as I should be. You know I feel that it's my fault that whatever is not happening, and eventually I end up bursting on him, as well like 'you don't know anything better about this or anything else', and then I think eventually I have to … I end up letting him in, which helps"*

Helena

Similarly, mothers feared that accepting compassion would mean that they were failing. Gemma explained that she feared receiving compassion from others because she would judge her abilities as a mother and feel like she was doing it wrong.

"you feel like you're not doing it right or that you shouldn't have to ask for help."

Gemma

Fearing that receiving compassion means that one is failing as a mother, led some mothers to conceal their distress from others. When distress is concealed the flow of compassion is blocked as others are less able to notice and respond compassionately. There was a sense that mothers judged themselves as failures if they accepted compassion, but also feared that others would judge them similarly. Victoria explained how she concealed her distress from family in order to prevent others, and herself, from judging her as struggling.

"I just wanted to feel like Superwoman or super-mum, so like be bossing it and like especially in front of my in-laws it wanted it to be like look I can cook for your son and I can look after the baby and cook for you all and blah blah blah and, when actually I was like I'm really tired. I'm emotional. I don't want to be cooking for you"

Victoria

Mothers feared being judged as 'failure' for accepting compassion, and many feared appearing weak and vulnerable to others. Other reasons for fearing compassion from others included pride and the belief that it is embarrassing to need kindness and compassion from others.

"you don't want to look weak, you know it can be a bit embarrassing, you want people to think that you're strong and then when you say 'look I'm struggling' it looks like a weakness and I think you're worried that people are going to judge you"

Lily

Guilt also acted a barrier to receiving compassion, as mothers feared feeling guilty after engaging with compassion from others. Mothers described wanting support and compassion from others, but feeling guilty about receiving it and taking up others time.

"All you want is somebody to say 'do you know what I'll take him from here, I'll go out, go and do something, go do whatever, go and do this, go and do that, and you're hoping that somebody does that. And when they do there's a lot of guilt there"

Hannah

Being independent is a characteristic associated with the 'Super Mum', and many mothers felt that accepting acts of compassion (e.g. babysitting whilst Mum showers) would involve being dependent on others. Mothers feared accepting compassion from others for fear of not being the independent mum they had aspired to be. Mothers also noted that being independent was an important part of their sense of self, therefore, accepting compassion from others posed as a threat to mothers' identity and how others may perceive them.

" I like doing things on my own. I like doing things for myself… to show people that I'm able to do it without having to depend on others."

Maria

"On one hand, it's that I've identified that like I don't need you, like I got this, I can do it, I'm strong, I'm independent. But there's a difference between being independent in a positive light and also recognising that no man is an island and it takes a village when you have kids. But it's hard to kind of like let go of that part if you've made it a little bit of your identity."

Louise

Mothers also resisted compassion because they felt it was unnecessary or that there are others with more challenging situations who would benefit from compassion more. Compassion was also resisted due to the belief that it will not change one's perceived failings and therefore was not considered helpful. Jodie described how she often resists other's compassion as she feels it is unnecessary:

"I mean it's certainly nice like sometimes it makes me feel emotional because I think I try not to let myself think that I need that, you know? So, like it's almost like sometimes if somebody is acting like that I think it's really lovely, and I'm really grateful for it and it almost feels unjustified…like I feel like it's unnecessary kind of thing"

Jodie

Mothers also feared compassion from others due to concerns that one is an annoying burden to others, which was accompanied by feelings of guilt.

"I also didn't want him to be like annoyed at me for being upset, even though he wouldn't be, but I think it's… yeah probably just me, I'd probably be like Oh no, I don't want to add more stress to his life or make him feel bad"

Victoria

<u>FBRs to giving compassion</u>

Fear of judgement also acted a barrier to mothers giving compassion to others. Mothers were fearful of saying the 'wrong thing' when giving others compassion or being perceived as patronizing, interfering or ingenuine to the distressed individual. Lily explained why she might not always offer compassion to others:

"not everybody takes compassion well, people who bottle things up and don't like opening out or don't like asking for help can sometimes see it as a little bit patronising and interfering"

Lily

Theme: The Exchange of Distress and Compassion

The exchange of Distress and Compassion refers to how compassion and distress are transferred between individuals and others. This theme explores the negative outcomes associated with the direction of the flows of compassion. 'Contagion of Distress' explores the transfer of distress between individuals, whilst 'Suspicion, Ammunition and Self-Defence' explores concerns about trust and others' intentions. 'Consent to Compassion' explores how mothers want choice when it comes to engaging with compassion. 'Reciprocity' explores how mothers value fairness in the giving and receiving of compassion with others.

Subtheme: Contagion of Distress

The exchange of distress in a contagious-like manner was a fear of first-time mothers that made it difficult for them to engage with the three flows of compassion.

<u>FBRs to self-compassion</u>

There was a sense that one's distress could be passed on to others and vice versa, which was a fear of mothers which prevented them from engaging with self-compassion. Mothers feared that attending to one's own distress may have an impact on their infants and other loved one's wellbeing, and lead them to experience similar distress and worry. As a result, mothers would attempt to ignore their distress and not engage in self-compassion.

Hannah described not prioritizing her physical health due to fears of her infant experiencing her distress.

"you don't want him to know that you're hurting either.. can he pick up on the fact that I've got a bad back? I don't know!... if he saw me upset that would upset him I think"

Hannah

FBRs to compassion from others

The view that distress was to some extent contagious, also prevented mothers from engaging with compassion from others. Mothers often concealed their feelings from others, as they feared that their loved ones may worry about them. As a result mothers' distress was not often noticed by others and this fear prevented the flow of compassion from others.

"not completely telling them what was wrong with me and keeping everything in [got in the way of others comforting me]…because I didn't want them to worry about me."

Maria

FBRs to giving compassion

Mothers also feared giving compassion to others as they were concerned about the impact it may have on their own wellbeing. Mothers feared that attending to others distress may result in them experiencing distress themselves, and therefore may choose not to give compassion to others.

"I tend to pick up on other peoples like moods and sometimes if someone's in a bad mood. around us, I kind of like soak that in. And I'm trying not to do that…Sometimes I just end up in a bad mood myself sometimes, so I end up just taking myself away."

Gemma

Subtheme: Suspicion, Ammunition and Self-Defence

Suspicion refers to mothers' reservations about engaging with the flow of compassion from others, whilst ammunition explores mothers fears of how engaging with others compassion may be used against them. This subtheme explores how mothers' fears and resistances to compassion are methods of self-defence.

<u>FBRs to receiving compassion</u>

Mothers reported to often resist compassion from others in order to protect themselves. Mothers reported to resist compassion from others if their felt unable to trust that individual or did not have a close relationship with them. Mothers felt more comfortable opening up about their distress and receiving compassion from others who they felt would be understanding and non-judgmental. There was a sense that mothers did not want to accept compassion and open up to others they did not trust for fear of judgement and others using their vulnerabilities against them.

"I am more open to receiving it from like through that small circle or people that I trust. Uh, as opposed to if it were somebody who was not that close."

Louise

This resistance was linked to the fear of the other person's intentions and being unsure of how genuine their compassion is. Mothers also feared that other's compassion was coming from a place of sympathy and pity, which was considered to be embarrassing. Fearing that the exchange of compassion is motivated by pity links to the mothers' fears of judgement from others and the self when receiving compassion.

"you don't know what their true feelings are, like do they genuinely want to help? Or do they just feel sorry for you and feel like they have to do it?"

Gemma

Receiving compassion was also difficult for mothers due to the fear that others may use it against them in the future, or let them down. Mothers feared allowing others to notice their distress and receiving compassion in exchange, as they worried that others may use it as 'ammunition' later on. Similarly, mothers resisted and rejected acts of compassion as they considered it easier to do things for themselves than to be let down by others.

"I don't like relying on others because I've just been let down a lot in life"

Gemma

Subtheme: Consent to Compassion

<u>FBR to receiving compassion</u>

Consent to receiving compassion was seen as important. If others' compassion was forced onto mothers and not offered, then they were more likely to resist it. Having the choice to accept or reject others compassion was important for mothers, and they were more likely to reject it if others did not acknowledge that they may be uncomfortable with accepting their compassion.

"I have noticed that I am much more receptive when somebody starts out like their offer with 'would it help if...?' Or 'What can I do to alleviate this' as opposed to saying 'let me come over and do this for you' or whatever like…giving the choice too of what it is and the choice of saying yes or no."

Louise

Subtheme: Reciprocity

<u>FBRs to giving compassion</u>

As noted in the 'Competing Demands Limit Compassion' subtheme, compassion was talked about as a seemingly limited resource. The many demands of mothers means that they often have little time to give compassion to others. Due to the rare and time-limited nature of mothers giving compassion, they feared that it may not be reciprocated which acted as a barrier to them giving compassion to others. Fairness was considered important in the exchange of compassion, particularly as mothers often felted exhausted and had little time for anything outside of their care, work and household demands.

"I think that if the other person isn't empathetic towards you it can be quite hard to then be empathetic towards them… because if it was the other way around you know you might not do that for me, and you might feel it is a bit unfair"

Lily

Theme: Going Through it Alone

Barriers to the flows of compassion for first-time mothers included being and feeling alone in their experiences of motherhood.

<u>FBRs to self-compassion</u>

Mothers referenced how geographical distance from friends and loved ones, as well as the COVID-19 pandemic, contributed to them feeling isolated and alone in their experiences of motherhood. Many mothers felt that loneliness and lack of contact with others made it difficult for them to be compassionate to themselves when there was no-one else around to support them in difficult moments. Helena describes how she finds it easier to be compassionate towards herself when she receives compassion from others, therefore, the lack of significant others close by to offer support can act as a block to self-compassion.

"if you have your partners support and your family support I think you can be kinder to yourself. Because the moment they start being kind to you, you think that 'OK this is possible' like 'you don't have to be so harsh to yourself."

Helena

Similarly, being unable to see loved ones in-person contributed to some mothers losing their drive to care for themselves.

"If it wasn't for the pandemic I'm sure we would be meeting lots of people and our friends babies and that would obviously I would take care of myself and I would make myself feel better and look better."

Maxine

FBRs to receiving compassion

Additionally, the lack of contact with others that mothers experienced whilst caring for their infant also acted as a barrier to mothers receiving compassion. Mothers had little opportunity to receive compassion from others due to being at home caring for their infant whilst many of their loved ones were at work or lived far away.

