Motherhood should not be this hard: Women seek relational care from their perinatal health providers

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Abstract

Mothering practices and underlying understandings of motherhood can vary with cultural, class, societal, and temporal contexts. In Aotearoa New Zealand, the Western-dominant construction of motherhood, known as intensive mothering, is child-centred and places the responsibility of child-rearing primarily on mothers. Poor mental health outcomes for mothers, and mental health inequities between mothers and non-mothers are rising; in Aotearoa New Zealand, this effects between 12 to 19 percent of mothers; likely higher for Māori women. The purpose of this study was to explore four cases to exemplify how new mothers navigate motherhood. With particular focus on how the dominant constructions of neoliberalism and managerialism, motherhood, disease and repair, and health and illness, transmitted through public organisations, influenced their identities and experiences. I further investigated whether the Aotearoa New Zealand health system is serving economically privileged, Pākehā women who have historically had more positive health outcomes than Māori women. This research was conducted using case-based narrative inquiry enacted through semi-structured interviews and participatory mapping to support the participating mothers to express their experiences in the contemporary health system. Findings suggest that not only is the health system not serving Pākehā mothers but also features what participants described is a Kafkaesque bureaucracy which obstructs the provision of quality healthcare and may have negatively contributed to their mental health during the perinatal period. Participants rejected the service providers which fell short of their expectations and instead opting for clinicians with whom they had a connection, and providers grounded in relational values. These findings have implications for how motherhood is understood in Aotearoa New Zealand and offer insights that support the need for implementing more person-centred healthcare support for mothers.

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Chapter One: Introduction

Motherhood is a complex phenomenon; despite the universality of women becoming pregnant and birthing babies, mothering practices and underlying understandings of motherhood can vary with cultural, class, societal, and temporal contexts (Hays, 1996). Effective child rearing can be as much an exploratory art as the application of insights from the human and physical sciences. Societal and cultural understandings of motherhood include expectations for women as to how they should behave; if and when a woman falls short of those expectations, the weight of the failure can have a profound effect on her wellbeing. Moreover, Neely et al. (2023) argue that motherhood is a determinant of health; and the Western-dominant construction of motherhood is contributing to rising poor mental health outcomes for mothers, and mental health inequities between mothers and non-mothers. McGovern et al. (2022) argue that maternal depression is a public health issue that impacts the quality of life of the mother and child. "Birthing and raising children impacts on physical, mental, social, and spiritual health across the maternal lifecourse" (Neely et al., 2023, p. 2). It has been estimated that in Aotearoa New Zealand, between 12 to 19 percent of mothers, and 10 percent of fathers develop depression, anxiety, or other poor mental health outcomes during the perinatal period, the period between conception and one year after giving birth (Ministry of Health, 2021). The Ministry of Health (2021) believe this figure to be higher for Māori (Indigenous people of Aotearoa New Zealand), Pacific, and Asian populations, similar to other health outcomes in Aotearoa New Zealand. Maternal risk factors for perinatal depression include history of mental illness; lack of social and practical support; previous traumatic experiences including childhood trauma and stressful life events; and history of alcohol or drug abuse (Neely et al., 2023). The Perinatal and Maternal Mortality Review Committee's (2024) Annual Report shows maternal mortality rates and specifically death by suicide is higher in Aotearoa New Zealand than in the United Kingdom and Australia, though the ethnic inequities are similar proportions. Globally, maternal suicide is the second most common cause of death during the postnatal period, attributed to up to one third of deaths.

Like motherhood, it is both true that bodies can become diseased and may repair, and social constructions of health and illness influence a person's self-concepts and their positions within society. With notable enclaves of public health and social medicine, and considerable innovations regarding broader cultural understandings of health and illness, the Aotearoa New Zealand health system is grounded in the Western biomedical construction of disease and repair and upheld by managerialism. This construction largely replaced Māori medicine following colonisation in the 19th century. “Cultural health beliefs and models of illness help determine the perceived importance of symptoms and the subsequent use of medical resources” (Wade & Halligan, 2004, p. 1398). The construction of disease and repair influences whether a person's experience of illness is validated as caused by disease, whether they are eligible to access healthcare, and whether they can enter or leave the sick role.

This thesis explores how four *Pākehā* women (non-Māori women living in Aotearoa New Zealand) experienced matrescence and motherhood within the temporal and cultural construct of 2024 Aotearoa New Zealand. Focusing on experiences and how participants construct their sense of motherhood, gives us insights into the social construction of their perspectives. Their experiences provide valuable insights into the factors that contribute to the health and wellbeing of new mothers. This introductory chapter begins by exploring the history of social constructions of childhood and motherhood. Starting by describing what we know of childrearing from hunter-gatherer groups, which scholars infer may be a representative example of pre-agricultural and pre-industrial child-rearing; and examining Māori child-rearing prior to the British colonisation of Aotearoa New Zealand. This is followed by a description of present-day mothering and child-rearing constructions and practices, starting at the turn of the 20th century when Western governments began investing in children and intervening in the home. A description of Māori resistance to Western-dominant childrearing practices will be included. Next, is a discussion of the transitional period of matrescence, and the health outcomes attributed to motherhood (Neely et al., 2013). This is positioned in relation to the provision of healthcare within the Aotearoa New Zealand health system. I use Māori healthcare as an example of person-centred care in Aotearoa New Zealand, available to all ethnicities of new mothers and their *whānau* (family), and as a counterpoint to the services provided by the Western-dominant institutions. The chapter concludes with the importance of studying women's experiences of motherhood and matrescence, and how different constructions of motherhood, disease and repair, and health and illness may influence their experiences and mental health outcomes. A brief overview of the thesis will also be provided.

Constructions of Motherhood

Studies of the childrearing practices of contemporary hunter-gatherer societies provide what Bridgers & Fox (2024) argue is typified of human evolutionary history. Evidence suggests that humans evolved to rear their children cooperatively, which includes the presence of allomothers. Allomothers refer to any person other than the child's mother who participates directly in their care, including fathers, grandmothers, older children, other kin, and non-kin. Allomothers help with childcare, feeding the family, and household chores. As an example, the Efe, a small-scale group of nomadic hunter-gatherers located in the Democratic Republic of Congo, depend on allomothers for 39 percent of a baby's physical contact at three weeks old, and 60 percent at eight weeks old, and nonmaternal breastfeeding is common. Bridgers & Fox (2024) theorise that lack of social support for mothers living in post-industrial societies is one factor contributing to the increased prevalence of negative maternal mental health outcomes. Māori childrearing constructions were dominant in Aotearoa New Zealand prior to colonisation. When the British Crown colonised Aotearoa

New Zealand in the 1800s, they systematically repressed what Simmonds (2016) terms as Māori maternal knowledges and practices, with respect to the diversity and complexity of Māori *iwi* (tribe), *hapū* (subtribe), and *whānau* (family) and their practices. Simmonds (2016) describes Māori maternities as embodied women practicing maternal knowledge and imparting this knowledge to subsequent generations. Maternal knowledge was also disseminated through storytelling, songs, and ceremonies. In creation stories, the maternal body is inextricable from the land and natural environment (Simmonds, 2016). Moreover, in *te reo Māori* (the Māori language) *whenua* means both land and placenta. In Māori culture, one's placenta is taken to the earth to nourish the land, just as it has nourished the baby in the womb. It also solidifies a connection to the whenua so that the child can return to the land and know it is their home. Likewise, the word whānau means both family and to be born. Te reo Māori does not include gendered pronouns, and the term 'mother' is not exclusive to women who give birth to a child; mother is attributed to all women in one's mother's generation, known to the child. This is the same for men of one's father's generation; they all have responsibility toward the child and the child toward their elders (Simmonds, 2016; Neely et al., 2023). Whānau emphasises collective responsibility for childrearing, a vastly different construction to the Western-dominant construction of motherhood in Aotearoa New Zealand today, transported through British colonialism in the 19th century.

Childrearing today is an individual pursuit, the responsibility and result of which are overwhelmingly placed on the shoulders of the mother. Scholars trace the Western-dominant construction of motherhood from Western Europe at the end of the Middle Ages, however for the purposes of this study, the most significant political, economic, and social changes began with the era of government intervention at the beginning of the 20th century. In 1900, Ellen Key, an early advocate for child-centred parenting and education, declared the 20th century to be the "Century of the Child." She emphasised children's autonomy, and the influence of parents and society on how they are reared, including the development of their moral character (Key, 1909). During this century, Western governments did begin to prioritise investment in institutions and campaigns focused on child welfare, education, and health. Industries were built to cater for children's needs and desires, and new fields of research were established to better understand children's physical, psychological, and cognitive development (May, 1999). During the early part of the century, children became a subject of state intervention, with the idea that investing in state health and education would produce useful adults and prevent social disorder (Hays, 1996). These institutions had profound impact on the social construction of childhood and in turn motherhood (May, 1999). In Aotearoa New Zealand, the Royal New Zealand Plunket Society (Plunket) was founded in 1907, by Dr Truby King during the infant welfare movement. King believed that although motherhood was natural, mothers needed to learn motherhood to successfully regulate their children. Such regulations included routine-based feeding and sleeping, exclusively breastfeeding, and self-reliance from an early age (Cox, 1996). By the 1930's however, the rigidity of King's advice fell out of favour; a new group of childrearing experts, such as Anderson and Mary Aldrich (1938), encouraged mothers to indulge their children, arguing that love and affection, and individual feeding and sleeping schedules were in the best interest of their children. This era of childrearing, known as the permissive era, focussed on the needs and desires of the child, above the good of their family or country.

During the mid-twentieth century, the concept arose that children were more than just small adults and had their own psychological and cognitive developmental stages (Hays, 1996). Psychologists such as Freud and Erikson began to weigh in on childrearing, arguing for infant and young children's natural antisocial tendencies to be seen as natural and not in need of correction (Wolfenstein, 1955). Furthermore, new research into mother-child attachment was shown to be integral to child development and at the same time overindulgence was considered a hostile act and likely to cause a number of childhood disorders, such as autism. For example, journalist Phillip Wylie, coined the term "momism" in 1942 as a derogatory term, attacking mothers of America as being:

> So smothering, overprotective, and invested in their kids, especially their sons, that they turned them into dysfunctional, snivelling, weaklings, maternal slaves chained to the apron strings, unable to fight for their country or even stand on their own two feet (Douglas & Michaels, 2004, p. 4).

Mothers once again were tasked with creating well-adjusted citizens, though working mothers were looked down upon as delinquent (May, 1999). This pressure to be perfectly affectionate, but not too affectionate, and never dismissive, put women in a situation where they were expected to rear socially desirable children, but would be held responsible if their child did not live up to this high bar.

One of the most influential childrearing figures of the twentieth century and of the permissive era was Dr Benjamin Spock, author of Baby and Child Care (1946), released just after the end of the second world war to guide mothers of the baby boom. Baby and Child Care incorporated Freud and Erikson's psychoanalytic theories and the child-centred, developmental stage approaches of the Aldriches. The book included information on physical and psychological development and provided guidance on daily care and routines. He encouraged mothers to always consult their doctors, and to "Trust yourself. You know more than you think you do" (p. 3). During this same era, both during and after the war, economically privileged women began to enter the paid workforce in droves and were faced with the cultural contradiction of working in the individualistic, competitive public sphere, while maintaining a safe harbour for their husbands and children within their homes. This dual role, known as the 'second shift,' acknowledges that women's roles as wives and mothers did not reduce once they entered the paid workforce, that they merely had less time to accomplish what was required of them at home (Hochschild & Machung, 1989). Some researchers have challenged the assertion that women do more work overall than men, when including both paid work and unpaid work at home (Robinson & Godbey, 1997; Bianchi et al., 2006). However, Craig (2007) conducted a study using the Australian Bureau of Statistics *Time Use* Survey to calculate total paid and unpaid workload of men and women, including time spent multitasking, such as with childcare and domestic tasks. When multitasking is included in the calculation, it shows women do more overall work than men. This illustrates the mounting pressure women faced as mothers as they entered the workforce.

Remaining influential through the 1980's, Spock and his contemporaries insisted that childrearing could be completely separated from the pursuit of self-interest in monetary gain of the neoliberal era. Neoliberalism argues against government intervention in economic and public life, to allow for natural market forces of supply and demand to optimally distribute resources within society, improving the wellbeing of all (Navarro, 2007). They asserted that a mother in paid employment could learn to be efficient, if not ruthless in the workplace, as well as flexible, warm, and completely engrossed in her childrearing duties at home (Leach, 1986; Brazelton, 1983). Sharon Hays (1996) wrote a book about this expectation of mothers called ‘The Cultural Contradictions of Motherhood,’ in which she explains:

> The same society that decimates an ideology urging mothers to give unselfishly of their time, money, and love on behalf of sacred children simultaneously valorises a set of ideas that runs directly counter to it, one emphasizing impersonal relations between isolated individuals efficiently pursuing their personal profit (p. 97).

Hays (1996) further coined the term "intensive mothering" to describe what she observed as the prevailing construction of motherhood in Western-dominant countries:

> The model of intensive mothering tells us that children are innocent and priceless, that their rearing should be carried out primarily by individual mothers and that it should

> be centered on children's needs, with methods that are informed by experts, labor-intensive, and costly (p. 21).

Since Hays conceptualized intensive mothering, feminist scholars have further explored the construction. For Das (2020), intensive mothering is part of a gendered, neo-liberal value, where mothers should take individual responsibility for their children, above and to the detriment of their own needs. Moreover, Sutherland (2010) found that intensive mothering is related to negative mental health outcomes for mothers. But mothers persist in adhering to this construction of motherhood because they think it makes them better mothers, even with the risk to their own wellbeing. O'Reilly & Caporale Bizzini (2009) condense intensive mothering into three interconnected themes:

> The first defines mothering is natural to women in essential to their being. Second, the mother is to be the central caregiver of her biological children, and thirdly, children must require full time mothering, or in the instance where their mother must work outside the home, the children must always come before the job (p. 241).

Unlike Hays (1996) who traces the origin of intensive mothering to the permissive childrearing era following the second world war; O'Reilly & Caporale Bizzini (2009) argue that intensive mothering emerged as a dominant construction of motherhood in the 1990s. They claim that although women were expected to stay at home with their children following the war, the demands on their time and effort were minimal compared to what was expected of mothers in the 1990's. Of intensive mothering Douglas and Michaels (2004) observe:

> Mothers today cannot just respond to their kids' needs; they must predict them--and with the telepathic accuracy of Houdini. They must memorize verbatim the books of all the child-care experts and know which approaches are developmentally appropriate at different ages. They are supposed to treat their two-year-olds with "respect." If mothers screw up and fail to do this on any given day, they should

> apologize to their kids, because any misstep leads to permanent psychological and/or physical damage. Anyone who questions whether this is the best and the necessary way to raise kids is an insensitive, ignorant brute. This is just common sense, right? (p. 5)

Douglas and Michael's tongue and cheek appraisal of intensive mothering takes the reader to the heart of the issue: the job of a mother is demanding and continues to demand more of women as information and technology becomes more accessible. Intensive mothering in the 21st century necessitates not just being in proximity to one's children, but that mothers spend time on the floor playing and reading with their children; attending classes from infancy; creating nutritious and ascetic meals; enrolling them in extra-curricular activities that cost time and money; interviewing early childhood education providers and external caregivers; volunteering at playgroups; and in classrooms; and consulting experts and reading child development literature. Furthermore, the percentage of mothers in paid employment continues to increase; between 1994 and 2014 in Aotearoa New Zealand there was an increase of partnered mothers in the workforce by 7.8 percent, and sole mothers by 23 percent, compared to 1.9 percent for women with no dependent children (Flynn & Harris, 2015).

Māori childrearing has evolved since colonisation with social and structural policies impacting cultural knowledge and practices. Ernest and Pearl Beaglehole, pioneers of the culture and social personality movement in Aotearoa New Zealand, conducted ethnographic research with Māori in the mid-twentieth century. They wrote about a Māori community struggling to maintain their identity while undergoing rapid urban change. They describe how the community transmitted their values and practices through the processes of enculturation, emphasising the importance of multi-generational relationships (Beaglehole & Beaglehole, 1946). In the 1950's, James Ritchie and later Jane Ritchie continued the Beaglehole's work with Māori communities, developing what Nikora (2007) describes as "one of the most sophisticated Māori values frameworks for operating in the Māori world and for understanding Māori culture" (p. 67). Ritchie presents five of the most dominant aspects of valuing: *whanaungatanga* (whānau or body of close kin), *rangatiratanga* (leadership and authority), *kotahitanga* (connection and unity), *manaakitanga* (the process of showing respect, generosity, and care for others), and *wairuatanga* (spirituality). The Ritchie's documented Māori and Pākehā childrearing patterns over a period of 40 years and describe the consistent Māori childrearing practices that they observed over their decades of research (Ritchie & Ritchie, 1997). A child is cared for by multiple generations who have parenting responsibility; this process which they refer to as 'multiple parenting,' provides support to the parents and the child, and exposes the child to a variety of personalities and ways of caring for others. Babies are indulged, whereas when a child starts to exhibit independence, they are encouraged to socialise and depend more on their peer groups. Peer socialisation allows children to learn about the values of consensus and inclusivity and how to adapt to a horizontal power structure (Ritchie & Ritchie, 1997). Colonisation and the Crown's continued discriminatory policies, attempted to systematically repress Māori knowledge. Throughout history, the most visible and influential constructions of childrearing in Western-dominant countries are those of economically privileged, white families, and the constructions of childrearing practiced by other cultures and social groups within those countries are often regarded as inferior (Hays, 1996). However, in the Ritchie's final book summarising Māori childrearing patterns over the 40 years in which they conducted their research, they conclude:

> Our research has shown that for all the difficulties, urban Māori families retained a style of childrearing from which has now emerged a variety of urban lifestyles which in various ways continue to express basic Māori cultural patterns. . . Even where there is no demonstrable kinship, kin-like bonding is strong. Tribe-like, in-group

> loyalties are 'staunch'; parenting responsibilities are shared to promote a sense of 'we' rather than 'me' (Ritchie & Ritchie, 1997, p. 192).