Geographical distance and COVID-19 social distancing rules left mothers unable to access support and compassion from others, and the use of video-call and phone calls made it easier for mothers to conceal their distress from others and block this flow of compassion. A lack of in-person contact with relatives and friends was a block for many mothers to receiving compassion.

"although we would text and facetime, it's easier to hide than when someone comes to see you. So people are like 'how are you?' and I just say I'm fine and then it just got left as that. Rather than questioning it and being like 'are you really alright?' and things like

that. And so, yeah, I think because I'm not close I don't live closer and that's why I'm didn't have more support."

Gemma

Mothers also felt alone in their experience of motherhood, and compassion was often rejected by mothers if they felt that the giver did not understand or relate to their distress. Mothers also tended to fear expressing their distress in front of those who they felt could not understand e.g. friends or family without children, therefore limiting others abilities to noticing and attend to their distress.

"I have reached out to family to kind of help me through areas I was struggling with as a new parent, did I necessarily receive help from them? No. Were their intentions in the right place? Yes. But they're just not experienced enough, right? For my parents they don't know what it's like to have a baby in the pandemic"

Maxine

Mothers were also fearful of others invalidating and dismissing their distress, and so attempted to conceal their distress from others to prevent the flow of compassion. Victoria described hiding in another room from her family in order to conceal her distress from them because she feared that others' compassion would invalidate how she felt:

"It really upset me, and I didn't want them to tell me that it was I was being silly. That probably sounds silly, doesn't it but... I didn't want them to say 'oh. Don't worry that's fine'. But actually, I was like it just… it bothered me."

Victoria

Compassion in itself could be perceived as invalidating of one's distress, and at times mothers resisted compassion as they felt that they had the right to be upset.

"[when others comfort me] I do get annoyed initially because it's like I have the right to be upset. I should be upset like… because I feel that that is how I should feel…because I'm not putting up 100%"

Helena

Due to a lack of understanding in others, not all acts of compassion from others were considered helpful by mums. Mothers resisted compassion from others as they feared appearing ungrateful when the acts of compassion did not help their situation.

"If people think you're struggling I think they don't tend to ask how they can help you. They just tell you how they think it's going to help… And like I think sometimes I do come across as ungrateful and I don't mean to but they don't see it through your eyes and how you see it. And I struggle to get that across"

Gemma

FBRs to giving compassion

Being unable to see loved ones in-person acted as block for mothers to give compassion to family and friends as they felt that it was more difficult to be compassionate over the phone or videocall, and did not always notice others distress through these mediums.

Lack of understanding was also a block for mothers giving compassion, as many felt if they were unable to relate to another person's distress they would struggle to know how to offer them compassion. Similarly, with the lack of understanding came the fear of not knowing what to say to those in distress. Victoria explained how the fear of saying the wrong thing may have acted as a barrier to her responding compassionately to a friend's distress:

"not knowing what to say…or like I guess saying the wrong thing [might have got in the way of me helping her in that situation"

Victoria

Table 3

A summary of the fears, blocks and resistances within each theme.

	Theme	***'Super Mum': an Unobtainable Ideal***			***The Exchange of Distress***		***Going Through it Alone***
	Subtheme	*Competing Demands Limit Compassion*	*Fear of Judgement, Judging the Self, and the Accompanying Guilt*	*Contagion of Distress*	*Suspicion, Ammunition and Self-Defence*	*Consent to Compassion*	*Reciprocity*
Flow of compassion							

Self-compassion	Block: care/competing demands contributing to lack of time, fatigue Block: overwhelm Resistance: prioritising others needs	Fear: failing to be the 'Super Mum' and not meeting their expectations Fear: one's standards will lower Fear: feeling guilty	Fear: attending to my distress will impact others	Block: loneliness Block: lack of in-person contact with family and friends

	Fear: attending to ones needs first would mean one is not the perfect mother	Fear: one is selfish and undeserving
		Block: societal pressures to put infants needs first
	Block: lack of time makes self-compassion unrealistic	Fear: others judging one as struggling and weak

	Fear: being perceived as a failure
	Block: self-criticism and self-doubt
	Resistance: it is uncomfortable
	Fear: others will judge me

Receiving compassion from others	Fear: compassion is unfamiliar and uncomfortable Fear: others will think I am not coping fear: losing control of the	Block: self-criticism and doubt Fear: I am a failure if need compassion Fear: others will see me as failure	Fear: others taking on one's distress	Fear: others are untrustworthy Fear: others will judge me Fear: others may have bad intentions	Resistance: compassion being forced	Block: lack of in-person contact with family and friends Block: feeling alone in their experience Fear: others will not

	demands will lead to mistakes fear: giving control to others is uncomfortable resistance: needing support is frustrating	Fear: accepting compassion is embarrassing. Resistance: feeling guilty about taking up others time Fear: accepting compassion will mean I am	Fear: others will let me down	understand my distress Fear: others will dismiss my distress Resistance: I have the right to be distressed Fear: others may perceive

	not	me as
	independent	ungrateful
	Resistance:	
	others need	
	compassion	
	more	
	Block:	
	compassion	
	wont change	
	ones perceived	
	failings	

		Fear: being a burden to others			
Giving compassion to others	Block: care demands – fatigue, lack of time, low patience, stress Resistance: there are more important things one must attend to	Fear: others perceiving one's compassion negatively e.g. ingenuine.	Fear: being compassionate may cause one to take on others' distress	Fear: compassion will not be reciprocated	Block: lack of in-person contact with family and friends Block: not understanding others distress

		Fear: saying the wrong thing
Resistance: one's own struggles are greater		
Fear: compassion being rejected and time and energy being wasted		

Discussion

The identified themes and subthemes illustrate how societal narratives (e.g., the 'Super Mum') about what it is to be an exemplary mother have placed increasing physical and emotional demands on women that are limiting their ability to engage with the three flows of compassion. The idea that mothers should be the primary caregivers, successfully run a household and maintain a career has contributed to many mothers have little time or energy to engage with the flows of compassion. Additionally, such societal expectations and pressures placed on women, by others and themselves, has contributed to mothers resisting engaging with self-compassion and compassion from others due to the fear that they may appear to be a 'struggling' mother, inadequate and weak.

Additionally, women's ability to engage with the flows of compassion was affected by feelings of being alone in their experiences and concerns about the cost of their interactions. The majority of mothers recognised the importance of compassion and reported to be working towards becoming more compassionate and kinder to themselves.

Mothers' experiences of being unable to engage with compassion due to the many demands, responsibilities and pressures that they face is supported within the literature as many mothers report feeling overwhelmed by their responsibility which has been intensified by the COVID-19 pandemic (Gray and Barnett, 2021). These findings also illustrate the impact of societal assumptions, that a mother hold primary responsibility for their children, have on mothers' relationships with compassion. The 'Super Mum' theme is illustrative of how mother-blaming and 'good mother' discourses contribute to building barriers to compassion for new mums. Previous research has highlighted how lonely new motherhood can feel, which is supported by the theme 'Going Through it Alone' (Lee et al., 2019).

Blocks to first-time mothers offering compassion to others included being too busy with their competing demands to notice others distress or having their own difficulties to manage, which links to CFT's three emotional regulation systems (Gilbert, 2005). Mothers' inability to notice and tend to others needs can be explained through an overactivation and heightened sensitivity of the threat system, which can impair our ability to notice others distress, and limit our drive system which would typically motivate us to relieve others distress.

Theme Map

A theme map was created to illustrate the themes discovered and how they interact with one another, see Figure 1.

At the centre of the map lies the 'Super Mum: the unobtainable ideal' theme, which has strong links to many of the other themes and subthemes. Mothers' drive to meet the 'Super Mum' ideal contributed to many of the FBRs that were discovered in the analysis. Mothers' desire to appear all-doing and all-capable, (how a 'Super Mum' should be) contributed to many of the FBRs that were discovered in the themes 'Fear of judgement, Judging the Self, & Accompanying Guilt', 'Competing Demands Limit Compassion', 'Going Through it Alone'. Mothers feared other's judging them as incompetent and weak, but also judged themselves if they required support and compassion. Mothers' many competing demands placed on them by societal expectations and socio-economic factors contributed to them being unable to engage with the three flows of compassion, which was exacerbated by being unsupported and alone in their experiences of motherhood. Additionally, a relationship was apparent between 'Going Through it Alone' and 'Fear of Judgement…', as mothers feared that others would not understand and invalidate their distress, and therefore were more likely to conceal their distress and isolate themselves.

‘Suspicion, Ammunition and Self-Defence’ was also closely related to ‘Fear of judgement, Judging the Self, & Accompanying Guilt’, as mothers feared how others may use their distress and vulnerability during acts of compassion against them or judge them as ‘weak’. The ‘Super Mum’ ideal fed into mothers’ drive to protect themselves and their appearance, and therefore resisting and fearing compassion from others.

‘Contagion of Distress’ and ‘Consent to Compassion’ were subthemes of ‘The Exchange of Distress’ and were also impacted by the ‘Super Mum’ ideal. This archetypal mother protects her infant from all harm and distress, displaying emotional strength at all times. Analysis shows that mothers feared displaying distress and attending to others’ compassion because of concerns about the impact this may have on their infant and others. Mothers’ drive to conceal their distress and protect their others is perhaps a result of them striving to meet this unobtainable ideal. Many of these themes contributed to mothers concealing their distress from others, and at times from themselves. In doing so, mothers experienced the short-term benefits of concealing distress – others do not judge me, I don’t pass on my distress to others, others cannot use it against me. These short-term effects reinforce and promote resistance to compassion in mothers, which overall reduces the number of compassionate experiences they engage in. With little compassion coming in from the self and others, mums remain in a cycle of self-criticism in which they continue to struggle towards achieving the ‘Super Mum’ ideal, as they view their efforts as failures that are not good enough.

There was a strong sense from themes ‘Reciprocity’, ‘Competing Demands Limit Compassion’, and ‘Going Through it Alone’ that mothers had little opportunity to engage in compassion and that it was a limited resource. The number of demands placed on mothers and the isolation that mothers reported contributed to mothers having little time to engage in self-compassion and little contact with others to give or receive compassion. As opportunities

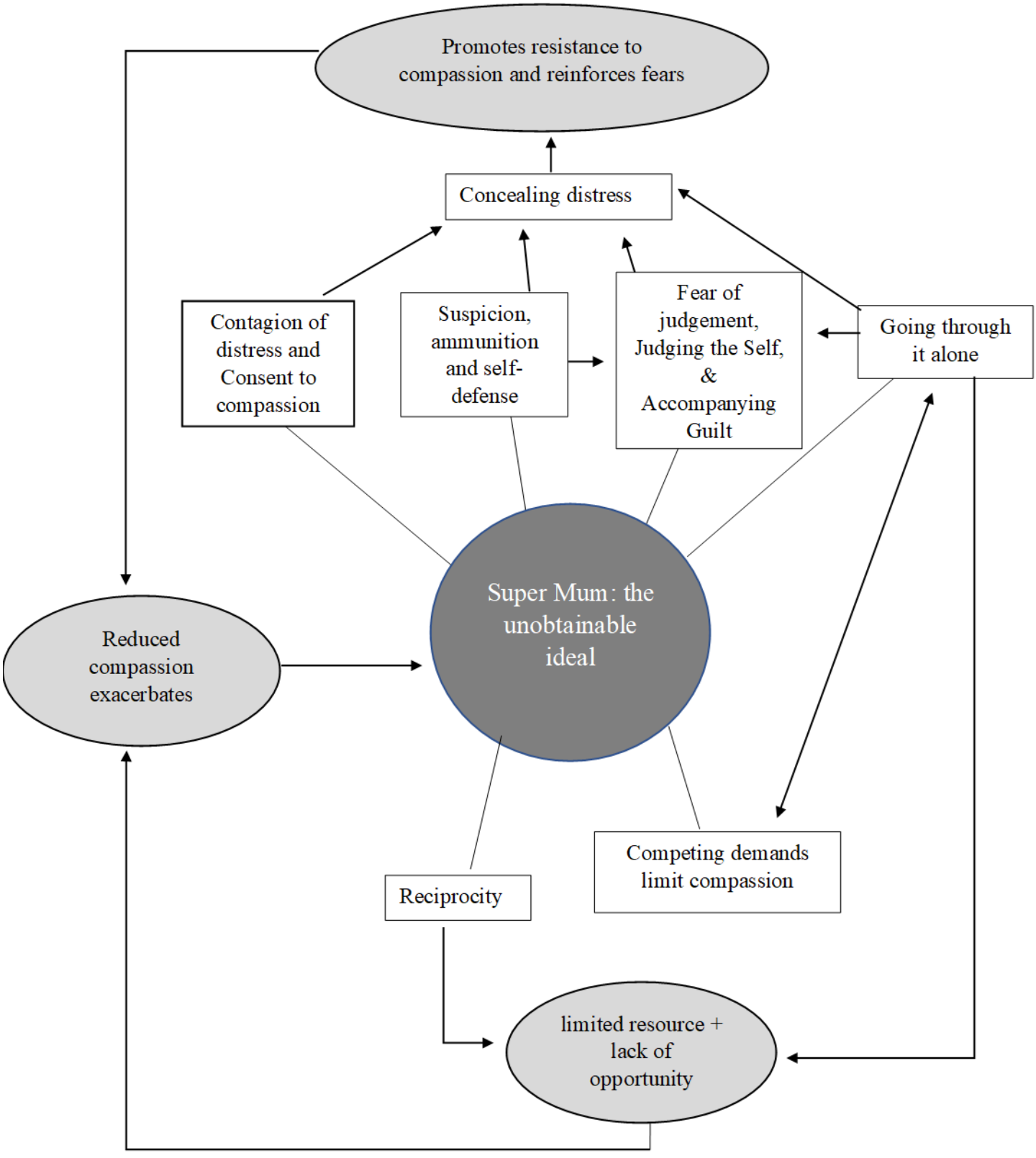
for compassion were scarce mothers chose to protect their flows of compassion – only giving it to those would reciprocate it. This sense of compassion as a scare resource leads to mothers having reduced experiences of compassion which, too, exacerbates mothers' drive to achieve the 'Super Mum' ideal.

Overall, the themes illustrate the dominance of the drive system from Gilbert's three emotion regulation model, as mothers were highly motivated to achieve the 'Super Mum' status and succeed in motherhood. The threat system was also very dominant for mothers and is illustrated in the themes, as mothers were suspicious, judged themselves and feared judgement from others. Mothers sought to protect themselves from others and were often self-critical of their efforts. Strong activation of the drive and threat systems leaves little space for the soothing system and suppresses its efforts to manage one's distress and regulate the other two systems. This is supported in the literature, with new mothers often moving between the threat and drive systems, with little activation of the soothing system (Cree, 2015).

A dominant drive and threat system can have implications for not only mother's mental health and wellbeing, but also mother-infant bonding. When these systems are overactive, the soothing system becomes suppressed and can lead to a reduction in the amount of oxytocin produced – a important hormone involved in mother-infant attachments and bonding (Cree, 2010). Therefore, mothers with an overactive threat and drive system can experience difficulties bonding with their infant, which further emphasises the importance of compassion for new mothers.

Figure 1

A theme map illustrating the relationships between themes, subthemes and the impact on mothers' experiences of compassion.


Promotes resistance to compassion and reinforces fears
Concealing distress
Contagion of distress and Consent to compassion
Suspicion, ammunition and self-defense
Fear of judgement, Judging the Self, & Accompanying Guilt
Going through it alone
Super Mum: the unobtainable ideal
Reduced compassion exacerbates
Reciprocity
Competing demands limit compassion
limited resource + lack of opportunity

Strengths and limitations

Although the women interviewed may have had FBRs to the flows of compassion before becoming mothers, this research highlights how new motherhood increases the number of barriers to compassion that they face on a daily basis.

The interviews took place over a period of easing of COVID-19 restrictions within the UK, and all mothers in the sample had experienced motherhood within the context of COVID-19, which posed additional challenges to new mothers (Gray and Barnett, 2021).

Differentiating blocks from resistances was done by staying close to the definitions laid out by Gilbert, although at times it was difficult to differentiate e.g. does one not have enough time for compassion (block) or is one choosing to not allocate time to compassion (resistance)? Further exploratory discussions with participants into these FBRs would have perhaps enabled blocks and resistances to be more easily distinguished from one another.

The researcher examined their own position throughout the process of conducting the research, as stated in the method, which facilitated the co-construction of knowledge between the researcher and participants. It is hoped that the steps taken minimised the researcher's degree of inaccuracy. Braun and Clarke (2019) recommend a sample size of 10-20 for doctoral research using thematic analysis. Unfortunately, due to personal circumstances and COVID-19 three participants withdrew from the study. The nine interviews that were completed generated rich data of which themes and subthemes were identified.

Using reflexive Thematic Analysis on the dataset whilst searching for FBRs in the interview data was challenging. The definitions of and theory around FBRs may have affected how knowledge was co-constructed between the researcher and the participants. Identifying FBRs required the research to take a deductive approach to TA, whereas

developing themes across the data set required a more inductive approach to TA. Therefore, the analysis was not always theoretically consistent. This research did not gather demographic data on the participants, apart from the country in which they reside. The majority of participants were from the UK or US and therefore shared similar cultural views about motherhood. Participants from India spoke about how their culture had shaped their views and experiences of compassion which at times contrasted to those of UK and US participants. Understanding how culture shapes mothers' perspectives of compassion was not the aim of the research but may be an important area of future research in supporting individuals to access compassion-focused interventions.

The findings identified many fears blocks and resistances to the three flows of compassion for new mothers. The range and number of FBRs reported indicates that many mothers struggle with compassion and is perhaps and a key area for perinatal mental health services to consider incorporating into their clinical practice. Compassion-focused interventions with mothers should consider focusing on reducing some of these FBRs in order to increase therapeutic outcomes. Services that offer support for mothers at-risk of experiencing a mental health problem should consider these findings and support mothers in minimising these barriers to compassion as there is a relationship between FBRs and mental health difficulties (Gilbert, 2014; Gilbert, 2019; Kirby et al., 2019).However, depression and anxiety were reported as blocks to self-compassion, therefore, clinicians should consider taking an integrated approach to working with these presentations because they may limit mothers' abilities to engage with strategies focused on building self-compassion.

Future research should examine the fears blocks and resistances to compassion for new mothers across the early years of motherhood, to understand whether mothers' FBRs are constant or change in relation to their experience and/or their infants' age and needs. Additionally,, in order to gain a wider cultural understanding of the FBRs highlighted by this

research, further research should explore the barriers to compassion that black mothers face, as their experiences of FBRs to compassion are not reflected in the current research. Black mothers may face additional barriers to the flows of compassion, including socio-economic factors (e.g. unsafe neighbourhoods) and systemic factors such as experiencing racism and implicit bias when accessing perinatal services (Lopez-Littleton & Sampson, 2020). Understanding the difficulties, the new black mothers face is of great importance as the prevalence of post-partum depression in this population is higher than in white populations and have been disproportionately affected by the COVID-19 pandemic (Meer, Qureshi, Kasstan, & Hill, 2020; Pao et al., 2019).

Conclusion

This research explored what fears, blocks and resistances might exist to the flows of compassion for new mothers. The findings highlighted that the 'Super Mum' social discourse and the number of demands mothers face act as significant barriers to mothers engage with self-compassion, compassion from others and giving compassion. The isolating experiences of new motherhood, concerns for the exchange of compassion, and mental health were too shown to be common barriers to the three flows of compassion. These themes have implications for clinical practice and further research into supporting mothers within mental health services and in the community. It is hoped that these findings shed light on the challenging experiences that new mothers face and will support the adaptation of compassion-focused interventions within perinatal services.

Declaration of Interest Statement

The authors report there are no competing interests to declare.

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Part Three: Appendices

Appendix A: Epistemological Statement

Ontology is concerned with the nature of being and what can be known, whilst epistemology is concerned with the nature and acquisition of knowledge and therefore has an important role in research methodology (Willig, 2019). This epistemological statement summarises the philosophical underpinnings of the portfolio thesis and how the epistemological assumptions guided the research methodology.

This research took on the ontological position of critical realism and was guided by a contextualist epistemology. Critical realism is ontologically realist (assumes that there is an external reality that is independent of the human mind) and epistemologically relativist (which assumes that different methodologies and individual perspectives produce different views on reality; Fletcher, 2017).