The Ritchies found that when Māori mothers who moved into urban settings still sought multiple parents for their children and encouraged them to seek out relationships with cousins and other Māori children living locally (Ritchie & Ritchie, 1970). In comparison with intensive mothering which values self-reliance, Māori childrearing is inherently relational.

In this section I have shown the Western-dominant cultural evolution of motherhood and how it led to intensive mothering. Intensive mothering coupled with paid employment demands perfection from women as they negotiate two vastly different roles. As a counterpoint, I explored Māori mothers' resistance to intensive mothering, in the way they maintain cooperative childrearing practices and promote collective values. Next, I will discuss the process women undergo when they become mothers; a major life course transition termed matrescence.

Maternal Wellbeing

Matrescence

Entering the perinatal period places women in new social and political positions with dominant and public policy measures straddling the private and public spheres. Das (2020) explains, early motherhood is placed “under the scrutiny of public and policy microscopes in rapidly successive ways, commensurate with the rapidity of foetal and infant development in the first year, which are not necessarily true for subsequent stages of motherhood” (p. 4). What many women and couples may consider private, such as conception and infertility; pregnancy and birth; and parenting decisions, become cause for public scrutiny (Das, 2020).

During the perinatal period, women experience matrescence; a transition, similar to adolescence, in which women undergo psychological, biological, and social changes as they become mothers (Raphael, 1975). During matrescence, women's brains undergo significant changes, more so than any other time in their life course (Gritters, 2020). "Mummy brain" or "pregnancy brain," is characterised by a pregnant woman’s or a new mother's forgetfulness as the result of these changes. Hoekzema et al. (2017) conducted Magnetic Resonance Imaging (MRI) scans, detailed images of the brain structure in 25 first-time mothers before pregnancy and again a few weeks after they gave birth. These images were compared to the brain MRI images of 20 women who had not given birth. The women who had given birth had pronounced biological changes in their brain; their grey matter had reduced in some areas, including the hippocampus which regulates memory. Moreover, their brain structure did not return to normal for up to two years post birth. The authors theorise that the brain of new mothers may allocate resources to parts of the brain that control theory of mind, which allows one to anticipate and respond to someone else's needs. Furthermore, the psychological changes women experience during matrescence is considered a maturation process, during which they develop a new self-concept as mothers. This change can be the most difficult due to unmet expectations of their birth process, and the perception of being unprepared for the demands of motherhood. This is particularly acute during the initial postnatal months when caring for an infant can be both physically and emotionally exhausting (Nelson, 2014). Barclay et al.'s (1997) grounded theory study shows women felt overwhelmed by what was expected of them during the first few months of motherhood. These psychological changes, and cultural expectations of mothering, in addition to other risk factors can contribute mental distress during matrescence.

Mental health

A certain degree of mental distress is expected during matrescence (De Sousa Machado et al., 2020). Some new mothers are affected by hormonal changes during pregnancy and can become distressed during the first four to six weeks of their postnatal period. This distressed state, known as baby blues, effects more than 80-85 percent of new mothers. If baby blues continues for more than 14 days, this increases the risk of postnatal depression (Appolonio & Fingerhut, 2008). Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) defines postnatal depression as a major depressive disorder that begins during pregnancy or within four weeks of giving birth. The diagnostic criterion for a major depressive episode includes depressed mood; diminished interest in activities previously enjoyed; significant weight loss; sleep disturbances; psychomotor agitation or retardation; fatigue; feelings of worthlessness, or inappropriate or excessive guilt; diminished ability to think or concentrate; and recurrent thoughts of death. For a diagnosis of major depressive disorder, five or more of these indicators must be present nearly every day, for a period of two weeks, and depressed mood or loss of interest must be present (American Psychiatric Association, 2013).

Yu et al. (2024) conducted a nationwide population-matched cohort study in Sweden to examine the relationship between postnatal depression and risk of short term and long-term suicidal behaviour. The study included 86,551 women with a diagnosis of postnatal depression from 2001 to 2017 and 865,510 women without a diagnosis, individually matched on age and calendar year at birth. They found that women with postnatal depression were three times more at risk for suicidal behaviour during the first year after diagnosis and two times more at-risk throughout the next 18 years of the researchers' follow-up period. They conclude, "This highlights the pressing need for vigilant clinical monitoring and prompt intervention for this vulnerable population to prevent such devastating outcomes, regardless of pre-pregnancy history of psychiatric disorders" (Yu et al., 2024, p. 9). Furthermore, Hagatulah (2024) conducted a register-based study with the same dataset to determine whether women with perinatal depression were at greater risk of death than women without perinatal depression, including sisters to account for familial factors. They found that even after accounting for siblings, women with a diagnosis of perinatal depression had an increased risk of death by suicide. The risk was highest during the first-year post diagnosis, with 28.5 percent of deaths as a result of suicide, compared with 7.5 percent of suicide deaths for women without perinatal depression. Moreover, 20,000 women with perinatal depression were three times at risk of suicidal behaviour then their sisters without the diagnosis. The authors argue that depression has a stronger association with suicidal behaviour than genetics or childhood environment.

Protective factors against major depressive disorder include strong social support and practical support; early intervention; primary and community support services for mild to moderate distress; and specialised services for moderate to severe mental health concerns. Interventions should be whānau inclusive and address environmental and situational risk factors (Ministry of Health, 2021). Small et al. (1997) asked depressed mothers why they thought they were depressed, and the most common responses were related to a lack of support and/or feelings of isolation. When asked what advice they would give to new mothers with postnatal depression, the most common suggestion was to find someone they could talk to. Social relationships which provide social support are shown to promote wellbeing (Leahy-Warren, 2018). Perinatal social support requires people from one's formal and informal social networks, who can provide informational, emotional, appraisal, and instrumental support through pre-pregnancy, pregnancy, and motherhood (Leahy-Warren, 2018). Formal social support is usually provided by health and social services; and informal support comes from whānau and friends (Schobinger, 2022). Perinatal social support should be individualised, aligned to a woman's needs and expectations, and provided by friend's, whānau, health and social service providers who have a genuine connection with and respect for the mother to facilitate the best outcomes (Leahy-Warren, 2018). I will now describe constructions of disease and repair, and health and illness that are prevalent in Aotearoa New Zealand. These constructions can have a profound influence on women's experiences of matrescence.

Constructions of Health

Biomedical healthcare, Neoliberalism, & Managerialism

The biomedical construction of disease and repair is grounded in dualism, Rene Descartes' theory that the natures of mind and body are completely different and could each exist by itself. In its historical and purist form, the biomedical construction assumes that health is the absence of disease; and all disease can be attributed to one or more physical malfunctions; and resolving these malfunctions will return a person to good health (Rocca & Anjum, 2020). It is grounded in reductionist ontology that all higher-level phenomena and processes like social relations, or psychology can be explained by lower-level phenomena and processes, such as biology, chemistry, and physics. In other words, it is a view of disease and repair that “reduces human conditions to merely the sum of their constituent parts” (Rocca & Anjum, 2020, p. 83). The biomedical construction has been critiqued as reductionist because it interprets illness as physical and biological, unchanged by context. Rocca & Anjum (2020) argue that the biomedical construction positions the patient as an object of disease, a passive actor without agency. For example, the biomedical construction does not account for illnesses that do not present with physical or biological disfunctions, which nevertheless cause disruptions to the day-to-day lives of many people. The scientific advances of modern medicine have made an incredible impact on the quality and longevity of the human life; however, once a phenomenon is categorised as biomedical, a biomedical solution is sought (Rocca & Anjum, 2020). Furthermore, like intensive mothering, the biomedical construction requires people to seek the assistance of experts with medical knowledge when they are ill; but also upholds the neoliberal values of individual responsibility and self-reliance, which holds people responsible for their own health.

Neoliberalism is an ideological critique of government intervention in the market economy, arguing the only role of government is to ensure the free market can function efficiently. There are three assumptions of neoliberalism that have far more reaching effects on society than mere economics. (1) individualism is the notion that people are inherently self-interested, without concern for others or the natural environment; (2) free market via privitisation and deregulation i.e., limiting government intervention in society; and (3) decentralisation, transferring central state power and responsibility to smaller, local government entities to better respond to local needs (McGregor, 2001). Furthermore, public good and collective responsibility are replaced by individual and familial responsibility. "Advocates of neoliberalism believe in pressuring the poorest people in a society to find their own solutions to their lack of healthcare, education and social security" (McGregor, 2011, p. 84). Moreover, neoliberalist dismiss social policies targeting certain groups, viewing them as preferential as only certain people may benefit, instead they assume that the free market will provide for all. As McGregor succinctly states:

> Nowhere in neoliberalism is there a legitimate role for the welfare of people, communities or societies, or for the state, except to ensure that government enforces the rules and logic of the free market – economic profit, technological progress and growth and development (p. 84).

Relevant to this study, public services that provide healthcare are seen as limiting economic growth and stymieing competition and innovation. Neoliberalists assert that private businesses are better at providing services than government; they argue private healthcare gives people choice in the kind of healthcare they receive and empowers them to be responsible for their own health (McGregor, 2001). However, McGregor (2001) argues that abolishing public healthcare reduces health equity and quality, putting at risk the health of people and groups that cannot buy into private healthcare.

Managerialism aligns with neoliberalism, in that it is concerned with low cost and efficient organisational structures (Kilkauer, 2013). Originally a fixture of private enterprises, managerialism has permeated public organisations and was later adopted by neoliberal governments striving to run public sector organisations more efficiently. Komesaroff et al., 2015) describe two tenets of managerialism: (1) all public organisations must adopt a single, prescribed structure; (2) corresponding to the neoliberal principles of free market and deregulation, all public organisations must conform to the regulatory principle of the free market. In an open rebuke the Royal Australasian College of Physicians, Komesaroff et al. (2015) describe the downsides of managerialism:

> The principle of the market has become the solitary, or dominant, criterion for decision making, and other criteria, such as loyalty, trust, care and a commitment to critical reflection, have become displaced and devalued. Indeed, the latter are viewed as quaint anachronisms with less importance and meaning than formal procedures or standards that can be readily linked to key performance indicators, budget end points, efficiency markers and externally imposed targets (p. 519).

In practice, public organisations are stripped bare; in the case of healthcare, this equates to staff-cuts and increased caseloads. Key performance indicators based on efficiency and resource management, and rigorous monitoring, such as reduction in bed stays. Managerialism places the administration of public organisations in the hands of managers, with exclusive managerial knowledge, rejecting the input of subject matter experts, like skilled clinicians, and creating a division in value systems (Komesaroff, 2015). True to Kafka's critique of bureaucracy, managerialism places systems before people, creating a series of dysfunctional practices, over which clinicians and patients have very little control (Clegg et al., 2016). Wong (2015) noted the values struggle in his study of managerialism and nursing, "the ideas and philosophies based on the care and wellbeing of patients compete for position against a hard-nosed community of managers, accountants and politicians" (p. 5). Here he describes the dichotomy that clinicians face balancing the wellbeing of patients within the constraints of the health system. Without being able to fully care for their patients, clinicians are often restricted to providing a biomedical service.

Person-centred healthcare

In critique of the Cartesian worldview which produced the biomedical construction of disease and repair, Merleau-Ponty argues our bodies are how we engage with the world, but our experience of the world is not limited to our bodies, and therefore our body and mind are inseparable (Gold, 1985). George Engel (1977) proposed the biopsychosocial construction of health and illness, which acknowledges that not all diseases have a recognisable biological cause and treatment, and that psychological and social factors may influence a patient's beliefs, behaviours, and how they experience illness. It recognises that higher level phenomena and processes can have a causal effect on lower-level phenomena: one's social and psychological wellbeing can influence their physical state. Rocca & Anjum (2020) conclude that the "biomedical model, based on the exclusive treatment of physical constituent parts cannot provide the correct concept of human suffering and healing, and consequently cannot guarantee effective healthcare" (p. 81). Consequently, in biomedical healthcare, capturing a person's psychological and social contexts is difficult, with each level evaluated by different clinicians and treated in isolation from each other. They are not captured as a "whole person" as Engel imagined.

While co- and multi-morbidity is the norm in medicine, clinical guidelines are for individual illnesses. "The 'guidelines mentality' often results in a situation that has been referred to as *silo medicine*... where each diagnosis has its own expert groups, patient organisations, industry sponsors and clinical guidelines" (Anjum, 2016, p. 423). The biopsychosocial construction attempts to integrate the psychological (the psycho) and the environmental (the social) into the traditional biomedical (the bio) aspects of health. This approach realises the relationships between people and their peer groups, whānau, communities, schools, workplaces and broad economic, social, cultural, and physical environmental conditions at the local, national, and global level, and their impact on individual health outcomes. Wong (2004) critiques the implementation of the biopsychosocial model, questioning the efficacy of healthcare provision within a political environment that promotes individual responsibility. "It is not what happens, or even what we do to our bodies, which produces ill health, but the sort of people we are" (p. 2). In practice, people are responsible for their own health outcomes, and their recovery can be relegated to the private sphere to reduce strain on public resources.

The person-centred care construction of health and illness yields further critique of the biomedical construction. Person-centred healthcare also empowers people to take an active role in their healthcare, but in partnership and through shared decision-making with their clinicians. It encourages involvement of family members; focuses on gaining knowledge from each level of the person, (biological, social, psychological, etc.); and prioritises building and maintaining trusting relationships between a person and their clinician, who coordinate and provide continuity of care across the person's life course (Kumar & Chattu, 2018). The World Health Organisation (2016) framework on integrated, people-centred health services argues that the biomedical construction has undermined health systems' abilities to provide responsible care that meets the needs of the communities they serve. However, an integrated, people-centred approach can respond to varied and emerging health challenges; while improving access to care, clinical outcomes, increased satisfaction for both patients and clinicians, and efficient, and cost-reduced services. They envision that:

> All people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment (p. 4).

Treating the whole person requires an ontological shift; internal, external, and contextual causes of illness must be considered as all levels affect and are affected by health and illness. Person-centred healthcare prescribes:

> Each individual is recognized as a unique person with distinct goals, needs, and preferences which is very important in providing the long-term services and supporting the medical care system. It also highlights the importance and impact of social, mental, emotional, and spiritual needs apart from diagnosis, physical, and medical needs (Kumar & Chattu, 2018, p. 487).

McCormack and McCance (2016) argue that person-centred care is widely espoused in healthcare as good practice, but poorly defined and implemented. Health services may apply some of the principles of the construction as a quality improvement measure without committing to a whole of system change, with person-centredness at its core. The implementation of person-centred healthcare is often hampered by managerialism, as discussed in the previous section, and paternalistic and binary understandings of health and illness. Clinicians are positioned in the expert role and patients' mere passive recipients of care. Furthermore, care often varies from clinician to clinician based on their personal beliefs, though patients are more likely to trust their clinicians when better informed of their decision process (Alharbi et al., 2014). McCormack and McCance (2016) reason that clinicians are responsible for developing and maintaining authentic connections with their patients as each encounter has the potential to be transformative to the patient. Moreover, clinicians must take note of their patient's beliefs and values, provide guidance, and facilitate decision-making based on the patient’s life experiences. Although widely accepted as good practice, the Aotearoa New Zealand health system does not seem to have a universal standard for person-centred care (Ministry of Health, 2024).