A contextualist epistemology assumes that all knowledge is local, provisional and context-dependent, therefore findings will vary according to the context in which the data was collected and analysed (Jaeger & Rosnow, 1988). The contextualist stance acknowledges the inevitability of the researchers bringing their personal and cultural perspectives to the research process. The interview data in this research reflects mothers' perspectives, and the analysis is the researcher's interpretation of this, where the findings are constructed by the researcher's understanding, experience and knowledge.

The methodology and reflective processes used in this portfolio thesis were guided by the contextualist position. A Qualitative methodology is compatible with a contextualist position, as knowledge is derived from individuals' experiences and is shaped by the context in which the data was collected and analysed by the researcher. Additionally, a qualitative methodology is suited to the researcher's preference for understanding individual's

experiences in the rich detail that quantitative data cannot depict. Both the systematic literature review and empirical paper were compatible with this view.

A contextualist approach to this research was appropriate given that all of the research in the systemic literature review and the participants in the empirical research had become mothers within the social context of the COVID-19 pandemic. Contextualism assumes that our knowledge is relative because it is knowledge of action within this specific socio-historical and cultural context. This position recognises that the knowledge gained is incomplete because the context in which the data was collected is a reality that is developmental and transformative.

The researcher engaged in reflective processes such as reflective diary keeping and reflective groups with other trainees. Such processes enabled the researcher to consider how their experiences, knowledge and context may influence the construction of knowledge in the research process. The researcher considered their own biases, assumptions, beliefs and how their position as a female without a child (an outside position), may influence the research findings. The researcher kept a reflective journal and made use of a reflective research group where they discussed their outside position and acknowledged the importance of remaining curious during the research process. The researcher's experience of relatives struggling with aspects of motherhood may have shaped their knowledge of motherhood and influenced their analysis. Regardless of these reflections, there will be aspects of the above that the researcher is unaware of but will likely contribute to the findings.

The structure of the interview schedule was considered through a contextualist lens, as it was important for the researcher to understand mothers' experiences of FBRs to compassion within the context of each of the flows. Participants were encouraged to draw on a situation in which they had experienced barriers to compassion to facilitate the researcher's

understanding of the context in which compassion was feared, blocked or resisted. It was considered important for the researcher to have an understanding of participants' contexts when constructing an understanding of the FBRs they experienced.

To conclude, as characterised by the critical realism contextualist underpinnings, the systematic literature review and empirical research would have been affected by the researcher's own cognitive, social, political and economic context. Areas that may have impacted the thesis include the assumptions, beliefs and meanings already held by the researcher about: barriers to compassion, the experiences of new mothers, the experience of motherhood during the COVID-19 pandemic, feminist discourses, and others that remain unknown. It was hoped that the reflective processes that the researcher engaged in minimised the impact of biases during the construction of knowledge.

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Appendix B: Reflective Statement

Throughout the process of developing, doing and writing up this research, I have developed a strong understanding of the research process and gained a range of skills. The knowledge and skills gained from the research journey will aid me as a scientist-practitioner in clinical psychology. In this reflective statement, I will share my reflections on key stages within the research process.

Developing the study

Choosing the research area

Selecting an area of research for my doctoral thesis was at first a scary decision, especially as there were a number of topics that were important and interesting to me. However, I have always had a great interest in perinatal psychology, and in recent years I have developed an interest in understanding the experiences of motherhood outside of the picture-perfect snapshot that we often see on social media. In addition to this, Compassion-focused therapy (CFT) was new to me on joining the clinical psychology doctorate, and I felt that this was a therapeutic approach that aligned well with my personal values. In understanding the principles of CFT increasingly, I have become passionate about enhancing my own and others compassionate selves. It was from joining these two interests together that my research idea developed, and my research tutors highlighted the lack of research into fears, blocks and resistances (FBRs). On reading about FBRs, I became aware of just how many FBRs I had of my own and became interested in how this impacted new mothers. My personal anxieties about motherhood contributed to my interest in exploring whether motherhood enhanced the number of FBRs to compassion a woman experiences.

Choosing the design

After choosing the topic of my research, I then had to consider an appropriate design and methodology. After reading around the literature, I was interested in Gilbert's Fears of Compassion Scale, however, noted that this only assessed one part (fears) of the FBRs triad. As there was little literature on how to identify FBRs, an exploratory qualitative methodology was necessary. My previous research experience has always been quantitative in nature, and therefore was considered safe and comfortable to me, therefore I was nervous about stepping outside of my comfort zone into qualitative research. The aim of this research was to identify how mothers experienced FBRs to the flows of compassion, therefore, Reflexive Thematic Analysis was chosen as this allowed for the discovery of patterns of FBRs across the participant interviews. I was initially very anxious and unsure about my decision to use this analytic approach as I have little experience with qualitative research. However, after discussing with my research supervisors, reading about other types of analysis (e.g., IPA) and reading related literature, I became more confident in my approach. My passion for exploring others' experiences in research has grown, and I strongly value the nature of qualitative research – where participants' perspectives and understanding of compassion is accorded an equal importance to 'experts' in the field of research.

Recruitment

Participants were mainly recruited via social media adverts and family and friends sharing the study information with potential participants. The recruitment process was hard-work and filled with ups and downs as participants expressed interest or returned consent forms but for various reasons the interview did not happen. I did not go into my research with the view of recruiting globally, I wrongly assumed that recruitment within the UK on my social media accounts would be sufficient. However, after a slow start to recruitment a world-wide Facebook advert was needed.

I was pleasantly surprised by the effectiveness of a worldwide Facebook advert and learned so much about the benefits of using social media in research recruitment. However, I also learned a lot about this method of recruitment, particularly the importance of being specific in selecting the regions of the world in which you want your advert to be shown. At first, I selected English-speaking countries (e.g., UK, US, Canada, New Zealand) however I noticed that most of the people responding to the advert were from only one of the countries selected. It appeared to be that I had chosen too many areas of the globe and so my advert was being limited to just one area. This limited the range of participants recruited worldwide.

Interviews

Interviewing first-time mothers was the highlight of the portfolio thesis, and I feel that it was a privilege to hear the incredibly raw reflections and difficult stories from these women.

As a woman without children, I was somewhat anxious about interviewing mothers, and had fears of mothers feeling like I couldn't understand or that they would fear of judgement from a 'non-mother'. I spent some time reflecting on my position as an outsider, and what preconceptions and biases I might bring to the research process. I also had to consider how my relationship with my sister, a first-time mother, may have influenced my assumptions and biases.

During the research process, my sister, became a mother for the first-time. I have a very close relationship with my sister, and I was able to discuss my position as a childless woman with her, a member of the population I intended to study. When conducting interviews, only one mother enquired about my parental status to which I answered truthfully. I was, in that moment, concerned about how this may have affected what she would discuss and the language she may use in the rest of the interview. On examining the interview before and after this question, there were some obvious differences in how this mother described

motherhood to myself as she began to use language and phrases which indicated my outside position. The effect of my parental status and outside position on the data is difficult to assess, although will have likely had an effect. The other eight mothers interviewed were not aware of my parental status, although may have made assumptions about this based on my age, class, appearance and status as a student researcher.

Mothers reflected at the end of the interview how much they had enjoyed the experience and shared that they had talked about things that they didn't expect from themselves and reflected on difficult experiences that they would have otherwise forgotten. Hearing such positive comments about the interview process was incredibly heart-warming and I understood in those moments the value of my, and other, qualitative research in giving mothers an opportunity to voice their experiences and for these to be used to support our understanding of new mother's FBRs to compassion.

After each interview, participants were emailed a sources of support document. When I made my source of support sheet I had, unintentionally, listed organisations, charities and services that were known and used within the UK. This provided a key learning experience for me, as after interviewing mothers from the US and India I realized that many of the sources of support I had listed were not available or accessible to non-UK countries. On realizing this, I researched appropriate services they could access in their home country and emailed these over to the participants. From this I learned the importance of having a clear recruitment strategy and adapting my resources to participants so that they are appropriate and accessible to all.

Data analysis and write-up

The data analysis process was lengthy and challenging and required multiple attempts of coding and drawing up themes. I was difficult to know how to structure my results as my

research question aimed to identify FBRs for mothers, however, thematic analysis demands that themes weave together to tell a coherent story about the data, which I felt would be difficult to do if the results were structured under headings of Fears, Blocks and Resistances.

There were apparent themes underlying the FBRs I had identified in my coding stages, and after several attempts at defining and refining these themes I felt that this was the most appropriate way to structure my results section. I feel that the structure of my results sections highlights the central concept that lies behind many of the FBRs to the flows of compassion identified, and the different manifestations of that idea.

A further challenge during the write up phase was selecting quotes that best supported the themes whilst ensuring that all participants experiences were represented. It was also challenging to limit the number of quotes in each theme, as each participant's words were important and reflected a unique experience of FBRs to compassion. On reflection, although I was not able to present quotes from all participants in each theme, I feel that their experiences are represented in each theme and provided an important contribution to the findings.

Thematic Synthesis

Carrying out the thematic synthesis was time-consuming and challenging, and I spent many weeks refining my search strategy and inclusion and exclusion criteria. Finding an area of research that was relevant to my empirical paper was exciting, but it was at times challenging to find an area of research that required a systematic review to be conducted. Given that my empirical research was conducted on a sample of mothers who gave birth or were pregnant during the COVID-19 pandemic, I felt it would be important for me to gain an understanding of the literature surrounding mothers' experiences during this difficult time. There was also a need for the findings of the qualitative research into mothers' experiences during the pandemic to be synthesized into a review that can inform services who support mothers and

families. It was important for me to reflect on my understanding of post-partum mothers' experiences during the pandemic, as I have some assumptions and limited understanding of this due to my sister's experience of becoming a mother during lockdown. By reflecting on these second-hand stories I have about motherhood in the pandemic I was more aware of when I was perhaps drawn to findings that echoed these and made efforts to remove this bias by engaging in reflective journaling and supervision.

Final reflections

Writing this portfolio thesis has been exhausting and challenging at times, however, I have thoroughly enjoyed the learning process, developing new skills, and learning more about myself and the 'type' of researcher I am and hope to be. It is sad to close the door on this chapter of doctorate, although I am now inspired and encouraged to engage in further academic research post-qualifying. I will forever be proud of what I have achieved in this research and thankful to the participants for sharing their experiences with me.

Appendix C: Author Guidelines for Systematic Literature Review Submission

to *Women and Birth*

GUIDE FOR AUTHORS

Your Paper Your Way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format'
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Submission Checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

i. E-mail address
ii. Full postal address
iii. Author's may include their Twitter handles on the Title Page if they wish to.

All necessary files are ready to be uploaded:
Please have the following items ready before you log-on to the system. Every submission, regardless of category, must include the following four items:

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v. Author Agreement
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Additional files that may be required depending on your manuscript:

- All figures (include relevant captions)
- All tables (including titles, description, footnotes)
- Response to reviewers (if resubmission)
- Research approach Checklist
- Graphical Abstracts and Highlights files (where applicable)
- Supplemental files (where applicable)

Further considerations

• Manuscript has been 'spell checked' and 'grammar checked'
• All references mentioned in the Reference List are cited in the text, and vice versa
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• A competing interests statement is provided, even if the authors have no competing interests to declare
• Journal policies detailed in this guide have been reviewed
• Please include the details under the headings " Acknowledgement", "Conflict of interest", "Ethical Statement", "Funding" and "Author Contributions" in a separate file and then select the file type as "Author agreement" and upload it to EM during the submission process

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Before you start we also suggest you look at the style of language and terminology used in the journal. This Editorial provides some information.
https://www.womenandbirth.org/article/S1871-5192(20)30088-3/fulltext

More details are provided later in these instructions.

First time authors are strongly advised to co-author with an academic supervisor or experienced colleague who has been successful in writing for publication. Articles submitted for review must be original works, and may not be submitted for review elsewhere whilst under review for the Journal.

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Our journal uses UK spelling, for example, recognise rather than recognize. We also spell fetal rather than foetal.

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Example of Statement of Significance

Problem

Poor assessment and clinical reasoning are major contributors to adverse birth outcomes.

What is Already Known

Midwifery decision-making during birth is mediated by hierarchies of surveillance and control. Midwives are often unable to implement their preferred decision. The international and national professional decision-making frameworks are not sufficiently detailed to guide midwives' clinical reasoning.

What this Paper Adds

Evidence that half of the midwives interviewed did not use clinical reasoning to make decisions. A new and detailed model of midwifery clinical reasoning which incorporates a role for intuition.

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Appendix D: Data extraction form

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
Barbosa-Leiker, Smith, Crespi, Brooks, Burduli, Ranjo, Carty, Herbert, Waters and Gartstein (2021) United States	Stressors, coping, and resources needed during the COVID-19 pandemic in a sample of perinatal women	To assess stressors, coping behaviours and resources needed by perinatal women in relation to the COVID-19 pandemic.	Mixed methods Open-ended questions Content Analysis	162 perinatal women – currently pregnant (n=125) or postpartum (n=37; given birth between 1/9/19-31/5/20).	April 2020 – June 2020.	Participants expressed concerns about: • their baby contracting COVID-19 while in the hospital • significant others missing the delivery or key obstetric appointments • wanting support from friends, family • birthing classes	+
Brown and Shenker (2020) United Kingdom	Experiences of breastfeeding during COVID-19: Lessons for future practical and emotional support	To understand how the COVID-19 pandemic affected mother's infant feeding	Mixed methods Questionnaire with a mix of closed and	1219 UK mothers who had breastfed their baby aged 0–12 months at least once during the	May–June 2020.	Themes: • Positive impact on breastfeeding • Negative impact on breastfeeding	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
		attitudes, choices and outcomes.	open-ended questions. Thematic Analysis	COVID-19 pandemic			
Critchlow, Birkenstock, Hotz, Sablone, Henderson Riley, Mercier, and Frasso (2022) United States	Experiences of New Mothers During the Coronavirus Disease 2019 (COVID-19) Pandemic	To describe postpartum experiences of women who gave birth during the coronavirus disease 2019 (COVID-19) pandemic, to identify short-term and long-term opportunities to address maternal–child health during this pandemic.	qualitative photo-elicitation and semi-structured interviews Content analysis	Thirty postpartum cis-gendered women (3-10 weeks) who did not deliver before 34 weeks of gestation nor require neonatal admission to the intensive care nursery. Half of the participants used public or no insurance, and half used	Decemb er 2020,- April, 2021	Stressors were worsened during the pandemic, namely: • Fear • childcare • older children • loss • Isolation • employment key support structures (self-care, interpersonal, and structural supports) at times helped to alleviate stressors but at other times were inadequate to counter stress and even enhanced stress.	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
				private insurance.			
Farewell, Jewell, Walls and Leiferman (2020) United States	A Mixed-Methods Pilot Study of Perinatal Risk and Resilience During COVID-19	To understand mental health, well-being, and sources of resilience for women in the perinatal period during the COVID-19 pandemic.	Mixed methods Semi-structured phone interviews A deductive, theory-driven approach, and an inductive, data-driven approach	Thirty-one women over the age of 18 years, English-speaking, currently living in Colorado, and pregnant (n= 16) or within the first 6-months postpartum (n =15).	March-April 2020	Four themes: • Uncertainty surrounding care and risk exposure • Lack of anticipated support networks • Positive coping and resilience • "Silver linings" of pandemic on mental health and well-being	++
Gray and Barnett (2021) United Kingdom	Welcoming new life under lockdown: Exploring the	To explore how first-time mothers in the UK experienced	Qualitative Semi-structured interviews	Ten first-time mothers who had given birth since COVID-	June-August 2020	Themes: • The buck stops with me • Overwhelming responsibility • Disrupted Motherhood	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
	experiences of first-time mothers who gave birth during the COVID-19 pandemic	new parenthood during the coronavirus (COVID-19) pandemic.	Reflexive Thematic Analysis	19 was declared as a pandemic			
Jackson, De Pascalis, Harrold, Fallon and Silverio (2021) United Kingdom	Postpartum women's psychological experiences during the COVID-19 pandemic: a modified recurrent cross-sectional thematic analysis	To explore the post-partum psychological experiences of UK women during the COVID-19 pandemic.	Qualitative Semi-structured interviews Thematic Analysis	Women <3 months postpartum, English speaking, given birth in the UK, residing in UK. Twelve women at T1, a separate twelve women at T2.	T1: April 2020 T2: June 2020.	Themes for T1: • Motherhood is much like lockdown • Self-contained family unit Themes for T2: • Incongruously held views of COVID-19 • Mothering amidst the pandemic	++
Joy, Aston, Price, Sim, Ollivier, Benoit, Akbari-Nassaji	Blessings and Curses: Exploring the Experiences of	To examine parents' experiences of the postpartum period	Qualitative Online survey with	68 mothers of an infant aged 0-12 months living in Nova Scotia, Canada.	May-June 2020	Themes: Positive experiences/Blessings: • The blessings of freedom	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
and Iduye (2020) Canada	New Mothers during the COVID-19 Pandemic	during the mandated health protection orders in response to the COVID-19 pandemic	open-ended questions Feminist poststructuralist discourse analysis			• The blessings of quiet enjoyment • The blessings of Bonding and Snuggles Challenges/the Curses: • The Curses of Isolation • The Curses of Robbed Moments • The Curses of Limited Socialization and Bonding • The Blessings and Curses of Partners	
Ollivier, Aston, Price, Sim, Benoit, Joy, Iduye, and Nassaji (2021) Canada	Mental Health & Parental Concerns during COVID-19: The Experiences of New Mothers Amidst Social Isolation	To understand parenting experiences in Nova Scotia during the first wave of the COVID-19 pandemic.	Qualitative Online survey with open-ended questions Feminist Poststructuralist	68 mothers of an infant aged 0-12 months living in Nova Scotia, Canada.	May-June 2020	Mental health and socialization were two major issues for new parents in Nova Scotia.	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
			Discourse Analysis.				
Reichert, Guedes, Soares, Brito, Dias, Santos (2021) Brazil	COVID-19 pandemic: experiences of mothers of infants who were born premature	To understand the experiences of mothers of infants who were born premature in the COVID-19 pandemic.	Qualitative Telephone semi-structured interviews Thematic analysis	21 mothers of infants born prematurely, who had been discharged from maternity care, who had their follow-up interrupted due to the COVID-19 pandemic.	June-July 2020	Themes: • Maternal knowledge and perception about COVID-19 and social isolation. • Experiences • of mothers of premature infants in the COVID-19 pandemic	+
Rice and Williams (2021) Canada	Women's postpartum experiences in Canada during the COVID-19 pandemic: a qualitative study	To examine how people in Canada have been affected by policies aimed at limiting interpersonal contact to reduce COVID-19	Qualitative Descriptive Telephone semi-structured interviews Thematic analysis.	65 postpartum (n = 57) and pregnant (n = 8) women living in Canada who had given birth or were pregnant during the COVID-19 pandemic.	June 2020-January 2021	Themes: • negative postpartum experience in hospital • poor postpartum mental health • Asking for help • Problems with breastfeeding	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
		transmission while giving birth in hospital and during the first weeks postpartum					
Schmiedhofer, Derksen, Dietl, Häussler, Louwen, Hüner, Reister, Strametz, Lippke (2022) Germany	Birthing under the Condition of the COVID-19 Pandemic in Germany: Interviews with Mothers, Partners, and Obstetric Health Care Workers	To explore the first-hand experience of the impact of the COVID-19 pandemic on mothers, their partners, and obstetric professionals regarding birth and obstetric care.	Qualitative Semi-structured interviews Content Analysis	Sample one: 25 mothers (< 12 months postpartum) and five partners. Sample two: 10 obstetric professionals.	Februar y -July 2021	• Mothers felt socially isolated and insecure, especially before transfer to the delivery room. • Staff reported burdens and tried to make up for the lack of partner and social contacts. • The exclusion of partners was seen critically but was necessary. • The undisturbed bonding time in the maternity ward was considered positive.	++

Authors, (year of publication) location of study	Title of study	Research aims	Study design and analysis	Participant characteristics	Study timeline	Key findings	Quality
Snyder and Worlton (2021) United States	Social Support During COVID-19: Perspectives of Breastfeeding Mothers	To explore perceptions of social support among breastfeeding mothers during the COVID-19 pandemic.	Qualitative A cross-sectional phenomenological approach Semi-structured interviews	29 currently breastfeeding mothers be up to 8 months postpartum.	March–June 2020	• Support with breastfeeding has been negatively impacted by the pandemic. • First-time mothers may be at higher risk of early breastfeeding cessation due to lack of support. • breastfeeding journeys have also been positively influenced by allowing mothers more time at home with their child. • More support expressing breast milk in the workplace is required during COVID-19.	++