Durie (2005) outlines three important principles for Māori health outcomes: indigeneity, clinical and cultural competence, and human dignity. Human dignity is of particular interest for this study as attends to the process of care, in that health interventions are required to respect human values, cultural worldviews and differing perspectives on health and illness, despite any advancement in technology (Durie, 2005). For example, Māori culture has a much stronger emphasis on the importance of family than the Western-dominant Pākehā culture. Māori culture privileges whānau, hapū, and iwi over the individual (Wilson et al., 2021). Wilson et al. (2021) conducted a qualitative literature review on Māori constructions of health and wellbeing and identified nine models which included four arching themes: "(1) Dimensions of health and wellbeing; (2) Whanaungatanga; (3) *Whakawhanaungatanga* (building relationships); and (4) Socio-political health context" (p. 3550). Using these dimensions of health and wellness, they developed a Māori-centred relational model of care, a person- and whānau-centred practice informed by *te ao* Māori (worldview) that upholds cultural values and connection, respect, and empowerment. The model asserts that clinical assessments and decisions should be informed by the socio-political health context including knowledge about Māori health inequities and should work to reduce marginalisation of Māori within the health system (Wilson et al., 2021).

Aotearoa New Zealand's Health System in General and Perinatal Care in Particular

As discussed in relation to neoliberalism and managerialism, healthcare provision is shaped by political ideology. With this in mind, it is important to review the history of Aotearoa New Zealand's health system in association with the politics of the day. Since 1983, Aotearoa New Zealand has undergone four structural transformations. Prior to 1983, the health system was centralised with both public and private healthcare provision. From 1983, under a conservative government and during the height of neoliberalism, the health system was decentralised, and 14 regional bodies were established to provide population-base healthcare. In 1993, a subsequent conservative government restructured the existing health system to make it more competitive. They established four regional bodies and granted them the authority to purchase health and disability services from both public and private providers. Furthermore, in an effort to make the health system more efficient, hospitals were restructured and run as publicly owned businesses, grounded in managerialism. In 1999, a liberal government came into power, pledging to reform the health system that they believed had become overly competitive, inefficient, and lacked both community input and public accountability. They established 21 regional bodies and recentralised funding to make hospitals less commercially focused. They also implemented national health and disability targets (New Zealand Parliament, 2009). Starting in 2021, also under a liberal government, Aotearoa New Zealand's health system was further centralised, the regional bodies were disestablished, and a centralised agency, *Te Whatu Ora* (Health New Zealand) was established. This transformation was in acknowledgement of inconsistent and fragmented care across the prior 20 regional bodies. Te Whatu Ora manages all community, primary and hospital specialist care with local offices in each region to service the needs of local communities. This is in partnership with the existing Ministry of Health, lead advisor to government on health matters (Te Whatu Ora, 2024a).

A second agency was established at the same time, *Te Aka Whai Ora* (Māori Health Authority) to address longstanding health inequities for Māori; to ensure the health system delivers tailored services and improved outcomes for Māori (Department of the Prime Minister and Cabinet (DPMC), 2021). The 1840 *Tiriti o Waitangi* (Treaty of Waitangi) formed a special relationship between Māori and the British Crown, but it was not incorporated into social and economic domains until the 1980s. In 1987, the Department of Health formally recognised *te Tiriti o Waitangi* (The Treaty of Waitangi) as important to health services and began to implement initiatives to give Māori more input into health policy and programmes (Durie, 2005). In 1988, *te Tiriti* principles of Māori partnership, participation, and protection, were incorporated into social policy agendas. In 2002, the renamed Ministry of Health included *Whānau Ora* in the Māori Health Strategy; to honour their Te Tiriti obligations and achieve health equity for Māori, the health system is required to adapt to be inclusive of Māori knowledge and practices (Wilson et al., 2021).

Māori are more likely than other groups to encounter discrimination in healthcare settings, which affects future help seeking behaviours (Cormack et al., 2018). Moreover, Māori receive poorer care from healthcare providers and are less likely to be referred to specialist services, prescribed effective medications or surgical procedures, and are more likely to be discharge from hospital earlier than other groups (Rumball-Smith et al., 2013). Furthermore, Māori experience more disease, mental illness, and maternal health complications than other groups (Wilson & Neville, 2009). However, Te Aka Whai Ora was disestablished when the conservative coalition government came to power in 2023, and Māori health was absorbed into the Ministry of Health. The government argues that a separate agency is not required to prioritise Māori health, although Māori-centred healthcare differs from the Western-dominant construction as it is grounded in person-, whānau-, and community-centred approaches to health and illness (Waitangi Tribunal, 2024). In 2025, the same coalition government has begun to openly discuss privatising the Aotearoa New Zealand health system. A coalition party leader, David Seymour, said that New Zealanders could get more value from purchasing public health insurance than accessing public healthcare. Objections have already been voiced by patient advocacy groups who argue that privatising Aotearoa New Zealand healthcare would lead to worse outcomes for middle to low-income households (Burns, 2025). This concern is well-founded as neoliberal policies have historically contributed to negative health and social outcomes for already disadvantaged groups (McGregor, 2001).

Pertinent to this study is the current state of perinatal health care in Aotearoa New Zealand. Perinatal healthcare is universally available and publicly funded through community maternity services, with access to secondary or tertiary maternity services if the health and safety of the mother or foetus deem it necessary. Women can also opt to pay for a private obstetrics service. Primary community maternity services provide women access to a Lead Maternity Carer (LMC), which in 95 percent of cases is a community-based midwife who provides continuity of care throughout pregnancy, labour, birth, and six weeks postnatal (Te Whatu Ora, 2024b). They also provide information and assist mothers and whānau with decision making, including labour and birth plans. They help with social stresses; refer mother or baby to specialist care, if required; visit or arrange for at least seven home visits after birth; and provide support to establish breastfeeding and resolve any feeding issues. At the five-week postnatal visit, the LMC hands over the whānau's care to their chosen Well Child Tamariki Ora provider (Te Whatu Ora, 2024c).

The Well Child Tamariki Ora (WCTO) programme, led by the Ministry of Health, is a universally available, publicly funded service available to all children and their whānau from birth to age five years, delivered by Plunket and other non-governmental organisations, such as iwi-led organisations. Although WCTO is prescriptive, with periodic appointments; health and development checks; and family health and wellbeing information and advice, they differ in their delivery of the programme (Te Whatu Ora, 2024c). Plunket was the first WCTO provider in Aotearoa New Zealand, dating back to the early twentieth century; it is currently contracted to service 85 percent of the population nationally. Plunket is committed to helping children in Aotearoa New Zealand get the best start in life through a range of community programmes, including WCTO, parenting education, and PlunketLine, a free 24-hour parent helpline (Clapham, 2024). Whereas Ora Toa WCTO provider is part of the Ora Toa Health Services run by Te Rūnanga O Toa Rangatira, a mandated iwi authority for Ngāti

Toa Ranagatira. They provide primary health care to Māori and non-Māori living within the wider Wellington region, and are grounded in Māori constructions of care, which prioritise whanaungatanga and *manaakitanga* (to take care of one another) (Ora Toa, n. d.). As I will show in this thesis, the participants who opted to engage with Ora Toa reported more positive experiences than those who engaged with Plunket, who provide of the same service.

Thesis overview

In this thesis, I seek to explore how four new mothers navigate matrescence and motherhood. By focusing on the experiences of four participants, I seek to understand how the dominant constructions of neoliberalism and managerialism, motherhood, disease and repair, and health and illness, transmitted through public organisations, influence the identities and experiences of these mothers. Furthermore, I want to ascertain whether the Aotearoa New Zealand health system is serving the economically privileged, Pākehā women who have historically had more positive health outcomes than Māori women. If it is not serving this population, I want to explore how the women may be challenging the system, and if there are other constructions of health and illness that may provide quality care to all women.

In this chapter I have provided the contextual information for this thesis, outlining the history of and social construction of motherhood starting with childrearing in contemporary hunter-gatherer groups which scholars believe give us an insight of pre-agricultural and -industrial social life, and pre-colonial Māori maternal knowledge and practices in Aotearoa New Zealand. I then traced the evolution of the intensive mothering construction from Key's (1909) Century of the Child and the Ritchie's seminal ethnographic research with Māori and Pākehā mothers, to motherhood in Aotearoa New Zealand today. I delved into how these conceptions of motherhood effect maternal mental health and women's transitions into motherhood. I positioned this in relation to the provision of healthcare within Aotearoa New

Zealand's health system. I used Māori healthcare as an example of person-centred care in Aotearoa New Zealand as a counterpoint to the services provided by the Western-dominant providers.

Chapter 2 outlines the feminist social constructionist approach to narrative inquiry I undertook to understand how women experience matrescence and motherhood, and how the constructions of motherhood, disease and repair, health and illness influence their experiences. I provide a description of my positionality and provide an outline of ethical considerations and how these are addressed. I then overview case-based narrative inquiry, with semi-structured interviews and participatory mapping, which I used with the four participants to support their recollections and to co-construct their narratives. I conclude this chapter with a description of narrative analysis I used to construct the individual case studies and conduct cross-case comparisons to identify shared experiences and meaning-making across the participants.

Chapter three presents the first of the four case studies which focuses on Louise and her whānau. I explore how Louise's pregnancies, deliveries, and births were shaped by her adverse childhood experiences and influenced by her encounters with perinatal healthcare providers. I also consider the expectations of intensive mothering for millennial generation mothers.

Chapter four presents the second case study of Pippa and her whānau. I explore how Pippa and her partner, who are both clinicians, experienced the patient-side of healthcare and their reflections on the power dynamic between patient and clinician within the biomedical construction. I also look closely at social support and the positive influence of peers during the perinatal period.

Chapter five presents the third case study of Jen and her whānau. I reflect on the pervasive and harmful public messaging around exclusive breastfeeding which can place undue pressure on new mothers. I then compare Jen's experiences of two WCTO providers and how although their roles were the same, their different approaches had a profound impact on Jen's postnatal mental health.

Chapter six presents the fourth and final case study of Sarah and her whānau. I reflect on the consequences of the global COVID-19 pandemic on new mothers, including the impact of the midwife shortage. I then explore the benefits of continuity of care, and the whānau centred approach Sarah received with a Māori WCTO provider.

The seventh chapter concludes the thesis, providing a cross-case comparison analysing the participants shared narratives. I consider key findings and issues raised in the four cases and relate it to broader literature. I consider how these findings add to the present knowledge of maternal mental health in Aotearoa New Zealand and consider and consider how these findings add to the present knowledge of maternal mental health in Aotearoa New Zealand.

Chapter Two: Method

This chapter outlines the research strategy I used to explore how new mothers experience motherhood and matrescence in Aotearoa New Zealand; and how dominant constructions of neoliberalism, managerialism, motherhood, disease and repair, and health and illness influence their experiences. The following section first introduces the feminist social constructionist epistemology that underpins my research. I then explain my positionality as the researcher and the relational and ethical considerations, and mitigations that were in place during my engagements with participants. I demonstrate how I used case-based narrative inquiry along with semi-structured interviews and participatory mapping to support the participants' recollections and to co-construct their accounts. Finally, I describe my use of narrative analysis to construct case studies of the participants using interview transcripts, participant maps, and my research notes. The analysis focuses on first outlining each case and then providing a cross-case comparison analysing the participants shared narratives. I consider key findings and issues raised in the cases and relate it to broader literature and consider how these findings add to the present knowledge of maternal mental health in Aotearoa New Zealand.

Feminist Social Constructionist Approach

Social constructionists are interested in how people make sense of ourselves and the world around us, and how the ideas and perspectives human beings construct produce key aspects of social reality and the world we occupy (Gergen, 1985). Social constructionists argue that the meanings people bring to their experiences are constructed through their interactions with the world; as people engage with different people in different environments, they construct different realities (Romaioli & McNamee, 2021). Social constructionists assert that reality is constructed through language, which includes all embodied activity (spoken and written words, gestures and prosodies, social practices, and relational implications)

(Romaioli & McNamee, 2021). Social constructionism is concerned with the meaning and subsequent consequences of presenting social categorisations and definitions as immutable facts, and by asserting that they are instead social constructions, dependent on historical, political, and cultural contexts, they can change or be made less potent. There are myriad critiques of social constructionism which deserve attention. King (2004) asserts, "the philosophical basis of social constructionism is the idea that social reality is not fixed and objectively determined, but is, rather, contingent and relative" (p. 37). King (2004) evokes relativism in this quote, as a warning against the dangerous end point of social constructionism. Relativism asserts that we are unable to see the world as it is; what we see is created by our interactions with the world and those in it. If you follow this assumption, then one may argue that human rights, for example, are relative and would be able to justify a number of acts which most people would consider unacceptable. King (2004) argues that social constructionism "is a theory that argues against absolute and immutable positions. However, it cannot do so without calling into question its own basis" (p. 41). In other words, social constructionists would have to agree that social constructionism is relative, making the epistemology redundant (King, 2004). Nozick (2001) argues that not everything can be a social construction, that there must be some objective facts from which to construct our social reality. King (2004) agrees that there needs to be some foundation or ground by which to judge social reality, and this foundation must necessarily be outside the particular social reality. He further argues that unless one believes that it is a fact that oppression is wrong, they would not be motivated to challenge it. Nozick (2001), asserts that the utility of social constructionism is its potential for emancipatory change; for example, by taking the position that the Western-dominant construction of motherhood may be contributing to poor outcomes for women, I can work with women to identify ways to challenge it. Furthermore, Jacobs & Manzi (2000) argue that social constructionism does not have to take a relativist stance; it can be moderated, or what King (2004) terms as weak social constructionism. Weak social constructionism maintains that there is an objective world that is not dependent on human perception; yet our perception of the world is mediated through human cognition (King, 2004). I consider myself accordingly, to be a weak social constructionist.

Another critique of social constructionism is that it denies the existence the physical environment or the materiality of the body (Edley, 2001; Burr, 1998). However, Romaioli & McNamee (2021) rebuke this as an oversimplification, “every time we define reality, we are bound to a cultural tradition, which allows us to know reality through its systems of norms and signs, shared symbols, and negotiated agreements” (Romaioli & McNamee, 2021, p. 319). Burr (2015) illustrates this by using the example of two plants, one of which has been designated a ‘weed’ and the other a ‘flower.’ These designations are useful for a person who is gardening and envisions their garden with a certain ascetic; however, they tell us nothing of the essential nature of the plants themselves. The ‘weed’ can therefore be uprooted and destroyed and the ‘flower’ watered and fed. Likewise, human understandings and our very identities are constructed agentively as we navigate various public and familial constructions that are culturally available to us. Social constructionists point to identities such as gender, sexuality, race, and class as being socially constructed rather than essential qualities of a person. Moreover, people are constructed from multiple identities, some of which combine seamlessly, while others come into conflict with one another. Identities are both enduring and in flux, constituted and reconstituted through talk, allowing for resistance and change (Burr, 2015).

Feminist researchers have long been critical of how women have been bound and oppressed in their positions as mothers, within hegemonic discursive fields. Rappaport (2000) describes dominant constructions as “overlearned stories communicated through mass media or other large social and cultural institutions and social networks” (p.3). Researchers can help to challenge and reconstruct existing dominant constructions that privilege some people and groups, while disadvantaging others. In fact, Oakley (1981) suggests that the role of the feminist researcher is "as a tool for making possible the articulated and recorded commentary of women on the very personal business of being female in a patriarchal capitalist society" (p. 49). Whereas Rappaport (2000) calls on community psychologists to use their tools to "assist others in the job of turning tales of terror into tales of joy" (p. 7). Moreover, Murray (2000) implores researchers to construct counter narratives that may have an emancipatory effect for individuals and groups that have been repressed by dominant constructions. This can be achieved through collaboration with communities, using critical analysis, narrative analysis, and personal stories (Rappaport, 2000). By focusing on the experiences of four women, I explore how the Western-dominant constructions of neoliberalism, managerialism, motherhood, and health and illness, transmitted through public organisations, influence the identities and experiences of these mothers. I further seek to identify the ways in which they resist and challenge these constructions, and in turn help them construct new ways experiencing motherhood and matrescence.

Case-Based Research

Case-based research tells the story of a person or community's experience of a specific phenomenon through their personal narratives. As Somers (1994) argues, "it is through narrativity that we come to know, understand, and make sense of the social world, and it is through narratives and narrativity that we constitute our social identities" (p. 606). Narratives reflect, refract, and reshape aspects of the cultures in which they are told, and shape the cultural worlds the participating women inhabit (Goodley, 1994). A common and ill-informed criticism of case-based research, according to Hodgetts and Stolte (2012) is that case studies of a single participant or small group of participants are not generalisable to a wider population (Hodgetts & Stolte, 2012). However, this criticism is invalid as qualitative researchers do not seek to generalise from samples to populations. We see cases as exemplars of system processes whereby people draw on public narratives to make sense of themselves and their experiences. Relatedly, social constructionists use cases to gain a deeper understanding of an issue within a certain context and identify broader social processes that may be translated to other contexts (Hodgetts & Stolte, 2012). In other words, "researchers focus on particular cases in depth so as to identify social relationships, processes, and categories that are simultaneously recognisable/typical and unique" (Hodgetts & Stolte, 2012, p. 382). Delmar (2010) highlights the 'doubleness' of knowledge that is revealed through case studies. Each case study has particularities specific to the person or social situation, and characteristics typical of people experiencing the same phenomena which can inform our understanding of broader social processes and may be applied to other people or situations. Therefore, case studies can produce both local benefits and derive learnings applicable to broader populations. Another critique of case-based research is that it can be subject to researcher confirmation bias, however, Flyvbjerg (2006) argues that case-based research is more likely to falsify, rather than verify the researcher's preconceived assumptions and hypotheses, due to the intensity of the researcher's engagement with participants and the opportunity for learning.

Relational and Ethical Considerations

Research shows that mothers seek trusted relationships with other women who have experienced motherhood themselves, for validation, encouragement, and support (Ni & Lin, 2011; Leahy-Warren et al., 2018; De Sousa et al., 2020; Darvill et al., 2010). As a mother, my peers have been among the most important support in the early days, months, and years of my motherhood, because there is no one that makes you feel more seen and heard than someone going through the same phase of life as yourself (Haslam et al., 2006). However, I was cognisant that when I ask research participants to tell me their stories, I am not just their peer as people enact numerous positions through conversation. Some of the more present positions I enacted during my interviews were that of peer (mother, age-group, ethnicity, education, socioeconomic status); researcher, as a master's student within a university institution, a position which socially affords me more power than the participants who within the interview context are positioned as lay-people; novice, during interviews I sought to position the participants as the experts of their own experiences of motherhood (Runswick-Cole, 1994). All these positions, and those that I have not named, or was not aware of, influenced the conversation between myself and the participants of my research.

Kvale and Brinkman (2009), propose that interviewers should maintain a professional distance from an interviewee as to not exploit the sense of rapport that may lead to an interviewee disclosing information, they would not want included in the research. Moreover, Horsdal (2012) argues that an interviewer should participate as little as possible in a narrative interview, and any questions or intrusions by the interviewer will interfere with the interviewees meaning making. On the contrary, Harrison et al. (2001) explain, “to get good data—thick, rich, descriptions and in-depth, intimate interviews—we are enjoined to attend to reciprocity in our method” (p. 323). There were points during the interviews where I felt more comfortable sharing my own experiences, and when I thought it was better to hold back to affirm, not challenge the participants experiences (Harrison et al., 2001). Upon reflecting on the interviews, I did wonder if I shared too much about my own experiences of motherhood, however listening back to the interviews I noted that in many instances, the participants asked me to share my experiences with them, and when I thought it would encourage their recollections, I did.

My research was unlikely to cause any undue distress among participants. The interviews resembled conversations mothers regularly have about motherhood and the issues that can arise for new parents. Several of the participants I interviewed reflected the ‘cathartic’ nature of the interviews, which reassured me that I had supported them to share their stories without judgment or insertion of my own values and opinions. This aligns with Oakley’s (1981) findings, when she interviewed mothers in the 1970’s for a longitudinal study of pregnancy, childbirth, and early motherhood. During their last interview she asked participants: “Do you feel that being involved in this research – my coming to see you – has affected your experience of becoming a mother in any way?” (p. 50). Nearly three-quarters of the participants said that being interviewed had affected them, and the three most common examples given were: (1) that they reflected on their experiences more than they thought they would have otherwise; (2) the interviews reduced their anxiety levels and/or reassured them that their experiences were normal; and (3) they provided them with a valuable outlet for their feelings. Moreover, none of the 55 women asked said that being interviewed had affected them negatively (Oakley, 1981). Nevertheless, I ensured the participants knew that they were welcome to have *whānau* (family) involvement and support during the interviews, though whānau were not present during any of the interviews. I also had a process in place if I discovered a participant was distressed: I followed standard healthcare processes by encouraging them to make an appointment with their general practitioner who could render appropriate assistance. This process is preferrable to offering the contact details for mental health care services as it is becoming nearly impossible to access such services directly in Aotearoa New Zealand.

My research was open to participants of all ethnicities, families, and socioeconomic groups, however due to time constraints and recruiting from my own social networks, all the women interviewed were Pākehā, had higher-education qualifications and lived with their heterosexual partners and children in a single dwelling. Therefore, their experiences will not reflect those of all mothers of young children living in Aotearoa New Zealand. It should be noted that the participants in this study are women whose gender identity corresponds with their sex assigned at birth, as I sought to understand the experiences of people who have been socialised as women, have become pregnant and given birth, and are now mothers. However, I appreciate that not all pregnant people or birthing people identify as women.

My research was screened using the low-risk tool (Application ID: 4000028682) on the Massey University Ethics website and deemed to be low risk and approved by my supervisors. As a result, it was my own and my supervisors’ shared responsibility to ensure that I complied with standard ethical practices when recruiting and engaging with participants. Accordingly, I utilised a two-step recruitment process to prevent any potential coercion of participants. The recruitment process was conducted through my own formal (playgroup), and informal (peer group) networks. Several mothers agreed to distribute an information sheet regarding the project to other group members via email. The information sheet introduced me, the project, and outlined participation requirements. Potential participants who were interested in the study were provided with my contact details by the recruiting parent and contacted me via email. In response I thanked them for their interest in participating in my research and ask to set up an introductory phone call with them the following week, during which we discussed the research, I answered any questions and explained consent and confidentiality procedures before they made their decision to participate or not. All four participants who contacted me agreed to be interviewed on two separate occasions, one week apart, at their homes. Through the consent processes outlined above, participants were provided the information resources made available to them to freely decide whether to participate in my research. I ensured that they understood the scope of the project and their potential involvement and that it was their choice whether to participate in the project, and that they had the option to decline to participate at any point in the process. I further advised participants that they could decline to answer any questions, or discuss certain topics, and could stop the interviews at any time.

Research participants have inherent data sovereignty; they own and have the right to access project data that pertains to their own narratives (Hudson et al., 2009). I facilitated this by stating where and how they could access these materials in the information sheet. Interview transcripts, findings, and any project submissions were anonymised so that participants cannot be identified in the research in any way, and pseudonyms were used to ensure anonymity and to preserve the participants' confidentiality (Massey University, 2017). Privacy and confidentiality can be crucial factors in a participant's decision to participate in research and therefore their narratives are secured and treated with the utmost respect (Moriña, 2020). Interviews were audio recorded and transcribed using transcription software and manual checking. Information sheets and consent forms were stored separately from interview transcripts, and hard copy consent forms were scanned into digital copies. Hard copies were destroyed as soon as they were converted to digital copies. All interview materials and participant information were stored on a password protected secure Massey University OneDrive folder and will be kept for 5 years. My lead supervisor and I hold the password to access these files.

Co-Constructing Narratives

Brinkmann (2013) observes that human beings are storied beings who use conversation as the primary means of getting to know one another. Accordingly, interviewing is a natural way to elicit rich knowledge from individuals about their experiences and meaning making, and to capture shared cultural understandings. Individuals in conversations draw on shared cultural understandings (or pre-understandings) to interpret each other's talk within the context of their own life experiences and narrative resources (Horsdal, 2012). Furthermore, interview participants do not just generate mental responses to interview questions. Human experiences are an active process of sense-making that emerges from their lived experiences, when asked to reflect on situations and events (Dewey, 1917; 1929).

Moreover, their lived experiences are shaped by their historical, social, and political contexts. (Nguyen et al., 2024). Objective and subjective knowledge is both necessary for the sufficient understanding of how people experience phenomena and how researchers can then make sense of their experiences. Subjective knowledge is one's experiences within the physical world (Dewey, 1917, 1929). Women physically conceive, gestate, birth, and care for babies, but their experiences of this phenomena is subjective based on their context.

From a social constructionist perspective, an interview is “a social activity where two or more persons actively engage in embodied talk, jointly constructing knowledge about themselves and the social world as they interact with each other over time, in a certain place, and through a range of senses” (Smith & Sparkes, 2016, p. 103). In other words, an interview is the co-construction of a narrative between the interviewee and interviewer (Runswick-Cole, 1994). “These co-constructed narratives remind us that each unique story of our own contains elements of someone else’s story, which contains elements of some else’s story” (Cozolino, 2006, p. 307). The interviewer contributes to the interviewee’s sense-making, through the questions they ask, and their verbal and non-verbal cues which may encourage or discourage the interviewees meaning making, depending on their shared constructions (Smith & Sparkes, 2016).

Feminist researchers are concerned with addressing power in the relationship between researcher and participant and employ strategies to address imbalances by fostering reciprocity (Harrison et al., 2001). Runswick-Cole (1994) challenges interviewers to reject traditional interview structures that maintain a professional distance between interviewer and participant and engage in what she calls ‘passionate scholarship’. Oakley (1981) in her chapter *Interviewing women: a contradiction in terms* reflects on her experiences interviewing mothers and concludes that interviewing should validate women’s subjective experiences, building relationships with participants, not treating them like data points. She describes the most successful interviews as when the relationship between interviewer and interviewee is non-hierarchical, and when the interviewer is willing to invest in a personal relationship with the interviewee during their interviews. She encourages reciprocity in interviews, wherein interviewers self-disclose their opinions, knowledge, or lived experience to generate thick data and co-construct the narrative with the interviewee (Oakley, 1998). Oakley (1998) further argues that it is impossible for interviewers to bracket their emotional responses, as they are a genuine part of the interview process.

Semi-structured interviews

I chose a semi-structured interview method which I found allowed for genuine, reciprocal conversation with participants. This method involves the researcher preparing an interview guide with open-ended questions and prompts to facilitate conversation related to their research question (Smith & Sparkes, 2016). Semi-structured interviews are flexible; researchers can refer to their guides to ensure they cover the topics required by their research question and ask unplanned questions to uncover unanticipated insights or direct the conversation to new topics of interest (Brinkmann, 2013). I prepared my interview guide with several topics I wanted to ask the participants about and prompts to use throughout the interview. These were informed by literature that I reviewed when developing my research question. Of particular importance was exploring the participants' experiences of matrescence. This transition also includes beliefs about what characteristics define ‘good’ and ‘bad’ mothers and their self-efficacy as mothers. Although the construction of motherhood differs between cultures, how a woman weighs themselves against that construction and how it contributes to their self-worth, exists across diverse cultures (Maxwell et al., 2023). I also sought to understand the institutions that influenced these experiences, both public organisations and peers and other social supports. Evidence shows that social support, particularly peer support, equips women to better handle the challenges of pregnancy and motherhood (Ministry of Health, 2021; Dennis, 2010). Moreover, the World Health Organisation (2016) states that women should have positive experiences with healthcare services at each stage of maternal health to ensure their wellbeing and that of their children. Negative experiences with services can contribute to poor maternal mental health and attachment between mother and baby (Hargreaves et al., 2022).

I interviewed four women all of whom were over the age of 30 and had children under 3 years of age. Spending longer with fewer participants allowed me to delve deeper into topics of interest, generate richer data, and elicit descriptions and narratives from the participants so I could better understand their experiences (Runswick-Cole, 1994; Brinkman et al., 2013). I conducted two one-hour interviews in the participants' homes at a time that worked with both of our childcare arrangements. As a mother of a small child, I could appreciate that finding time to have an in-depth and frank conversation is not easy. Two participants with very young babies had their babies present during both of our interviews which accommodated their on-demand sleep and feeding schedules. Our conversations moved around their homes so they could settle or feed their babies, and I held one of the babies while their mother made tea and participated in the mapping exercise. For one participant, their toddler was attending pre-school during our interviews, and for another, their baby slept through both interviews.

The morning of the first interview with Louise, I prepared by reviewing my research question and interview prompts. I envisioned that we would sit at the table in her home, and I would write the occasional note and refer to my interview guide from time to time when in need of a prompt or reminder of my interview goals. However, when I arrived at Louise's home, it soon felt like sitting down with one of my mum friends for a chat and a hot drink. I brought along some biscuits and Louise made us both a cup of tea, while I held her 5-month-old baby. We reviewed consent, and I gave her time to read and sign the physical consent form. We then talked more about my research and what she could expect, and I asked her if she had any questions before we began. I used the Voice Memo function of my iPhone to record the interview, making sure I was granted consent before pressing ‘record.’ I began this and each subsequent first interview by asking ‘when did you know you wanted to be a mother?’ with the expectation that the participants’ answer would direct the conversation. As Louise began to tell me her story, I realised I would rather actively listen, than write notes which made the conversation feel stilted. I also found that I did not need to check my interview guide for prompts, that I knew the topics I wanted to cover and that we could explore anything I missed during the next interview.

After the first interview with Louise, I felt more confident going into the subsequent interviews. Upon entering their home, I presented each participant with biscuits I brought for them and accepted the offers of a hot drink. We sat down in a space where they were comfortable, either in the lounge or at a table. Once we went through the consent process and I answered any questions they had, I started the recording and they began to tell me their story, starting with when they first knew they wanted to be a mother. Each participant was candid and generous with their story, they answered all my questions with careful thought. In my reflections after each interview, I wrote:

[Louise] was open, warm, and honest. She did not hold back.

[Pippa] reacted to my questions just as one would in a conversation with a friend or peer.

[Jen] was very thoughtful and forthcoming, she didn’t hold back or become emotional even when discussing difficult subjects.

[Sarah] was very open and willing to tell her story.

I ended the interviews when I felt a natural break in conversation, asking whether they had anything more they would like to tell me before we wrapped up. I thanked the participants for their time and generosity and let them know they could contact me any time before our interview the following week if they had any questions or concerns. They all agreed to meet with me again in their homes for the second interview.

Participatory mapping

I enhanced interview two by using participatory mapping to further unpack participants' support networks and how they may have influenced their experiences and meaning making of motherhood. McGrath et al. (2020) suggests that the resulting maps, far from objective, create and represent shared understandings of the world. Utilising participatory maps in qualitative psychological research allows the researcher and participant to explore meaning making. When used in conjunction with individual interviews, this approach allows participants to represent their subjective experiences using simple elements including lines and circles, that do not require artistry or creativity that may intimidate participants who do not consider themselves adept at other visual activities such as, drawing or photography (Bravington & King, 2019). For the interviewer, mapping can assist in keeping the participant focused on the research question and can be used for cross-case comparisons. Furthermore, mapping support networks can help participants construct their narratives, and the interviewer to identify areas for elaboration and/or novel insights (Copeland & Agosto, 2012). Utilising mapping to understand participants engagement with their support networks focused the participants on that topic of my research and allowed me to compare engagements across cases. I was cognisant that some of the critiques of participatory mapping are that it may lead to loss of context or rich details of the interviewee's experiences, which is why I prepared prompts to draw out nuances from participants during the exercise (Bravington & King, 2019).

The second interviews began just like the first. I contacted each participant the day prior to our scheduled interview to confirm the date and time. Two participants asked to reschedule, both due to illness. I arrived at the participant's homes, again with biscuits and accepted a hot drink. We again reviewed consent, and I explained how the interview would be structured. I brought large sheets of white paper and a selection of coloured pens, and I explained to the participants the basic underlying structure of the map of their social networks I wanted them to construct. I had prepared a map of my own social network as an example: I had sketched a small circle that represented my family, followed by two concentric circles which radiated outwards. People and groups that had the most influence on my experiences of motherhood were represented in the circle closest to my family, and those with least influence were represented in the outer circle. I used coloured pens to draw spokes to represent negative or positive experiences (Bravington & King, 2019).

Each participant agreed to create a map of their support networks. An example of a social network map from one of the four participants is shown below in Figure 1. I explained that my map was an example, and they could be as creative as they wanted to be. As they sketched their map, I asked them to talk me through what they were thinking. We covered some of the same content as the first interview, but through the mapping exercise I was able to point to different supports and delve deeper into their experiences. The participants all used my example map to prompt their own recollections of various supports. I was initially worried about how this may skew how they thought about their experiences; however, they used my map more as a list of potential supports to include on their own maps, rather than an expectation of how they should talk about them. When the participants had completed the mapping exercise, I concluded the interviews by asking if they would like to share anything else with me and if they had any questions about the process moving forward with my research. I explained that I would send them the transcripts of our interviews over email for them to review and make changes. I thanked them for their time, and they all thanked me in return for providing a space for them to talk about their experiences of motherhood. The participant maps were included as data for analysis along with their reviewed interview transcripts, and my own notes and observations (Bravington & King, 2019).