Key

++	*All or most of the criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.*
+	*Some of the criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.*

- *Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.*

Appendix E: NICE Quality Appraisal Checklist – Qualitative Studies

https://www.nice.org.uk/process/pmg4/chapter/appendix-h-quality-appraisal-checklist-qualitative-studies

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate?	Appropriate	Comments:

For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Inappropriate Not sure	
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:

Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		

4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered?	Clearly described Unclear Not described	Comments:

• Does the paper describe how the research was explained and presented to the participants?		
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example:	Reliable Unreliable	Comments:

• Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Not sure	
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e., is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable?	Rigorous Not rigorous Not sure/not reported	Comments:

• Is it clear how the themes and concepts were derived from the data?		
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data?	Reliable Unreliable Not sure/not reported	Comments:

• If so, how were differences resolved? • Did participants feedback on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?		
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:

12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined?	Adequate Inadequate Not sure	Comments:

Is there adequate discussion of any limitations encountered?		
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g., do they address consent and anonymity? • Have the consequences of the research been considered i.e., raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:

Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (See guidance notes)	++ + –	Comments:

Appendix F: Summary of NICE quality assessment ratings

Paper	**Checklist Item**														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Rating
Anderson (2022)	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not reported	+
Barbosa-Leiker (2021)	Appropriate	Unclear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not reported	+
Brown (2020)	Appropriate	Unclear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Critchlow (2022)	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Draganović (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
DeYoung (2021)	Appropriate	Clear	Not sure	Appropriately	Not described	Clear	Reliable	Not sure	Rich	Reliable	Convincing	Relevant	Adequate	Not reported	+
Farewell (2020)	Appropriate	Clear	Not sure	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Gray and Barnett (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Jackson (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Joy (2020)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Ollivier (2021)	Appropriate	clear	Defensible	Appropriately	Unclear	Clear	Reliable	Not reported	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Reichert (2021)	Appropriate	Clear	Indefensible	Appropriately	Not described	Clear	Not sure	Not reported	Rich	Not reported	Convincing	Relevant	Adequate	Appropriate	+
Rice and Williams (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Sanders (2021)	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Not reported	Rich	Not reported	Convincing	Relevant	Adequate	Inappropriate	+
Schmiedhofer (2022)	Appropriate	Clear	Defensible	Appropriately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Snyder and	Appropriate	Clear	Defensible	Appropriately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not reported	++

Worlton

(2021)

Key

++	*All or most of the criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.*
+	*Some of the criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.*
-	*Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.*

Appendix G – Documentation of Ethical Approval

UNIVERSITY OF HULL

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PRIVATE AND CONFIDENTIAL
Harriet Cackett
Faculty of Health Sciences
University of Hull
Via email

11th October 2021

Dear Harriet

REF FHS349 - First-time mothers' experiences of the fear, blocks or resistances to the flows of compassion – Form C

Thank you for submitting your ethics Form C: Notice of Substantial Amendment to the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY OF HULL

Liz Walker | Professor of Health and Social Work Research | Faculty of Health Sciences
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Appendix H – Recruitment Poster

ARE YOU A FIRST-TIME MUM?

VOLUNTEERS NEEDED FOR RESEARCH STUDY

This research is interested in the general idea of how compassion can help new mothers adjust to parenting. Research suggests that compassion can be helpful for our wellbeing, but there are also reports that, sometimes, compassion can be difficult to let in and I would like to find out more about why that might be.

If you have become a mother for the first time in the past year, you may be eligible to be involved in this important research study into new mothers' experiences of compassion.

What is involved?

If you choose to take part, you will need to attend an online interview with the researcher via video call, for approximately 30-60 minutes. In the interview you will be asked to discuss your experiences of compassion since becoming a mother. The researcher will use a specific meaning of compassion which will be broken down in asking the interview questions. This meaning is the idea that compassion involves being sensitive to and noticing when you or someone else is distressed, and then taking helpful steps to stop or prevent the distress.

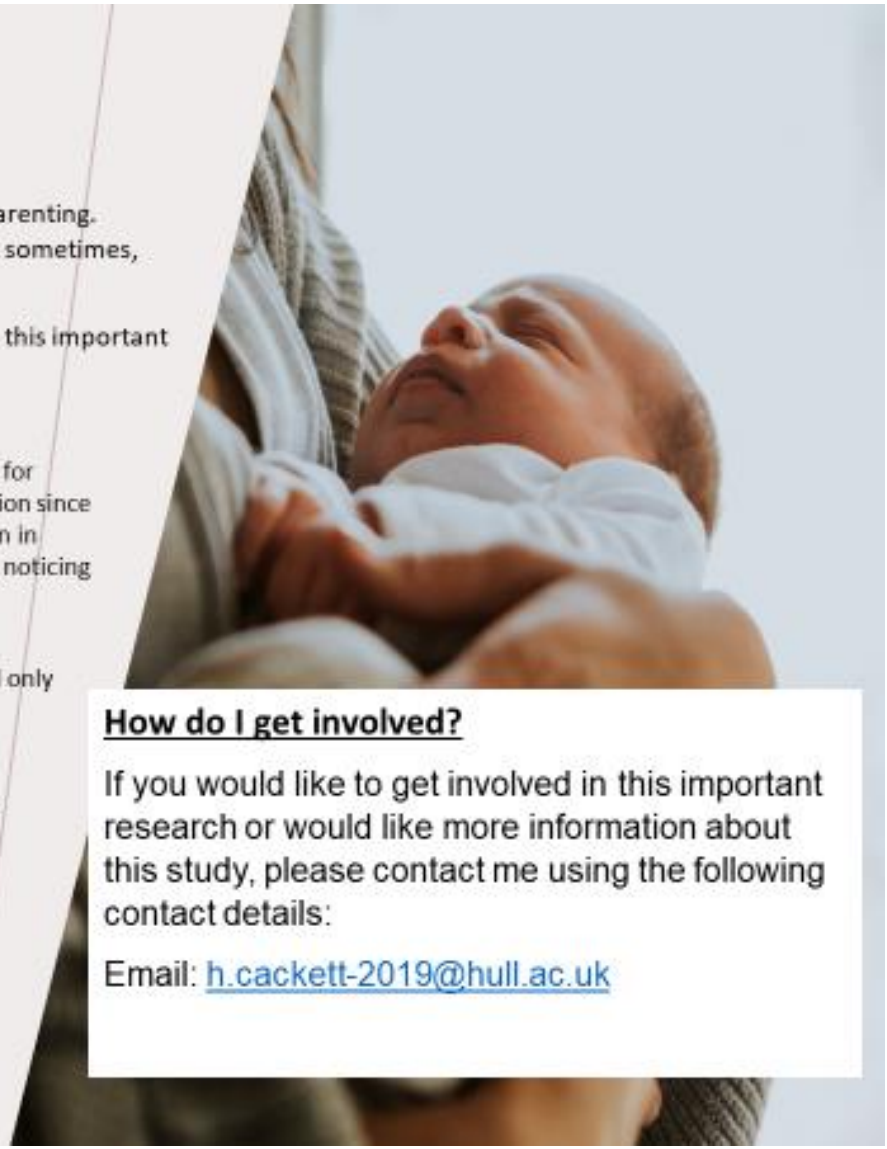
If you are unable to attend an online interview, the researcher can arrange a face-to-face interview. The interview will be recorded (audio only), transcribed and analysed. Audio recordings of the interview will only made with your consent.

Why should I take part?

Your participation in this study will contribute to the research knowledge in maternal mental health and wellbeing and influence how mental health services support new mothers.

You may be eligible to participate if you:

- Are a first-time mother
- Are aged 18 years or older
- Have been a mother for at least 1 month, but for no longer than 1 year.
- Are proficient in speaking English
- Are one of the primary caregivers of your infant
- Have not had thoughts about self-harm or suicide in the past month.

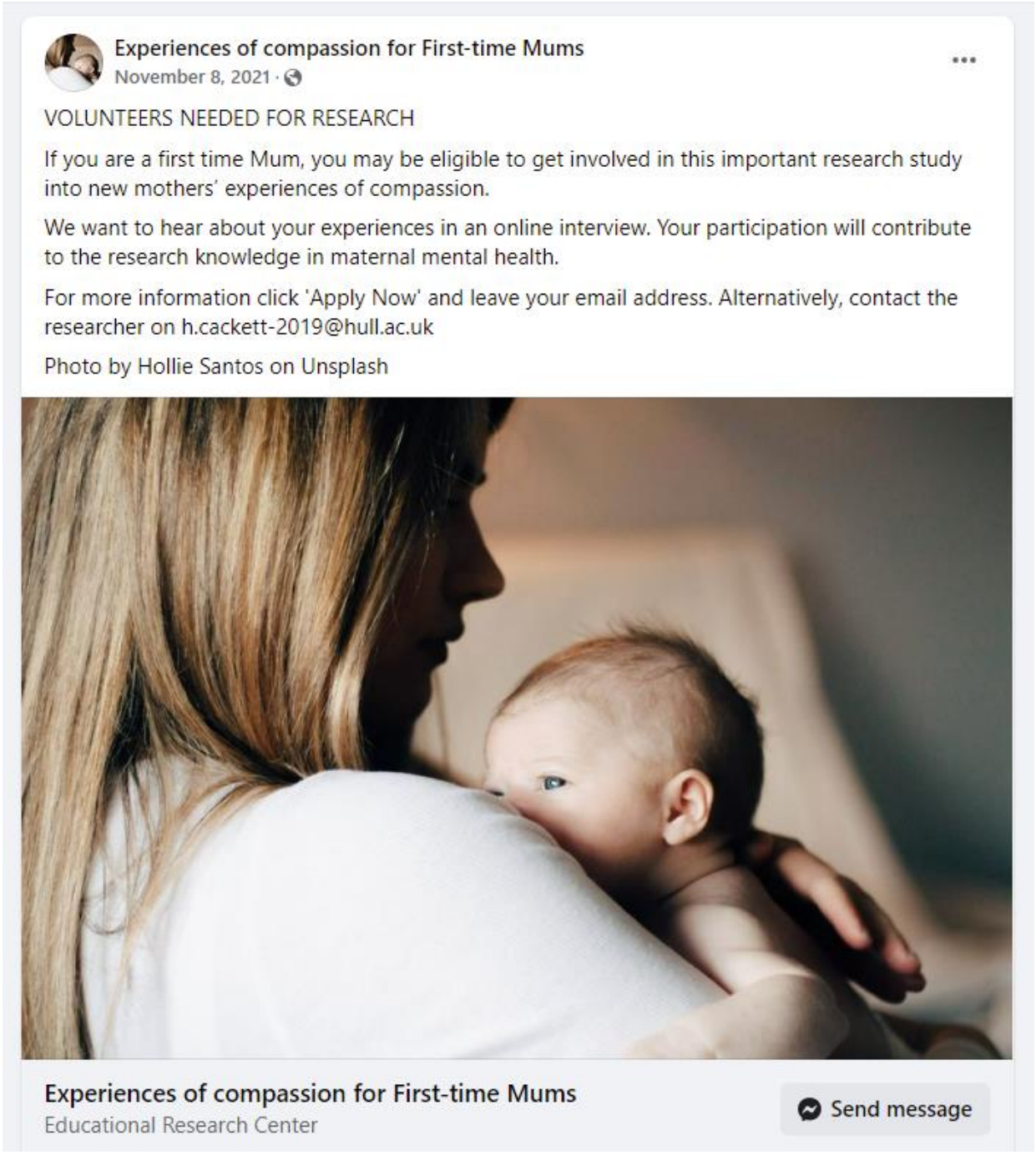


How do I get involved?