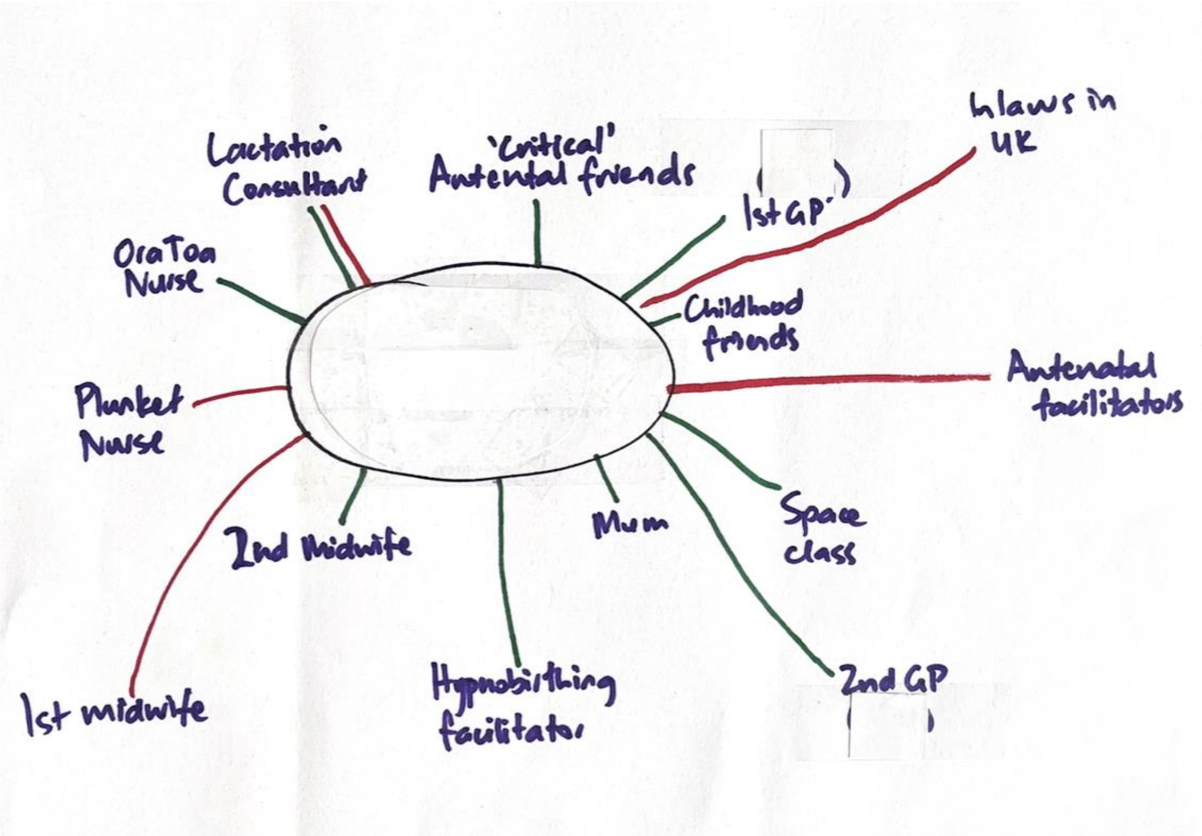

Figure 1: An example of participant support network map

Narrative Analysis

Narrative analysis can be used by researchers to uncover the meaning individuals attribute to their experiences and identities through their personal narratives. Doise (1986) outlines a structured approach to narrative analysis, defining four levels of analysis: personal, interpersonal, positional, and ideological. At the personal level, researchers seek to understand people's accounts of their experiences and define their identity. At the interpersonal level, is the acknowledgment that interviews produce co-constructed narratives between the interviewer and interviewee, paying particular attention to the role of the interviewer. At the positional level, researchers should look to how the interviewee performs their identity against the context of society's values. Finally, at the ideological level, researchers should position the narrative within broader public constructions. Stephens

(2013) provides a more integrated approach, utilising three levels of analysis, that he describes as intertwined. These levels are the personal story, the interpersonal, and the public construction, the latter incorporating Murray's positional and ideological levels. He argues that an individual's moral positions reveal narratives of social life and identities, for example, one can identify themselves as a 'good' mother if they can position themselves within the public construction of good motherhood, which has a certain set of duties, obligations, and rights associated with the role. It also allows individuals to position others against public constructions and make a judgement on where they stand. Through personal narratives, individuals reveal important aspects of how the social world is organised. Put succinctly, "narratives capture private troubles, while exposing public issues" (Goodley, 1994, p. 130). Goodson (1995) argues that narrative analysis is necessary as personal narratives do not highlight marginalisation or bring about change to power structures on their own.

Using the data from interviews, visual diagramming, and my own research notes, I employed narrative analysis to construct in-depth case studies on the participants' experience of motherhood. I honoured the participants' emplotment and left their chronology of events unaltered, choosing anecdotes that contributed to my research question (Horsdal, 2012). I cut and pasted words directly from the participants' interview transcripts, only changing or erasing the names of places and individuals to protect their privacy. My editing was based on practical concerns such as word count, readability, and clarity.

I then conducted a cross-case comparison to identify what was shared across the four mothers' narratives and what was unique to the individual. My analysis considered links between personal narratives and dominant constructions, transmitted through public organisations, and how they may have influenced the identities and experiences of the mothers. I also looked for counter narratives constructed by participants, that challenge the dominant constructions that do not serve them.

Chapter Three: Louise

Louise lives with her husband, and their two-year-old daughter and five-month-old son in a charming townhouse in the Mount Victoria suburb of Wellington. The couple met at university in the United Kingdom (UK) in their early twenties; now in their mid-thirties Louise reflects on their relationship since becoming parents, “I feel really lucky . . . we are really great, and I feel like we're such a good team. I love him even more; I'm really blessed in that department.” Louise and her husband moved to Wellington from the UK in January 2020, two months before the Aotearoa New Zealand borders would be closed for over two years to non-permanent residents. They were both recruited by The Treasury in 2019, offering a better life to young professionals residing in the UK, who may have become “disgruntled” by their government’s decision to exit the European Union. The couple made friends quickly with other recruits and settled into their life in Wellington; and when Louise fell pregnant for the first time, they signed up for a Parents Centre Aotearoa (2024) antenatal course where they bonded and became friends with several couples who they still see regularly, years later. When we meet Louise proudly shows me a photograph of one of the couples and their daughter. She explains that they spend almost every weekend together and attended their wedding earlier this year, “I think as a British person who moved here four years ago, being invited to a Kiwi wedding is like, we made it, we've got new friends here.” Her new mum-friend is a member of a group Louise describes as her “critical friends,” whom she goes to for child-related troubleshooting and emotional support.

Like many women her age who spent time travelling and live in a country that differs from their place of origin, Louise communicates with her critical friends mostly over WhatsApp, an instant messaging service. This group consists of friends she goes to for parenting advice, like sleep training, or who provide more emotional support: “I'm thinking of one particular friend who I saw yesterday and just hanging out and just making me feel like a human." Social support in proximity is critical for the wellbeing of new parents especially when living far away from their family of origin, like Louise and her husband (Rözer, Poortman, & Mollenhorst, 2017). Of their life in Wellington, Louise shares, "I feel like because Wellington is a small place, you all live within five kilometres of each other. I actually feel like we have a really supportive community here and I really, I'm so pleased about that." Louise has a complicated relationship with her family of origin, she left the UK and what she describes as a "very dysfunctional family and very dysfunctional relationships." This is front of mind for Louise during our conversations, as her husband is in the process of interviewing for a job in the city, they left four years ago:

> I've been the happiest I've ever been, living in New Zealand, and I think it's a fantastic place to grow up, but my husband is not happy here really, so if he really wants to go and if he gets this job, which is a really good job, then I would do it, I guess. Yeah, I really don't want to go though, but we're in a partnership and we had four great years here.

Louise expresses her commitment to her marriage and the family she and her husband have nurtured, a unit that she is sure will remain strong despite what changes may come.

Pregnancy and Childbirth

Louise recalls being in "a complete state of shock" when she first found out she was pregnant with her daughter and later "delighted;" and with her son she remembers "a very happy feeling" upon learning she was pregnant. However, Louise's pregnancies were very difficult; physically she suffered from hyperemesis, characterised by extreme nausea and vomiting during pregnancy, and iron-deficiency anaemia which causes fatigue and an increased risk of infection (American Pregnancy Association, 2024a). Psychologically, Louise describes having a "serious level of anxiety;" during adolescence, she was abused by her stepfather and the effects were exacerbated during pregnancy, causing her to feel both physically vulnerable and extremely fearful of delivering her daughter vaginally. She recalls, “I just didn't want anyone to be near me physically. I felt so, so vulnerable and the thought of a vaginal birth with people being down there and so on, just completely gripped me with fear.” It is estimated that 14 percent of pregnant women are affected by an extreme fear of childbirth (FOC) (Nilsson et al., 2018), which may also predispose them to postnatal depression and post-traumatic stress disorder (O’Connell et al., 2021a). Some women suffer from FOC so acutely that it interferes with their daily lives and relationship with their partner. Documented physical and psychological effects include insomnia, somatic complaints, such as stomach aches, and depression and anxiety leading to panic attacks (O’Connell et al., 2021a). Slade et al. (2019) interviewed ten pregnant women with FOC and 13 midwives, and identified several themes that may contribute to FOC, including lack of trust in healthcare personnel, fear of pain, harm, and death to themselves or their baby, and loss of control. Moreover, Nermeroff (2004) argues early life alterations, including childhood trauma, may have an adverse effect on one’s neurobiological stress regulation systems. The classification of childhood trauma encompasses five dimensions: emotional, physical, and sexual abuse, and emotional physical neglect, all of which are shown to be associated with increased risk of psychiatric disorders, including depression and anxiety (Carr et al., 2013).

Furthermore, people who have experienced childhood trauma like Louise often have similar personality traits, such as anxiety-prone personality (Porthan et al., 2023; Spice et al., 2009). Women with anxiety-prone personality traits, and reduced resilience may feel incapable of childbirth due to the pain and unpredictability associated with the experience, increasing levels of FOC (Porthan et al., 2023). In a recent study, Porthan et al. (2023) examined the relationship between all five dimensions of childhood trauma and FOC; the results did not show any associations between FOC and sexual abuse, physical abuse, or physical neglect, about which the authors theorise could be due to known underreporting of childhood sexual abuse. They did, however, show that emotional abuse, emotional neglect, both of which Louise experienced by her mother which will be discuss in a subsequent section, and a greater total burden of childhood trauma, are associated with an increased risk of FOC. They conclude that the effect is large enough that antenatal healthcare providers should both recognise and screen for history of childhood trauma when treating FOC (Porthan et al., 2023).

Louise sought expert support from the Little Shadow service in early pregnancy, a service recommended to her by a trusted colleague who had also given birth. Little Shadow (2024) provides counselling to support parents experiencing perinatal distress from pregnancy through the first years of their baby’s life. Louise says she doesn’t know where she would have been without the counselling, it was “absolutely pivotal” to her recovery. Louise was also referred by her general practitioner (GP) to Wellington hospital’s Maternal Mental Health (MMH) team. She explains that both mental health practitioners were “wonderful” and specialised in perinatal mental health. The MMH service is a free resource; Louise explains that a psychologist “comes to your house, and they meet you where you are, literally. And I remember her offering to go for a walk on Mount Vic, if that's where I wanted to talk things out.” With the help of her mental health team, Louise was able to make the decision to have an elective caesarean section (CS) delivery with her daughter. Louise’s decision aligns with research that shows women with FOC are more likely to opt for elective CS or undergo an emergency CS to deliver their baby (Webb, et al., 2021). However, she still felt the weight of societal expectation to deliver her baby “naturally,” “I felt like too posh to push was a phrase in my mind, but I didn't think I could have a vaginal delivery. I didn't want to talk about all this stuff with people and explain it, it was really harrowing.” Unfortunately, even with the support of two mental health providers, Louise was required to advocate for herself within the public health system, which intensified her FOC.

Healthcare

Managerialism

Despite starting her search early in her first pregnancy, Louise was unable to find an available private midwife. She reached out to Wellington hospital and was placed under the care of the hospital Community Midwifery Team (CMT) which provides complete pregnancy care for people who are unable to access a private midwife. (Capital & Coast District Health Board, 2024). Pregnant women under the care of the CMT see a team of midwives throughout their pregnancy, labour, birth, and six-week postnatal period. This model, although a valuable resource when a pregnant woman is unable to obtain a private midwife, meant that Louise had to repeat all or parts of her story to each new midwife she met, and when calling the service for advice throughout her pregnancy. She recalls this process was "especially [difficult] given that what was showing up towards the end of pregnancy the first time was all that trauma, and it was horrendous." The CMT referred Louise to an obstetrician to discuss her birth plan and book a date and time for her elective CS. The referring midwife explained that "having a C-section is a negotiation with the consultant [obstetrician]." Louise remembers:

> [It] sent me into a panic attack basically because I was terrified that they were going to force me to have a vaginal labour when I had all that trauma. So, I went like I would at work as a public official and prepared my case.

Fortunately, the appointment was nothing like the midwife had described; Louise remembers the obstetrician as "lovely," and recalls they "picked up the phone there and then and booked it in."

Constraints brought about by managerialism in the health system, including an emphasis on efficiency and reduced resources, may restrict clinicians to providing a biomedical service, despite their own beliefs about patient care. It has been argued that biomedical healthcare is focused on the removal or treatment of physiological causes of poor health; invalidating psychological, social, and cultural factors that may contribute to a person’s health outcomes and behaviours (Mali, 2017). O’Connell et al. (2021b) argue that although perinatal healthcare should be women-centred in terms of making decisions about their own care; in practice, women’s healthcare is often dominated by clinician’s personal views. As in Louise’s experience, her perception was that the midwife who referred her to the obstetrician, favoured non-surgical birth plans, which made Louise fearful of being denied control over her birth plan. Such fears have been well documented in previous research (O’Connell et al., 2021b).

Louise also developed her birth plan with her Little Shadow counsellor, so that she could relay to the surgical team what she needed to feel safe in the operating theatre as a CS is performed while the woman is awake. An epidural anaesthetic is administered, meaning the woman should not feel pain, but she can feel the sensations of the surgeon operating on her body (National Women's Health, 2024). Louise recalls, “I discovered with Little Shadow that what I needed in my first birth was for them to tell me what they were doing as they were doing it: the feeling of control over my body.” Louise communicated this to the surgeon and anaesthetist during their pre-operation discussions. Unfortunately, during both her first and second CS', her needs were not initially respected by the surgical team. When she arrived in the surgical theatre for the birth of her daughter, she remembers, “it felt like 12 people just came all around me all at once and I burst into tears. I was like, “whoa, whoa, whoa, whoa, whoa, whoa. What's going on?” Louise turned to her midwife for support who asked the surgical team to stop what they were doing, so that Louise could take a breath, and her needs could be communicated to the whole team. She says, “once we got back onto it, [it was] a calmer way of operating.” Following the birth of her daughter, when Louise was still on the surgical table, she felt an uncomfortable sensation and began to panic; the anaesthetist offered her gas which helped her to feel calmer. The surgical team did not however, inquire or explain why she was feeling uncomfortable or reassure her that it was a normal sensation.

Person-Centred Healthcare

In contrast to biomedical healthcare, person-centred healthcare (PCC) requires providers to build a trusting relationship with their patients to ensure they are empowered to make their own decisions about their healthcare (O’Connell et al., 2021b). "PCC has been defined as care that is respectful of and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions" (Ramlakhan et al., 2019, p. 1). During her second pregnancy, Louise was able to secure a private midwife who was part of a midwifery practice, and describes her experience in stark contrast to her first pregnancy:

> She knew the story that I've just told you, which had come out much more in tears earlier on in the journey. And she was just there for me, and she was doing breathing with me [during labour and birth], and she just felt like my absolute champion. And I don't know, I just felt so safe in her hands. It was wonderful and it was a much more pleasant birth experience as a result.

Louise’s second midwife referred her to the same obstetrician so that she did not have to repeat her story, and the obstetrician again agreed to proceed with Louise’s birth plan. Moreover, before her second CS, Louise asked her surgeon about the uncomfortable sensation she felt after her daughter was born; they explained that this was a normal sensation caused by surgical instruments as they assessed her abdomen after delivery. Taking the time to explain this process, meant that Louise could conceptualise the sensation and did not feel panicked after her son was born. Female survivors of childhood sexual abuse report that they find it helpful to minimise distress when providers prepare them for what kind of sensations they will experience prior to a procedure (Muzik et al., 2013).

By recognising that psychological factors like trauma experiences can have a profound impact on people's health behaviours, health services and providers can build trauma-informed environments to address trauma-related prevention, intervention, and treatment issues. Correspondingly, Grossman et al. (2021) recommend health services adopt a "universal precaution method by asking patients a broad trauma inquiry, such as: "Have you had any life experiences that you feel have impacted your health and wellbeing?" Furthermore, the Substance Abuse and Mental Health Services Administration (2014) in the United States, recommend health and social service organisations implement a trauma-informed approach, grounded in four assumptions, wherein all people at all levels of the organisation have a basic realisation of how trauma affects the individuals and communities they serve in their practice; people in the organisation are able to recognize the symptoms of trauma in their patients; the organisation responds by embedding a trauma-informed approach into all their functions; and take all measures to resist re-traumatizing patients. Examples of this approach include, appropriate trauma-related screening tools and assessments, implementing interventions using a collaborative and strengths-based approach to promote resilience, support women's choice, control, and autonomy, apply trauma-informed treatment planning strategies, and decrease the incidence of inadvertent re-traumatisation.

Depending on the severity of a women's FOC, which can range from low to severe, different individual interventions may be beneficial. For women with FOC lower on the spectrum, a midwife providing counselling, education, childbirth preparation, and postnatal care may be appropriate; however, women who experience severe FOC like Louise, could also require psychiatric intervention, such as cognitive behavioural therapy, although the efficacy of non-pharmacological interventions for severe FOC are mixed (O'Connell et al., 2021a). However, there is evidence to suggest that the way an intervention is delivered, may be more important than it's theoretical underpinning for reducing the severity of FOC in pregnant women (Webb et al., 2021). O’Connell et al. (2021b) meta-synthesis of women’s experiences of interventions for FOC, found that interventions with a women-centred ethos, meaning that they felt listened to and were able to develop trusting relationships with providers, was critical in moving from fear to ownership of childbirth. Moreover, they found that FOC interventions which increased feelings of empowerment in women were those that championed supportive alliances with providers, education, and birth choices. Louise reflects that what made her birth experience with her son different, was that she had the same midwife throughout her pregnancy, labour, delivery, and six-weeks postpartum, who knew her story and what she required to feel safe. Whereas, with her daughter she had no control over which midwife would be responsible for her care at any given time and was unable to build a trusting relationship with any single clinician.

Millennial Motherhood

Millennial mothers have unbridled access to research and examples of how different parenting approaches may impact their children, now and in the future (Holmes, 2024); underpinned by the Western-dominant construction of intensive mothering. Throughout our conversations, Louise shares the research she has conducted, and expertise she has sought to strengthen her self-efficacy and validate her parenting choices within the intensive mothering construction:

> We're just in a point of time in our generation where all this information is available, lots of it is free. We’re able to judge for ourselves whether things are useful, appropriate or whatever. And we may be wrong, but I guess in a way I feel lucky. I feel lucky in a way that I had such a traumatic awful start in life, but then somehow have worked through so much of that to come into this era of parenting, hopefully with an open mind and to draw on evidence and so on. I think I grew up with the antithesis of that.

Louise is highlighting features of millennial generation parenting; a determination to be better parents than our own, and an abundance of expert advice and child development research easily accessible from a smart phone. However, there are risks to this drive for perfectionism.

Better Parenting

Louise explains that her identity as a mother is in part driven by how different she is from her own mother. A poll of 1,000 millennial parents conducted by researchers at the Ann & Robert H. Lurie Children's Hospital of Chicago (2024) found that Millennial generation parents like Louise and her husband, parent differently than preceding generations, with 88 percent reporting that their parenting style is different from the way they were raised, and 73 percent believing they are doing a better job at parenting their children than their own parents. As a result, millennials think a lot about the kind of parent they want to be. Louise shares, “there's a whole arguably more important emotional how do you parent and show up for your children thing, and that's where I'm hugely impacted by my own upbringing.” Her own mother she shares was “incredibly inconsistent and narcissistic,” and says she has always been concerned with trying to “keep her happy and rescue her.” She says of her kids, “I don't want them to ever feel they have to rescue me or that I'm a victim.” Louise says at times her mother behaved in ways that frightened her children. She recalls an experience as a child, and presents it as the antithesis of the mother she wants to be to her children:

> I have this memory when I was seven or eight or something, of asking my mum for a snack. She didn't get it and then I asked her again a few minutes later, and again, and she got a plate out of the cupboard, and she smashed it on the kitchen side. Looking back, it can't have been that I was bugging her, it must have been some other stuff going on, but I've had this intrusive thought of, I just want to smash a plate.

Louise goes on to explain that she represses these thoughts because she does not want the relationship with her children that her mother has with her and her sisters, “it's like a boundary that is quite important.” With access to an abundance of information on child psychological development which was not available to previous generations, millennial parents have a unique focus on teaching their kids how to manage their emotions; in fact, 98 percent of millennial parents talk with their children about mental health whereas, 2 in 3 millennial parents say their parents never talked with them about mental health.

On Instagram Louise follows Dr Becky Kennedy, an American clinical psychologist who was labelled the “millennial parent whisperer” by Time Magazine (Shafrir, 2021). Dr Becky, as she as known to her followers, promotes her parenting principle which affirms that all parents and children are all essentially “good inside” and when a child acts out, it does not mean that the parent or the child are “bad.” Her bestselling book, app, podcast, and social media content support parents to manage their child’s behaviour through compassion and authority. Louise explains her approach:

> . . . she uses this analogy, if your kid was learning basketball and they couldn't shoot in a hoop, you wouldn't shout at them and tell them to sit on the stairs and have quiet time because this is a skill they're trying to learn. So, when your child acts out, they're learning. So, with that in mind, yes, they need to make boundaries, but that punishment doesn't need to be so severe.

Dr Becky first became popular on Instagram during the Covid-19 pandemic, through which she created parenting advice content from inside her apartment in New York City. She was profiled in Time Magazine (Shafrir, 2021) who explained:

> These mostly millennial parents flock to Dr. Becky not just because they want to be better parents but because they want to understand how the way they were raised impacts the way they’re raising their own kids—which, for many of them, means

> rejecting the highly anxious, carrot-and-stick reward-and-punishment style of suburban American middle-class boomer parenting that they grew up with.

Through her Instagram account, Dr. Becky teaches her 2.9 million followers, who are predominantly millennial mothers that just because they were not taught as a child to regulate their own emotions, it does not mean they cannot teach their own children to do just that. Dr Becky teaches that parents may need to reassess their own childhoods and reparent themselves to unlearn problematic behaviours, so they are not ‘triggered’ by their own children’s behaviour and perpetuate the dysregulation across generations (Shafrir, 2021). The emotional regulation she preaches refers to awareness and acceptance of emotions, maintaining goal-directed behavior in the presence of intense negative emotions, and use of effective emotion regulation strategies (Gratz & Roemer, 2004). Dr Becky represents the continuation of the ‘respectful’ parenting approach made popular by Janet Lansbury in 2014 with her book, No bad kids: Toddler discipline without shame. Respectful parenting is a departure from a behavioural approach to parenting which tries to eliminate ‘bad’ behaviours through punishment and reinforce ‘good’ behaviours through reward (Shafrir, 2021). However, as Louise has found, this form of parenting and the overload of information available puts immense pressure on parents to avoid making what they believe to be mistakes that may have lasting impacts on their children’s development.

Expert-Advice

In addition to advice from critical friends and expertise from the healthcare providers, Louise often seeks out experts for parenting advice on social media, podcasts, and parenting books. When she was pregnant with her daughter, she was introduced to Emily Oster’s first book Expecting Better (2013); a data-driven guide to pregnancy, which provides facts, debunks common pregnancy myths, and empowers women to make their own decisions. Oster, an economist, wrote a subsequent data-driven book Cribsheet (2020), a guide to parenting children from birth to preschool which Louise has read and keeps on hand as she strives to make considered evidence-based parenting decisions. Louise explains, “I'm not a fully-fledged economist by training, but it's been part of my training, so I just have a lot of respect for data and what it tells you.” Louise followed the data that Oster (2020) presents about sleep training, a common approach in Western-dominant cultures, when a baby reaches at least four months old and is perceived ready to learn how to sleep alone and unaided. Louise, decided that this approach to sleep aligned with her personal values:

> There are other communities of people [that say] it's okay to have [your child] in your bed all night, it's really natural and all that sort of thing. I just realised that wasn't for me, they need to be in their own bed, they need to be in their own room, I don't want to feed all night. They need to be independent, and they can do it; the data tells me that they can do it.

The morning of our first interview Louise breastfed her son to sleep for his first nap, so she would be on time for a phone call she had scheduled before I arrived, she says, “I felt like I failed a little bit. . . when I don’t have the energy to be patient and let him cry, I have this voice in my head . . .” I asked where she thinks that voice comes from, and she expands:

> When you’re parenting, there are so many paradoxes you can hold at once. Like mums need to be kind to themselves and perfection is futile; also, it will be better in the long term if your baby can go to sleep by themselves…two things are in tension, right? Because it's so hard.

She admonishes herself for resettling him by breastfeeding him to sleep but also reasons if she does, he will sleep for two hours over lunch and give her a much-needed break. Louise ambivalence is clear, and something she struggles to rationalise for herself:

> I can see that the reason why I feel bad for feeding more is driven by a want for perfection. But because I can see it, you know what I mean? I'm trying not to let it

> drive me. It's like two different people are trying to take the wheel of a car at the moment. I think that's the competing narrative in my mind.

Louise speaks frequently about raising "independent" children. She worries about breastfeeding her son until he falls asleep, because she wants him to be an "independent sleeper." The is in part due to her how her daughter slept during her first year, which Louise recalls as "diabolical" explaining that she "never wants to go back there again." However, recent research shows young babies have less developed physiological systems which indicate to adults that night is the time to sleep; and immature neurological systems which rely on caregivers for emotional regulation to feel relaxed enough to fall asleep (Joseph et al., 2015). Moreover, like adults, babies have different sleep requirements for optimal functioning, both the timeframe in which they are ready for sleep, and the hours of sleep they need. This is why the expectation that every baby sleep for twelve-hour overnight, preferably from 7am to 7pm, with one plus daily nap, all unaided, may cause undue stress to parents, if they are unable to train their baby to conform to this rigid schedule (Ruggeri, 2022).

Geering (2024), a parenting coach explains to online news site Huff Post explains the pressures of being a millennial parent:

> What I see with this generation is they give and give and give to their kids ... and they wear themselves down. The real tragedy is that when a parent gets worn down like that, it impacts their kid's mental health, too. Taking care of yourself is taking care of your kid! But that part of the message doesn't seem to have filtered through.

Louise is worn down: the strict sleep schedule she has adopted for her son has culminated in a "rough" few weeks.

Perinatal Depression and Recovery

The week of our interview she decided to look at the Little Shadow website for resources to help her with her increasingly low mood. There she found a link to the

Edinburgh Postnatal-Depression Screening Tool, the most widely used and extensively studied 10-point self-administered questionnaire to assess postpartum emotional and cognitive depressive symptoms (Cox et al., 1987; Boyd et al., 2005), which she completed: "You do the survey, and it asks you questions, *are you looking forward to anything?* No; *Do you feel regularly that you can't cope?* … yeah, very often." Louise knows the signs of depression and what she needs to do as she has experienced depression in the past; of her current mental health she says, "it's not pretty." Unfortunately, she does not think it is the right time to confide in her husband, or close friend, she explains, "I'm going to see a doctor tomorrow, but I don't know who to tell because I don't want to burden anyone with my poor mental health and what can anyone do?" Louise's close friend, who she would usually confide in, has a baby six weeks younger than her son and she does not want to worry her, "she's got enough on her plate," and she does not want to tell her husband as he "needs to focus on his job interview." She reflects that she may have also had perinatal depression or anxiety after her daughter was born, in part due to lack of sleep but she now thinks she may have overcorrected with her son:

> Because of this fixation with the nap schedule, because I'm sort of maybe overcorrecting from my experience with [Daughter], I feel like I can't do very much [out of the house] because I don't want him to fall asleep on the way back or whatever. The wake window is what it is, so, I'm just like, my life is just shuttered down to this very small thing that is boring and lonely and stuff.

Louise says when she's feeling better, she has a plan for getting out of the house more during the week, but in the meantime, she will seek help from her GP. Louise's perception of her burdening her loved ones by confiding in them about her declining mental health is another outcome of the neoliberal value of self-reliance. That one should be able to take care of themselves and should not have to depend on anyone else for support, particularly when it involves emotions.

Chapter Conclusion

Louise's asserts that she was let down by the Aotearoa New Zealand health system when she was pregnant. The fragmentation and biomedical approach contributed to the severity of her FOC. This could have been avoided by the health system implementing a trauma-informed care approach to provide safe and consistent treatment to their patients. From the point in which Louise made her first disclosure of child abuse, she should have had multidisciplinary support, that meant she did not have to retell her story, advocate for herself, or be made to feel like she was not in control of her birth process. Louise is the epitome of a millennial generation mother, driven by the Western-dominant constructions of intensive mothering and self-reliance; hungry for evidence-based information, advice, and validation from parenting experts. However, the pressure on mothers to be models of perfection, never taking a misstep in fear that they do long term damage to their children, is too much for one woman to bear.

Chapter Four: Pippa

Pippa, who is in her mid-thirties lives with her partner and their 10-month-old daughter in a modern townhouse overlooking Wellington harbour. She moved to Wellington to continue her career as a cancer nurse in one of the few centres for cancer care in Aotearoa New Zealand. Motherhood was always in the back of her mind, but she first prioritized travel and adventure:

> I kind of thought to myself in sort of a faraway thought, "yeah, one day I'd like to be a mother." I'm in the nursing profession; that's quite a caring profession. But I also, throughout my life, felt quite selfish. I wanted to do all the things I wanted to do before I settled down and that was really important to me.

As a cancer nurse, Pippa spent two years working in Saudi Arabia and travelling the world. Returning home and settling in Wellington, Pippa met her partner, a doctor now specializing in palliative care, who she describes as "a very soft-spoken person, no topic is taboo. He's someone that you could pour your heart out with." About the decision to have a baby, she recalls, "I felt ready, me and [partner], it was sort of the right time of our lives." Pippa's decision to wait to start a family is a growing trend for Aotearoa New Zealand women, who, on average, are bearing children at increasingly older ages. Data collected by Stats NZ (2019) shows that in the previous 16 years, birth rates for women over 30 years old are increasing, while birth rates for women under 30 years old are decreasing. They reason that this change may be due to increase access to contraceptive and women prioritising study and careers prior to starting a family (Stats NZ, 2019). Pippa describes finding out she was pregnant, "I was stoked to be pregnant, absolutely over the moon. I was like, thank fuck, when you're trying to get pregnant, you're not getting pregnant, you're like, "oh my God, is there something wrong with me?" What Pippa is expressing is a fear that many women in their 30's, and even as young as mid-20's express, "have I waited too long to start my family?"

There is a broad awareness of the relationship between age and declining fertility, and 35 years old is understood as the age in which a woman’s fertility declines at the steepest rate. Although statistically there has been an increase in Western countries in the number of women over 35 years old giving birth (Bunting & Boivin, 2008).

Pregnancy and Childbirth

Pippa and her partner decided to engage an obstetric service for her pregnancy, labour, birth, and six-week postpartum care, where she was under the care of both an obstetrician and a midwife. Like Louise, she suffered from hyperemesis gravidarum during the first trimester of her pregnancy, and in her third trimester, swelling and persistent headaches forced her to stop working earlier than planned. She recalls, “I would cry every morning before [work] because I felt miserable, but then I had bad swelling, and I went to the obstetrician and they were like, “no, that's normal.” They checked it and they were like, “that's normal.” She continued to phone the on-call midwife at the obstetrics office, and was assured what she was experiencing was within the normal range for a woman in her final months of pregnancy. However, as her pregnancy progressed the swelling and headaches worsened, and Pippa and her partner became more concerned about her physical health. She recalls one night when her partner was working a late shift at the hospital, she developed a “banging headache,” and could not sleep as lying down made the pain more intense. She shares that when her partner returned home from work at midnight, “I just was sobbing. And he's like, “what's happened?” “I just have this headache, I can't shake it, and I'm taking Panadol.” And it was just so bad, he was like, “call the midwife because that's a sign for preeclampsia.” She called the on-call midwife who told her to go to the hospital immediately. From then on, Pippa says she was in and out of hospital for three weeks on the “cusp” of preeclampsia, a condition that only occurs in pregnancy and is characterised by high blood pressure and protein in the urine (American Pregnancy Association, 2024b). Pippa’s obstetrician, who had been encouraging her to slow down for some time, told her it was no longer safe for her to be working. During this period Pippa struggled to transition from her identity as a clinician to one of a patient. She reflected on what it was like for her when she was admitted to the hospital for high blood pressure, “they were like, “no, you've got to stay in for that.,” and I'm like, “what?” It's really hard to be on the other side of healthcare because you're like, “I'm fine.””

Pippa planned to deliver her baby by elective CS at 37 weeks when a foetus is considered full-term, for two reasons: (1) there are substantial risks and no substantial benefits for either mother or baby for the pregnancy to continue (American Pregnancy Association, 2024b); (2) her daughter was in the breech position meaning the baby’s buttocks, feet, or both were positioned to come out first during birth and without medical intervention, Pippa and her baby’s life may have been at risk (American Pregnancy Association, 2024c). Moreover, she was warned by her obstetrician that women with preeclampsia are more likely to go into spontaneous labour pre-term and advised her on signs of pre-term labour and to get to the hospital as soon as possible. And that is exactly what happened; Pippa went into spontaneous labour with her daughter, five days before her elective CS.

> So, I was 36 and two [weeks pregnant], and after the last admission, they said, “we'll just get [daughter] to 37 weeks and then we will deliver her because we don't want to put you, it's a balance of giving her enough time to come to term but not putting you at risk. And the longer we keep you pregnant, we put you at risk, but we don't want to pull her out and put her at risk by bringing her out too early.