If you would like to get involved in this important research or would like more information about this study, please contact me using the following contact details:

Email: h.cackett-2019@hull.ac.uk

Appendix I: Worldwide Facebook advert



Appendix J: Information sheet

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INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: First-time mothers' experiences of the fear, blocks or resistances to the flows of compassion

Becoming a parent is a joyful but also challenging time for many and there is often little time for ourselves or others close to us. Compassion is widely understood to be important for our mental health, but for some people it can be difficult to be compassionate to themselves and is not often a part our everyday lives. This research aims to understand how first-time mothers experience compassion.

I would like to invite you to participate in this research project which forms part of my Doctorate in Clinical Psychology. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of the study is to understand how first-time mothers experience compassion and what can help or hinder them from receiving compassion from others, being compassionate to themselves, or being compassionate to others. Understanding what helps or hinders first time mothers to have compassionate experiences can help us understand how we can better support first-time mothers' mental health and wellbeing.

Why have I been invited to take part?

You are being invited to participate in this study because you have become a mother for the first-time within the last 12 months, are proficient in speaking English, and have been a mother for at least 1 month. You report being one of the primary caregivers of your child, and do not report having had thoughts about self-harm or suicide in the last month.

What will happen if I take part?

If you choose to take part in the study you will be asked to attend an interview with the researcher to discuss your experiences of compassion since becoming a mother, for example "please tell me about a time you have been compassionate to yourself?"

Participation will take place online via a video call on the website 'Zoom' for approximately 30 – 60 minutes. The researcher will contact you before the interview to provide you with the link to the video call. If you are unable to attend an online interview, please inform the researcher and a face-to-face interview can be arranged.

As part of participation, you will be asked to provide an email address for the researcher to contact you on and details of your experiences of compassion since becoming a mother. The interview will be recorded (audio only) transcribed and then analysed for themes relevant to the research question, alongside interview transcriptions of 10-20 other participants.

Audio recordings of the interview will only made with your consent.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form or provide verbal consent which will need to be audio recorded. You will be given a copy of this consent form to keep.

What are the possible risks of taking part?

Whilst it is not the intention of the research process to cause any distress, during the interview there is a risk for some people that they may become distressed about the things they are talking about. You will not be asked to speak about anything you do not feel comfortable talking about.
The researcher will provide you with a list of supportive agencies that you can contact if you are experiencing any difficulties following the interview.
If you are unable to attend an online video-call interview and need to arrange a face-to-face interview with the researcher, there is a risk of transmission of COVID-19 when coming into contact with the researcher. The researcher and you must wear personal protective equipment (i.e., face covering) throughout the interview (unless you are exempt), with a window open and be seated 2m apart. The researcher will wipe down any surfaces touched by the researcher during the interview with sanitising wipes.

What are the possible benefits of taking part?

There are no intended benefits to you for taking part in the research, however, your participation will contribute to the research knowledge in this area and influence how mental health services support new mothers.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

All data collected from you throughout the study will be anonymised. This will involve your name being replaced with a numerical code which will be attached to your consent form and interview data. Any names mentioned in the interview will be replaced with pseudonyms (a false name).
Anonymous data collected during the interview will be stored securely at the university of Hull in locked cabinets for 10 years after the research has been completed. Personal data collected from you (e.g., name, contact details) will be destroyed at the point at which data can no longer be withdrawn due to anonymisation.
Data will only be shared within the research team, and this will only be done with your consent.
Data collected in this research may be used to support future research and may be shared anonymously with other researchers.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until the point of analysis, which is anticipated to be March 2022, after which withdrawal of your data will no longer be possible as the data will have been anonymised and would be impossible to remove from the data set. If you choose to withdraw from the study, we will not retain the information you have given thus far.

How is the project being funded?

This study is being funded by the University of Hull, Cottingham Rd, Hull HU6 7RX.

What will happen to the results of the study?

The results of the study will be summarised in the researcher's thesis for the award of Doctorate in Clinical Psychology and may be presented at research conferences. The research may be published in a relevant scientific journal and the researcher will provide you with the link to a blog where the researcher will post the research findings for you to view. The Anonymised data set will not be made publicly available.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been approved by the Faculty of Health Sciences Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Email: h.cackett-2019@hull.ac.uk
mobile: 07976071084

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Philip Molyneux: p.molyneux@hull.ac.uk
Dr Tim Alexander: t.alexander@hull.ac.uk

Alternatively, please contact coo@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix K: Consent form

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CONSENT FORM

Title of study: First-time mothers' experiences of the fear, blocks or resistances to the flows of compassion

Name of Researcher: Harriet Cackett

	Please initial box
1. I confirm that I have read the information sheet dated 04.05.2021 (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to a satisfactory standard.	☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving a reason, and without my legal rights being affected. I understand that if I choose to withdraw from the study the researcher will not retain the information I have given thus far.	☐
3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations.	☐
4. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.	☐
5. I give permission for the collection and use of my data to answer the research question in this study.	☐
6. I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix L: A semi-structured interview guide informed by the literature

Introduction

I am interested in the general idea of how compassion can help new mothers adjust to parenting. Research suggests that compassion can be helpful for our wellbeing, but there are also reports that, sometimes, compassion can be difficult to let in and I would like to find out more about why that might be. I am therefore going to ask you some questions to help to understand this and would like to hear about your experiences of compassion since becoming a mother.

I am using a specific meaning of compassion which I am going to break down in asking the questions. This meaning is the idea that compassion involves being sensitive to and noticing when you or someone else is distressed, and then taking helpful steps to stop or prevent the distress.

Can you think of a situation/some examples/themes where you have struggled and have been upset with some aspect of being a new parent?

- Tell me what happened;

Compassion to Self:

- What did you notice about how you felt? *Optional: And/or How do you know when you're distressed/upset?*
    - *Prompts about attributes for noticing distress: sensitivity, sympathy, distress tolerance, empathy, non-judgement, care for well-being;*
    - *Is this typical?*
- What might have got in the way of you noticing your distress/how you felt?
    - *Prompts about attributes for noticing distress: sensitivity, sympathy, distress tolerance, empathy, non-judgement, care for well-being;*
- How did you help yourself to manage your distress?
    - *Prompts about skills for resolving distress, e.g. imagery, reasoning, behaviour, sensory, feeling, attention.*
- What might have got in the way of you helping yourself to manage feeling upset?
    - *Prompts about skills for resolving distress, e.g. imagery, reasoning, behaviour, sensory, feeling, attention.*
- What might have helped you in this situation?

The idea of being compassionate to the self can be difficult or uncomfortable for some people. Drawing on your experiences of being compassionate to yourself:

- What do you think about the idea of caring for your own wellbeing, or being empathetic to yourself?
- What opportunities do you have to care for your own wellbeing?
- What helps you to care for your own wellbeing?

- What gets in the way of your caring for you own wellbeing and being empathetic towards yourself?
- What are some reasons why you might choose to not care for your own wellbeing?
- What are some reasons why you might choose to not be empathetic towards yourself?

Allowing Compassion from others:

Similar questions to above, e.g.:

Can you bring to mind a situation where you have struggled with some aspect of being a new parent when someone close to you has been there/or told someone about a struggle you've had?

- Tell me what happened;
- What did that person(s) notice about your distress?
- What might have got in the way of others noticing your distress?
- How did others try to help you to manage feeling upset?
- What might have got in the way of you letting others help you with your distress?

The idea of receiving compassion from others can be difficult for some people. Drawing on your experiences of being receiving compassion from others;

- What do you think about the idea of others being empathetic towards you and caring for your wellbeing?
- What opportunities are there for others to care for your wellbeing?
- What helps you to be receive/accept empathy and care from others?
- What gets in the way of you receiving empathy and care from others?
- What are some reasons why you might choose to not allow others to care for your wellbeing/show empathy towards you?

Giving Compassion to Others:

Can you tell me about a time that you noticed someone else close to you struggling with some aspect of their life/being a parent.

- Tell me what happened;
- What did you notice about their distress?
- What might have got in the way of you noticing their distress?
- How did you try to help them with their distress?
- What might have got in the way of you helping them with their distress?

The idea of being compassionate to others can be difficult for some people. Drawing on your experiences of being compassionate to others;

- What do you think about the idea of being empathetic towards others and caring for their wellbeing?

- What opportunities do you have to be show empathy for others and care for their wellbeing?
- What helps you to be empathetic and care for others wellbeing?
- What gets in the way of you being empathetic and caring for others wellbeing?
- What are some reasons why you might choose to not be compassionate to others?

Appendix M – Sources of support sheet provided to signpost participants following completion of the study, if necessary.

Sources of support and information for new mothers

UNIVERSITY OF HULL

Best Beginnings

https://www.bestbeginnings.org.uk/

this website can offer you more information on how to support your own wellbeing as well as your children's long-term physical, mental and emotional development.

This website has an app named 'Baby Buddy' which is a free NHS-accredited app for smart phones that offers evidence-based information and self-care tools to help parents during pregnancy and early stages of parenting.
The app allows you to have access to a confidential, text-based Crisis Messenger which provides 24/7 support for new and expectant parents who are feeling extremely anxious or overwhelmed.