When they arrived at the hospital she felt a sense of calm; Pippa was in a place where she felt comfortable and had a great deal of confidence in the system and the clinicians taking care of her and her baby:

> It felt all very orchestrated, it felt very calm. Me and [partner] waddled in; they checked my cervix to see how far along I was. My obstetrician got there within minutes of me getting in there, and she just quickly scanned to see baby's position. And then, yeah there was just lots of people around me and asking questions and just getting informed consent, making sure I knew what was happening.

Pippa’s confidence extended to the operating theatre where she described going into a professional “zone” as she would at work, where she was completely focused on what she needed to do to keep herself calm and her baby safe. A stark difference to Louise’s experience. She remembers:

> Me and [partner] were just chatting, he was saying stupid shit, talking about the cat, just keeping me distracted. And people just came over to me and I think they were checking that I was all right because I was completely, almost a bit cold, I think. Which I'm not a cold person, just when it's business time I just get a bit objective and I'm like, just get it done.

Prior to labour, Pippa asked her partner to stay with their daughter when she was born, so she would not be alone. She told him “Take that off my stress list,” and that she would be in good hands with the surgical team. Just after her baby was born, Pippa says she experienced an involuntary tremor, common for women who undergo a CS. When the midwife placed her daughter on her chest, she remembers being both delighted to meet her for the first time and panicked that she did not have enough control of her body because of the anaesthesia:

> I'm like, “I can't hold her,” and I was panicking, but it was lovely. As soon as she came out the obstetrician very proudly showed her to me first, and she was like, “look, it's your baby,” and she was so lovely.

She remembers feeling relieved to hear her baby cry, “just hearing her scream her lungs out, I was like, “good girl, strong girl.”” Overall, Pippa describes her birth experience as “very calm and orchestrated.”

Breastfeeding

The World Health Organisation (WHO) (2014) recommends breastfeeding initiation within the first hour after birth, that infants are exclusively breastfed for six months, and are continued to be breastfed to account for one half their nutrition needs until they are one year old, and one third of their nutritional needs until they are two years old. Overwhelmingly, Aotearoa New Zealand mothers intend to breastfeed their infants, and the government and health system have robust policies in place to ensure women have the resources and opportunity to meet the WHO (2014) targets. Pippa reflects:

> Everyone tells you that's the best thing to do for your baby, because it's so nutritious . . . it's like, and I guess, I don't know, even just the mixing up the formula, it just feels like it's processed so, you kind of want the most natural. And if you're told that the best thing for them is breast milk, then you want the best thing for them.

However, she describes having experienced a “rocky start” with breastfeeding. When a baby is delivered pre-term, like Pippa’s baby and via a CS, the mother’s body is not always ready to transition to postpartum milk production. When their daughter was born, the attending midwife told Pippa and her partner to feed her six ml (millilitres) of formula every two hours through a tube, for the next 12 hours, or until Pippa started producing breastmilk. So, over the next day, every two hours the new parents rang the bell in their room to request 6 ml of formula for their baby from the postnatal ward midwife. They were concerned when a paediatrician then came to examine their daughter and asked them why their daughter was only being fed six ml of formula. Pippa recounts, “I was like, “oh, because that's what they told us, why, what she's supposed to be having?”” The paediatrician advised Pippa and her partner that their daughter should be fed 30 ml of formula every hour. Pippa and her partner were confounded, “we were like, “okay, so why over the last 12 hours, every time we've called the bell, every two hours, at no point in time did each one of these midwives say to me or my partner, why are you asking for six ml?”” The couple felt let down by the midwifery staff on the postnatal ward; it could be reasoned that their perceived disinterest in the amount of formula the parents were requesting for their daughter, was due to the hospital’s policy that formula not be provided to infants, unless it is clinically indicated to do so. Moreover, if a parent asks for formula, the responding clinician must first provide education, including the risks of formula use, and have the parent sign a consent form prior to administering the formula. What is not accounted for in the policy is that it is common during the first few days of a baby’s life, that the mother may not be producing milk, or they baby may have difficulty latching, or removing enough milk from their mother’s breast, which in turn tells the breasts to increase or maintain milk production. Moreover, breastfeeding is a skill that mothers and babies need to learn together over the first few weeks after the baby is born (Davie, 2021). The hospital's one-size-fits-all to breastfeeding and formula use, puts new mothers who have not yet established breastfeeding in a difficult position, in which they have to advocate for their new babies to have the nutrition they need, while attempting to establish breastfeeding.

Over the next few days while Pippa and her daughter worked on learning how to breastfeed, her partner continued to feed the newborn formula through a tube. Most new mothers believe that they and their baby will learn to breastfeed in time (Davie, 2021), and at this point Pippa recalls thinking this herself:

> I guess I thought it would come in time or something and so, I didn't [worry] with the breastfeeding, I'd kind of have a cuddle and put her there, but she wouldn't do it. So, I thought, oh, that's okay, we'll try again next time. And then it took next time, rolled into day one, and then next time rolled into day two, and she wasn't latching.

While in the hospital’s postnatal ward Pippa saw two lactation consultants: the first, an older more experienced consultant observed Pippa and her daughter trying to breastfeed and advised her that she was not latching, although she remembers, “they try to get you to not bottle feed, once you offer the bottle, that's your baby feeding. They were like, “we don't offer bottle until the very last moment.”” She says the experienced lactation consultant, “was good, and then she got really busy, and then they sent in more of a junior lactation consultant. And she was not very good.” Pippa remembers the junior consultant being unsure of how to help Pippa and ending the consultation quickly as she was nearing the end of her shift. She explained to Pippa, ““oh, some babies just never get the hang of latching.” So, I'm like, okay, I was just kind of like, I don't know, is that a thing? I don't know, but I mean, she's a lactation consultant, so she knows more than me,” Pippa was discouraged by this interaction and the lack of support the midwife provided to her and her daughter, she continues, “It just was frustrating, like, “you're now leaving, you are going at four thirty and now you're leaving us for another 12 hours without being able to [breastfeed],” I was just like, “it's just shit, you've not given us an action plan, you've not given us something that we can work on, you're just telling me too hard, got to go.”” Schmeid et al. (2011) found that "for women who were feeling less confident or more vulnerable, conflicting and contradictory advice tended to compound difficulty with a further loss of confidence. Women reported feeling confused but also feeling pressured, undermined, blamed, and guilty as a result" (p. 58). Their findings correspond with Pippa's experience under the care of hospital lactation consultants.

Moreover, after seeking additional advice from an outpatient breastfeeding clinic that she says was “not realistic,” she decided to stop trying to latch her daughter, and began to express breastmilk using a breast pump. Her or her partner would feed it to their daughter in a bottle and then prepare formula to ‘top up’ her up, to ensure she was getting enough milk. Flaherman et al. (2014), ran focus groups with 56 women who had recently given birth and were experiencing low milk supply issues. They too found that some women experienced a greater sense of control through express breastfeeding, however some women also report that this method interferes with caring for their infants in other ways. Additionally, some women worried that they were not producing enough milk to feed their baby by expressing, and they decided to move their infants onto formula. This aligns with Louise’s experience; her mental health improved when she started expressing so her husband could give their son her first feed of the night, and she could sleep. From a feminist perspective sharing feeding responsibilities provides for more equitable division of childcare and greater autonomy for women.

Perinatal Depression and Recovery

For Pippa, express breastfeeding began to take its toll on her mental health. At one of her regularly scheduled Plunket appointments, she divulged to her Plunket nurse that she was finding expressing breastmilk exhausting and distressing, and she had started debating whether it was worth it when her baby could be given formula exclusively instead. She remembers:

> I kind of went to her at one point being like, “I feel quite distressed because I'm tired, if I'm not feeding her, I'm expressing, it's a lot, it’s a full-time job,” and she was only getting, my supply was low because she wasn't breastfeeding. so, I'd get maybe 60 ml each express, which I was like, I don't know, I was like, “is that fucking worth it if she's getting, I don't know, a 180 ml bottle? Is like 60 ml, is that?” And she was like, “yes, any breast milk is better than nothing and it's going to do a world of good.” And she put the pressure on, like “keep expressing.””

She concludes that although the Plunket nurse was “pleasant” as a healthcare professional she expected them to “use a little bit of critical thinking,” as opposed to the one-size-fits-all approach, which deprioritised Pippa's lived experience, common in a biomedical healthcare.

After three months of express breastfeeding, Pippa confided in one of her mum friends, who had had similar difficulties breastfeeding her baby. She told her to stop expressing, explaining, “if there is any impact on your mental health, you stop expressing immediately, she'll [Pippa’s daughter] be fine.” Pippa says she needed to hear this advice from a trusted peer, “it's like someone that you really trust that's practical.” A woman’s social network (health care professionals, peers, and partners) is shown to influence their beliefs, attitude, and behaviours about breastfeeding (Schaffer et al., 2015). Moreover, Schaffer et al. (2015) found that personal experience-based advice from a woman’s social network is positively associated with the method of feeding she chooses for her infant. Health care providers are more likely to recommend exclusive breastfeeding to women; whereas peers who provide emotional support and who’s opinions are perceived as important, are more likely to advise breastfeeding in combination with formula. This influence is particularly strong when a woman is facing feeding challenges similar to a peer's experience, as they are able to respond to her emotional needs. For Pippa, her friend who had had to make a similar decision as a mother, gave her permission to stop expressing breastmilk and prioritise her mental health, while helping her realise that her baby would be safely fed with the use of formula:

> She's like, “I know how hard that is. I was tortured having to make the decision, but for me, once I made the decision and I was like, done.” She was like, “you will feel so much better. I promise you, and it's okay. It's going to be a distant memory and you're going to love formula, full formula because you can give it all to [partner].” And she was right, and because someone had gone through it, that influenced me a lot because I was like, well, she did it and it's been all fine.

Pippa said after she stopped express breastfeeding her mental and physical health improved, “I found my hormones really got back to, well, more back to normal once I stopped expressing, and that did me a world of good.” About her experience breastfeeding, Pippa reflects, “it's just another unrealistic expectation or hard to achieve standard. There should be more awareness or people - society educating each other on how it can be hard. Not everyone can breastfeed for different reasons, which that's not really told to you.” Here Pippa echoes Louise in acknowledging the pressure mothers are under to provide the socially constructed image of perfect care for their children, even when it is not realistic.

Another similarity between Pippa and Louise's experiences of early motherhood, is their decision to sleep train their babies. Pippa’s daughter was good sleeper from birth; consistently sleeping for 12-hours per night until six months, when she experienced her first sleep regression. She remembers being influenced by other parents’ stories about their babies sleep during their first year, “everyone tells you their stories and you’re like, “oh, I shouldn't be doing this or should be doing this.” And you're just like, “it's just all so fucking hard.” And you're like, “what do I do? What do I do?”” It was at this point that she started to think about sleep training her daughter, though she was not sure what was the right approach for her family. She shared neither she nor her partner wanted to become a “miliary regimented sleep trainer” like some of her friends, and that they would be more suited to a “flexible,” “gentle” approach to sleep training. However, there came a point during her daughter’s sleep regression when her partner was getting out of bed every 45 minutes to rock the baby back to sleep. Pippa explains that her partner is a night person and did not mind having to be up with their daughter through the night, while Pippa needs an early night so that she feels energised the next morning. She says she was feeling “very fragile” as their sleep as a family became more and more broken, in fact this period is what her partner refers to as Pippa’s “Britney Spears - nearly shave your head era,” a very relatable pop-culture reference to sleep-deprived millennial mothers everywhere.

Pippa contacted a sleep consultant recommended by one of her friends who had used their services for her two children. The consultant used a “spaced soothing” approach which Pippa explains is essentially the divisive “cry-it-out” method which would in fact turn her and her partner into military regimented sleep trainers. Pippa surprised herself when she decided they would proceed using the method, “I never thought I was a cry-it-out kind of gal either, because it's very hard to start doing that very, very hard.” However, her partner was soon starting a period of night shifts at hospital, and she did not think she had the physical or mental strength to rock her daughter to sleep through the night, she relays their conversation, “He was very like, “no, we are not doing cry-it-out.” And I was like, “well, get on board. You can push against the current, but this is what we're doing. I've already paid the money to the sleep consultant.”” Pippa describes the training as “a game changer,” and now that her daughter is once again sleeping through the night, her and her partner get the rest the need.

Healthcare

Managerialism

As clinicians, Pippa and her partner are both comfortable in clinical settings; they felt safe in the operating theatre and were confident that Pippa and her baby were provided exceptional care from the surgical team. When they arrived in the postnatal ward after birth, they explained to each new clinician who were providing Pippa and their daughter care, that although they are clinicians themselves, to act “as if we know nothing, because we don't know anything about babies or obstetrics, so please treat us as if we're dumb.” The phrasing that Pippa uses here, “treat us as if we’re dumb” reveals a problematic power dynamic between doctors and patients.

In biomedical healthcare the doctor is positioned as an expert and the patient as unknowing, this stance neglects the patient’s agency and implicit knowledge (DeCaria, 2022). In a qualitative study with Dutch women who had given birth within one year, Petit-

Steeghs et al. (2019) found that person-centred maternity care should be responsive to women's needs and preferences across four domains: client, interaction, professional, and organisation; requiring healthcare providers to develop reflexive skills, which include listening to feedback and respecting women’s implicit knowledge, within a flexible healthcare organisation. Furthermore, participants in this study did not expect an equal relationship with their provider, deferring medical decisions to them, however they did expect transparent and individualised interactions. Pippa and her partner were comfortable with transferring of power to the providers treating them; however, Pippa describes several incidences in which the care they received in the postnatal ward was neither transparent nor individualised.

As their daughter was in the breech position at birth, Pippa and her partner were told that she would have an orthopaedic assessment prior to discharge to inspect her hip and knee joints, as breech babies can be born with misalignments of their joints. The orthopaedic registrar who examined their daughter after birth cleared her of joint issues. However, when a paediatric registrar was assessing her for discharge, he noticed that she had hip dysplasia. Pippa remembers, the paediatric registrar asking her and her partner whether their daughter had been assessed by the orthopaedic registrar:

> He goes, “what did they say?” And I was like, “nothing, that she's fine,” and he went, “well, I'm very sorry to say, but she's actually got hip dysplasia.” He's like, “I am 90 percent sure; I'll get the orthopaedic reg to have a look or get my consultant to have a look. But yeah, I'm not entirely sure how that was missed because I'm a layman in terms of orthopaedic things, but it's very obvious.

Pippa remembers the orthopaedic registrar who first assessed her daughter, returned to their room to reexamine her joints, and admitted that he had missed her hip dysplasia during his first assessment. Pippa was frustrated by the registrar’s perceived indifference, “He's like, “oh yeah, yeah, she does,” not like “sorry, that could have been a huge developmental milestone that we fucked up for you guys.”” She goes on, “. . . it all felt very unprofessional, and it felt like quite wild, wild west, we really have to watch what people are doing here.” Without treatment for her hip dysplasia, the growth of their daughter’s hips could have been affected, and she would be much more likely to develop osteoporosis later in life (Capital and Coast District Health Board, 2019). Pippa's experience with the orthopaedic registrar mirrors that of Louise's experience with the CMT in which they both received inconsistent and at times contradictory clinical advice.

Their daughter was then referred to an outpatient orthopaedic clinic for treatment. Pippa says she experienced what she describes as “humble pie,” as a clinician experiencing the health system as a patient. She remembers observing clinicians treating her daughter “on autopilot” as they walked into their examination room without introducing themselves to Pippa or her partner, “they'll just kind of walk into the room and then be like, “cool, just check your hips,” and I'm like, “who *are* you?” She says when she goes back to work after parental leave, she will be much more conscious of making sure she introduces herself to patients and their *whānau* (family), a simple but important aspect of PCC. “It's so important and people instantly will feel connected with you if you take that simple step. And I know it's like, “well, duh, isn't everyone doing that?” But actually, they're not, and that's something that we very much found.” Pippa also remembers bundling up her newborn during winter to arrive to the orthopaedic clinic on time for her appointment and being told they do not have an appointment. She says in the cancer unit where she is associate clinical nurse manager, appointments are missed when the team are juggling patients with doctor absences. This is an example of under-resourcing in which clinicians are required to make choices that neglect non-physical aspects of patient health. Of the orthopaedic clinic, she reasons, “I think probably what's happened is appointments have been moved and not been picked back up again, they've just been dropped.” But as a new mum she could relate to an “irate patient's mum who's just sitting in a reception refusing to leave,” a figure she has encountered in her job. She reflects, “previously I was like, “oh, can't people just be reasonable? Can't they just understand that shit happens?” And now I'm like, “no, they can't, they carve time out of their day to come here.” What Pippa describes as clinicians “on autopilot,” is a common critique of biomedical healthcare, in which the focus of the clinician is on the medical issue a patient is presenting with, not with the individual or the context in which they are situated.