Baby Buddy App is available to all through Google Play and the App Store but is designed, in particular, for those who may not be in education, training or employment.

Association of Postnatal Illness

If you would like to access support for postnatal illness, you can call the Association of Postnatal Illness Helpline on:

0207 386 0868 (Mondays to Fridays between 10am – 2pm)

Alternatively, you can use the chat box on the bottom left of the website to engage in a live chat with a member of their team for support.

Netmums

Netmums offer peer support via their Maternal Mental Health Drop-In Clinic, which you can access on the following webpage:

https://www.netmums.com/coffeehouse/drop-clinic-984/maternal-mental-health-995/

24-hour National Domestic Violence Freephone Helpline

This is a completely confidential, nationwide service for women experiencing domestic violence, their family, friends and others calling on their behalf. Translation, facilities and service for callers who are deaf or hard of hearing are also available. You can access more information or speak to someone on a live chat on their website below:

https://www.nationaldahelpline.org.uk/

or you can call for free and in-confidence 24 hours a day on:

0808 2000 247

Samaritans

If you are struggling with your mental health and would like to speak to someone about it you can call Samaritans on:

116 123 (free to call and will not appear on your phone bill)

Should you have any specific issues regarding taking part in this study has raised then you can call the researcher on:

Email: h.cackett-2019@hull.co.uk

Phone: 07976071084

You can also seek advice from your GP, midwife or health visitor.

Appendix N: Author guidelines for submission to *International Journal of Qualitative Studies on Health and Well-being*

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Appendix O: Preliminary theme development and discovery of FBRs within each of the flows of compassion.

	Fears, Blocks, Resistances
Self-compassion	**Block: Care and household demands** • Demands of infants care • Demands of infant • Demands of being primary care giver • Demands of household • Putting infants needs before one's own • Demands of household • Infants needs are put first • Other demands are prioritised e.g. infant's needs, household tasks • Expectations or need to put infants needs above your own • Childs needs prioritised • Attending to infants needs first • Demands of household/caring • Feeling that others needs are more important that one's own. • Worrying about others wellbeing makes it hard to notice ones distress/attend to ones needs • Demands and responsibility to ones infant **Block: fatigue** • Tiredness • Lack of energy • Tiredness • Tiredness/lack of sleep • Tiredness **Block: Lack of support** • Lack of support – alone • Lack of support • Lack of support from others • Lack of support from others • Loneliness and isolation **Block: lack of time** • Lack of time

	• Lack of time, being busy • Time – block for not noticing own distress **Fear: Fear of judgement** • Fearing others judgement, fearing being perceived as struggling. • Judgement from others – enhances self-criticism. • Others expectations • External pressure/expectations to parent in certain ways (e.g. breastfeed) – often led to self-doubt self-criticism • Expectations that you must think of others before oneself **Resistance: feeling guilty about being compassionate to the self** • feeling guilty for not having done better, feeling undeserving of SC • Feeling guilty for taking time for self • feel guilt if self-compassionate/take time for oneself • Guilt about not tending to infants needs instead • Feeling selfish • believing SC to be selfish • Putting own distress aside in order to protect others from experiencing distress **Fear: being self-compassionate will mean that I am failing** • Comments from others leads to self-doubt, low self-esteem – fear that what others have said is true? • Expectations and hopes for self, wanting to be Super Mum, - stopped one from attending to and acknowledging their distress. Fear that attending to this would mean failure • Self-judgement – feeling like one 'should' be able to do this • Self-doubt • Expectations of self • Doubt of ones own abilities **Fear: being self-compassionate will lower my standards** • Self-compassion will lower my standards, not allow me to succeed/improve, not allow me to be the best • Perfectionism – wanting to have done the best, feeling guilty for not having done better • Putting pressure on self – perfectionism • Perfectionism • Putting pressure on oneself **Resistance: I am underserving of self-compassion** feeling undeserving of SC

	Feeling that one is undeserving of self-compassion as ones situation/distress is not as bad as others. **Block: compassion is not meant for the self** Self-compassion and self-appraisal is 'not right', narcissistic Belief that being self-compassion is self-centred, others are more worthy **Resistance: Self compassion is unfamiliar** • Finding self-compassion uncomfortable, frustrated by having to tend to one's own needs. • Unfamiliarity with self-compassion – makes it feel uncomfortable **Block: overwhelm and mental health** • Feeling overwhelmed with responsibilities. • Depression and anxiety • Depression and anxiety • Becoming overwhelmed by ones distress and self-criticism **Fear** that attending to my own distress and displaying this distress will impact on infants development and cause them to experience distress. Dismissing ones own feelings as due to hormonal changes Being isolated during the pandemic – lack of drive to care for oneself
Receiving/accepting compassion from others	**Resistance: Others do not understand my distress** • Others not understanding • Others not understanding • Belief that others don't understand ones distress/struggles – therefore conceal distress from them • Others not understanding • Feeling that others do not understand ones difficulties, unshared experiences **Resistance/fear: accepting compassion will mean I am not independent** • Wanting to be independent • Wanting to remain independent – threat to identity • Desire to remain independent • Wanting to remain independent – accepting compassion would suggest I need others help • Desire to be independent, if I accept compassion from others I will not learn from my mistakes • Wanting to remain independent manage it alone **Fear: being a burden to others** • Fear it would annoy others

	• Fear of being a burden to others • Fear of inconveniencing others/being a burden • Feeling guilty for burdening others **Fear: that others will think I am not coping** • Fear that others will think one is struggling, wanting others to think one is coping • Fearing that one will appear weak and struggling/wanting to appear strong and independent – threat to one's identity. • Fear that others will think you are a failure, wanting to appear as coping • Fears that accepting compassion and support means you're doing it wrong • Fear of appearing weak/vulnerable • Fearing being seen as a failure • Feeling like a failure if one is given compassion from someone else • Fear that accepting compassion from others means we are struggling • Fear that accepting compassion means that I'm struggling • Fear that accepting compassion means one needs help **Fear: fearing others judgement** • Concealing distress from others due to fear of dismissal of feelings or judgement • Fearing that others will judge/respond negatively if you express your distress • Fear of appearing unappreciative • Fear of judgement • Fear of judgement from others – 'bad mum' • Fear that others would think one is inefficient, incapable – fear of judgement • Fear of others seeing you as weak, or perceiving self as weak • Fear that others will not think you are strong and capable • Fear of judgment from others – thinking you are a bad parent • Fear others will see one as ungrateful, as not all acts of compassion is helpful **Resistance: receiving compassion in unfamiliar and uncomfortable** • Experience is uncomfortable due to be unfamiliarity with receiving compassion. • Resisting due to unfamiliarity with receiving compassion **Fear/resistance: uncertainty about the persons intentions** • Feeling unable to trust that person

	• Not being close to the person giving compassion (close friendship)/ not trusting the person – fearing their intentions and how genuine they are. • Feeling unsure if they are being compassionate or feeling sorry for you. Fearing that others are taking pity on you. • Fearing their compassion is not genuine, fearing their true intentions. • Fearing that others will use it against me in the future. **Resistance: feeling undeserving** • Feeling like one should have done better as a mother and therefore does not deserve compassion • Guilt – feeling undeserving • I am undeserving of others compassion because I should have done better • Feeling that it is ones own fault that one is distressed • Resisting accepting compassion because one feels like there are others who would benefit more from it instead. • I should have done better – accepting compassion will not change the fact that I should have done this better **Fear: that accepting compassion means I will fail and lose control** • Fearing that accepting compassion would mean losing control/not staying on top of things • Fearing being out of control, • Wanting to be the perfect mother – and do it all. • Wanting things to be done perfectly - perfectionism • Fear of not being in control, and things going wrong if not in control • Embarrassment – wanting others to perceive self as supermom • Accepting compassion will not allow me to improve/succeed/progress • Fearing that accepting compassion means I have failed as a mother • Rejecting others compassion because of a strong desire to remain in control • Fear that accepting compassion will reveal my inadequacies, others think I'm not coping, incapable – desire to prove one is a good mother • Fear that accepting compassion will mean I will lose control of the situation • Feeling patronised, inferior. **Blocks: geographical distance** • Others not able to notice distress due to distance, lack of in person contact/communication • Distance/proximity from family and friends

	Fear: being let down by others • Fear of being let down/abandoned • Fear of being let down, easier to do it myself **Resistance: accepting compassion is embarrassing and shows weakness** • Pride • Belief that accepting compassion from others is embarrassing – shows that one is weak/vulnerable **Fear: if I others notice my distress, it may distress them** • Concealing distress to prevent others from being impacted by ones distress – not wanting them to worry • Concealing ones distress from others to prevent others distress/worry **Fear: others will dismiss my distress** • Fear of others not validating ones feelings/distress • Rejecting compassion because I have the right to be distressed, fearing that their compassion will dismiss how I feel Not being given the choice to accept/reject compassion.. the way compassion is offered. When others do not acknowledge that I may be uncomfortable with accepting their compassion.
Giving/being compassionate to others	**Block/resistance: being unable to relate, unshared experiences** • Not knowing what to say • Not being able to relate to others distress • Not being able to relate **Fear: others will reject my compassion** • If compassion is regularly rejected – fear of rejection • Fearing others will reject your compassion • I might say the wrong thing **Blocks: care demands** • Demands of caring for infant • Demands of caring for infant • Caring demands of infant • Mind is preoccupied with other demands – infant, work etc. • Infants needs are prioritised

	Blocks: fatigue • tiredness • Tiredness • Lack of energy • Tiredness • Tiredness • Lack of energy/exhaustion **Block: lack of time** • Lack of time • Lack of time – being busy • Lack of patience • Lack of time to notice others distress • Lack of time/patience **Fear: being compassionate to a person's distress, may cause me to take on their distress** • Fearing that offering compassion may lead to one taking on others distress **Fear: compassion will not be reciprocated** • Fearing/believing that your compassion would not be reciprocated from the other person – fairness • Compassion not reciprocated **Fear: how others may perceive my compassion** • Fearing others may perceive it as patronising or interfering • Fear sounding ingenuine/fake **Resistance: 'bigger fish to fry'** • Feeling that one's struggles are greater than others, therefore others distress is not as deserving of compassion/limited resource which is needed more for oneself • Resist giving compassion if other more important things are happening in one's own life • One's own stress Others: Hormones Geographical distance