Chapter Conclusion

Pippa’s experience of the health system is not uncommon, the one-size-fits all approach denies patients and whānau autonomy and agency over their care. Person-centred maternity care could have prevented Pippa from having to make the difficult decisions to first express breastmilk for her daughter, and then to transition to formula, by providing her practical and individualised advice and support. Furthermore, Pippa and her partner were let down by the lack of comprehensive and coordinated care in the postnatal ward. First when they were not advised that they were feeding their newborn the incorrect amount of formula after birth, and then when the orthopaedic registrar missed their daughter’s hip dysplasia, which could have set her development back months. These experiences taught Pippa and her partner the value of PCC in the health system, a learning they will take back to their clinical practice.

Chapter Five: Jen

Jen, who is in her late thirties has a lovely, large home in a suburb outside of Wellington which she shares with her husband and two little boys. She has a PhD in glaciology and worked in several high-stress emergency management roles within Aotearoa New Zealand government prior to having children. Jen and I bonded over the pressure we both felt trying to keep up with the demands of mothering young children. Jen is now a stay-at-home mum, though prior to when her and her husband decided to start their family, she did not imagine children in her future. She reflects, that although her husband had always wanted kids, he was respectful of her decision and “never pushed it or anything like that, he kind of knew where I was at.” As Jen aged into her thirties, she started to feel pressure to have children. She says it was not external pressure, “but I still felt pressure, and it was probably coming from myself in terms of, I really need to decide what's going on and I had quite severe anxiety from it from my early thirties.”

What Jen is describing is internalised pressure for women to adhere to gender norms, including motherhood, although, there is a growing number of women resisting this pressure (Donavan, 2021). From 2010 to 2020 there was a 20 percent decrease in the Aotearoa New Zealand birth rate from 2.1 to 1.6 children per woman, which Donavan (2021) attributes to availability of contraceptives, women’s access to higher education and career development, the gender wage and unpaid labour rates, and the cost of living, including the projected cost of having a child. McDonald (2000) explains, “if women are provided with opportunities near to equivalent to those as men in education and market employment, but these opportunities are severely curtailed by having children, then, on average, women will restrict the number of children that they have to an extent that leaves fertility at precariously low, long-term levels” (p. 1). For women, the decision to have a child requires a cost-benefit analysis. Moreover, Morgan & Berkowitz King (2021) suggest that for women to see benefits that outweigh the costs in childbearing, then measures must be taken to achieve gender equity across social institutions. However, they also suggest the perceived emotional or psychological benefits to having children, such as “to have a child to love” and “joy that comes from watching a child grow” often outweigh the economic arguments against having children (p. 11).

The normative decision to have children reduces the uncertainty one may feel about their future (Morgan & Berkowitz King, 2021). With so many different life courses available, it is difficult to measure one’s progress and form a coherent identity without ticking off socially prescribed boxes. Starting a family reduces any anxiety that may arise from this ambivalence, as it is a well-trodden path that provides routine and predictability, and an abundance of measures against which to judge one’s progress (Gidden, 1991). In other words, “individuals need established routines in order to reduce anxiety and to feel secure. Raising a child can bring predictability to daily life that promotes well-being and that provides some continuity to one’s “narrative”” (Morgan & Berkowitz King, 2021, p. 13). Jen sought expert advice through a counsellor and for 18 months worked through her ambivalence toward having children. She recalls that she was worried that if she had children, she would regret the decision: “you're stuck, most other things you can change your mind, right? But this one you can't, but yeah, so I did it, but now I'm very glad that I did.”

Pregnancy and Childbirth

When Jen found out she was pregnant, she remembers feeling, “absolutely terrified,” and worried that she had not made the right decision. She says she “never really got to the really excited stage” of pregnancy with her first son. Because of this, she said she waited for two to three weeks before trying to find a midwife. She started contacting midwives, using findyourmidwife.co.nz, a service provided by New Zealand College of Midwives (2024a), but by that point there was only one private midwife available in her region. Jen felt lucky that she was able to find an available midwife as the alternative is the CMT at the hospital where she would be under the care of a team of midwives just like Louise. Jen wanted to see one midwife through pregnancy, labour and birth, and six weeks postnatal care. “I ended up calling every midwife in the Porirua area. There was one that had availability, so it was either go with her or go through the community ones. I did kind of want that consistency of the same person.” As this was her first pregnancy; Jen was not sure what to expect from a midwife and in retrospect she realises that her midwife fell short of the care she should have received. She reflects that she did not “have that real sense of connection with her,” and that she “listened to me, but I don’t feel like she really listened,” Jen illustrates this by describing her experience attempting to make a birth plan with her midwife:

> A couple of times I was like, “at what stage do we talk about the birth plan?” They're like, “oh, yeah, we don't really need to.” And in the end, I actually printed something out and was like, this is kind of the things that I'd perhaps like or not.

During Jen’s second pregnancy she secured the services of a different midwife who scheduled an appointment to discuss her birth plan, during which she provided examples of different birth plans, and several labour and birth scenarios to ensure that Jen had a good understanding about how labour and birth may proceed.

Jen was surprised when her first midwife did not attend her labour or the birth of her son. She later learned that her midwife was not on call that weekend; instead, two of her colleagues helped birth her son. In comparison, during Jen’s second labour she recalls her “[midwife] wasn't on call that weekend, but she was still there, and she was there the entire time.” Jen compare’s her first and second midwives in a similar way to Louise; she describes the service her first midwife provided biomedical healthcare, wherein the midwife with the help of a team provided appropriate medical care to their client, but did not respect Jen's needs and preferences. Whereas her second midwife provided PCC, building a relationship based on transparent, shared decision-making, and continuity of care (O’Connell et al., 2021b). Research into PCC specifically for women is limited; Gagliardi et al. (2019) conducted a scoping review on how PCC is conceptualised in women's health. They found no established frameworks within PCC literature that gave exclusive consideration to women’s needs and preferences. A similar theoretical rapid review by Ramlakhan et al. (2019) came to a similar conclusion that there has not been enough attention given to women-specific PCC. However, many of the principles of PCC are generalisable for all patients, including individualising care to the patient, their whānau, and the specific context in which the healthcare is delivered; to build trusting relationships between clinician and patient; and to empower people to take an active role in their care.

Jen planned to birth her first son at home in a birthing pool with the assistance of her midwife as she did not want to make the 40-minute drive to the hospital during her labour. Moreover, she says she did not want to give birth in a “real sterile kind of hospital environment which I'm not familiar with.” She said she felt more “safe at home,” which is a common sentiment made by women who give birth at home, who report higher rates of satisfaction related to their home being more comfortable and feeling more in control of their birthing experience (Zielinski et al., 2015). Home births are commonly associated with the ‘natural’ childbirth movement, a feminist critique of biomedical healthcare. The movement encourages women to birth their babies as was done prior to Western medicine: without the assistance of pain relief, aside from water and massage, or any interventions aside from those able to be carried out by a midwife (Brubaker & Dillaway, 2009). However, critics of the movement say it promotes biased information and does not empower women, rather it puts them at risk (Dietz & Exton, 2016). Jen’s labour was long and progressed slowly, she says by the time she was 24-hours into labour she was “shattered” and wanted an epidural for pain relief, which can only be administered by an anaesthetist at a hospital. However, a hospital birth and an epidural were not part of the birth plan she had provided to her midwife and husband.

When I asked Jen, what made her decide she did not want pain relief prior to labour? She said “I wanted to feel like I had a little bit more control, I guess. And I was like, if I don't need to, if I can deal with the pain of it, then I don't really want to have an epidural, and I was trying to tell myself that I could do it.” She remembers telling her husband and the on-call midwife several times that she wanted to go to the hospital, that she had changed her mind about her birth plan, “they were like, no, it's okay, you can do it. I'm like, no, seriously, I know what I've said, but I'm absolutely 100 percent sure I want that.” When they arrived at the hospital, like Pippa, Jen felt safe in the clinical environment, “I probably felt like calm when I got in there. I was kind of like, “oh, okay, there’re people around me that know what they're doing” sort of thing.” Jen exerted her agency at this point in her labour, an important feature of PCC, which is centred on the needs of the person receiving care (Ramlakhan et al., 2019).

Breastfeeding

Like her millennial peers, Jen wanted to be as prepared as possible for the birth of her first baby. She attended several courses while she was pregnant, including a hypnobirthing course, a breastfeeding course, and an antenatal course run through Parents Centre. She attended the breastfeeding course as she wanted to be as prepared as possible to exclusively breastfeed her son. Jen says she thought breastfeeding “might be tricky, but never really heard or understood that it could be so difficult.” She reflects, “I thought it was something that would be innate and natural and it would happen. That’s so not true.” Like Louise and Pippa, Jen was committed to breastfeeding her sons; she reasoned breastfeeding is natural and easy, and her role as her sons’ mother to provide them her milk, “my body's making this milk, boobs are designed to feed babies, this is their job. And so, my job as a mother is to give them milk and it's easy, it's there, it's cheaper, and it's just on tap.”

Like Pippa, Jen reports being ultimately unable to breastfeed her sons, a reality that took a significant toll on her mental health. Dias and Figueiredo (2014) systematic review of breastfeeding and depression literature found that women who experience breastfeeding problems may be at higher risk of developing postpartum depression. When Jen started trying to breastfeed her first son shortly after he was born, the hospital staff discovered that he had a tongue tie and had it snipped the next day. A tongue-tie or ankyloglossia, is a condition that impairs tongue movement and is a common complication that may cause trouble breastfeeding. Most tongue ties are asymptomatic but infants with a tongue tie have greater incidence of difficulty breastfeeding by causing maternal nipple pain and interfering with milk supply. Treatment for tongue ties wherein a clinician makes a cut in the frenulum which connects the tongue tie the bottom of the mouth, is growing in popularity, however there is some concern that the procedure is not as benign as previously thought (Borowitz, 2023). Although this was a quick process, Jen remembers, “by that stage my nipples were destroyed already, so I tried, I kept trying [to breastfeed], but I had so much damage.” Proper latching is paramount to successful breastfeeding; if an infant does not have a correct latch the infant may not receive sufficient nutrition, and the mother may experience breast pain. Furthermore, an incorrect latch often reduces milk production, causing the infant to want to feed more regularly and become difficult to settle (Davie et al., 2021).

Healthcare

Managerialism

Jen remembers one night when her son was unsettled during their stay in the postnatal ward, a midwife offered to prepare some formula to help settle him. However, first they explained that Jen would have to sign a consent form acknowledging the risks associated with formula and bottle feeding. She reflects:

> It's signing that you're willing to introduce all this stuff that could really harm your baby, and I think now, that's horrendous. Surely, they should be fully focused on whatever feeds that baby and keeps them happy and content, and what the parents are wanting, not signing disclosure.

Jen is trying to make sense of what is a confounding situation: she has just given birth, and her newborn is unable to access enough breastmilk to feel satiated. He is crying and Jen is unable to settle him; a midwife offers to feed him a breastmilk substitute (formula) that is regulated and deemed safe by Food Standards Australia and New Zealand (Infant Nutrition Council Australia & New Zealand, 2024). Although Jen is relieved that her son will be fed, her intention is for him to be exclusively breastfed. She says, “I thought it was something that would be innate and natural and it would happen.” Before the midwife can provide Jen formula to feed her son, she asks her to affirm that she understands formula may put her son at risk and does she agree to proceed? The consent process forces Jen to decide to either put her son at risk by not feeding him, or to put him at risk by feeding him formula.

In 2010, NCT (formerly, National Childbirth Trust), the UK's largest charity for perinatal support, providing antenatal courses and postnatal individualised breastfeeding counselling, commissioned an impact report on how they could improve their work on infant feeding. The impact report found the following problems:

> 1. Some mothers who use formula milk feel under-supported and judged.
> 2. Mothers who run into breastfeeding problems feel that they have been given unrealistic expectations in antenatal classes.
> 3. Many mothers who experience breastfeeding problems do not access the breastfeeding support available (Trickey & Newburn, 2012, p. 74).

Trickey and Newburn (2012) address these problems using a theory of constraints conflict resolution methodology to clarify the charities infant feeding position and then find solutions to the identified problems. The NCT's Baby Feeding Policy states that: "NCT believes it is important for parents to have every opportunity for positive feeding experiences" (National Childbirth Trust, 1999). This position places the experience of the parent as the primary focus, not the method of feeding, which conflicts with the WHO (2024a) and the UK government's commitments to breastfeeding as the safest option for infant feeding, framing it as a public health issue (Public Health England, 2021). Trickey and Newburn (2012) explain the difference in positions may have effects on breastfeeding outcomes. Promoting choice and positive feeding experiences prioritises mothers' autonomy and decision making; whereas framing breastfeeding as a public health issue, has led mothers who have difficulty breastfeeding to believe they are putting their babies at risk, diminishing their self-efficacy. Furthermore, having two binary feeding narratives, formula feeding and breastfeeding, does not reflect real-world experiences which often include mixed feeding.

For the following few weeks, Jen reports continuing to try to breastfeed. However, every time her son struggled to consume enough milk and Jen began “dreading every single feed. Anytime we weren't feeding, I'd be thinking and dreading the next one,” she says, “it was just this horrendous cycle.” In Davie et al.’s (2022) study of women’s perceptions and practices of infant feeding behaviours in the early postpartum period found that mothers who experienced breastfeeding latch pain or trauma had a negative experience of breastfeeding and it was the most common reason to stop breastfeeding in the first week, independent of whether the infant was feeding well or not. Furthermore, mothers determined to continue breastfeeding, “. . . described breastfeeding with pain as “frustrating,” physically and emotionally “challenging,” and reiterated that they “struggled and persevered” (Davie et al., 2021, p. 365). These descriptions show the physical and psychological toll of breastfeeding with pain. Jen attended a breastfeeding clinic where she and her son were assessed by a lactation consultant who told her to continue to breastfeed her son for a few minutes on each breast; she remembers this as “horrendous advice.” At week two, Jen began to mix feed her son, using expressed breastmilk and formula. About this decision, she said she “still had hope” and “people kept telling me it could work but keep your supply up. And so, pumping was a way of keeping my supply up.” In fact, Jen’s midwife shared that one of her children did not latch until six weeks old, and that she had express breastfed up to that point. In this case Jen’s midwife was acting as her peer, who had experiential knowledge of what appeared to be the same breastfeeding issue (Dennis, 2010). Jen followed this advice and thought once her nipples healed, she could restart breastfeeding, but at six weeks, breastfeeding was not any easier and she made the decision to exclusively express breastfeed:

> It was still painful, [son] would scream and cry and arch his back and was obviously hating it. And so, then I was like, okay, well that's not working, so I'll just keep pumping. And it was one of those things where I didn't want to make a decision, I didn't want to make a decision to stop or to keep going.

She continued this process for six months.

When Jen’s first son was six weeks old, their family’s postnatal care was transferred from their midwife to Plunket. Jen’s family has a long history with the organisation, she still has her own and her father’s Plunket books that chart a child’s development from birth to five years old. Her mother shared her experience of Plunket with Jen:

> Mum with my oldest brother really struggled early on, and so she said they had a centre where she actually moved into this home for a week, and they helped her set up a routine for [brother]. She could sleep, nurses would look after them . . . Mum said it was absolutely life changing for her, that got her sorted and back on track.

The "home" Jen references is one of the 27 Plunket Karitane Family Service centres that were operational during the latter part of the twentieth century. The centres' primary purpose was allowing the mothers to rest as much as possible, and then to provide them support on breastfeeding, sleep, and other infant concerns. A Plunket nurse who was interviewed by a journalist in 1978 shared, "many mothers are so desperately overtired when they are sent to us that they are quite incapable of taking anything in until they have had a few days complete rest," which they could take in the beds they had available at the centres (Bryder, 2003, p. 252).

In contrast, Jen had a profoundly negative experience with her local Plunket nurse. She remembers, meeting with her when she and her son were struggling to direct breastfeed and he was losing weight:

> She was pretty much saying that I was not feeding [son] enough, and that he would get to a year old, once he'd had solids for a few months, and his weight would shoot up. And I would look back in hindsight and realise, come to my senses, and realise that I wasn't giving him enough milk.

This experience made Jen feel like she was at fault for her baby's weight loss and shortly after, she transferred from Plunket to Ora Toa, the local Māori WCTO provider.

Māori Healthcare

Both Plunket and Ora Toa are funded by Te Whatu Ora (Health New Zealand) to provide WCTO services which were developed using the Plunket model. Jen describes her experience with Ora Toa as "completely different." They assured her that she was doing all she could to ensure her son was fed enough and that she was not "starving" him. They explained:

> "He's just on the small side" and they could clearly see that, and they looked at the whole picture. They're like "developmentally, he's doing all the things that he kind of

> needs to be, he's very observant." And so, they, they looked at everything rather than just the dot on the graph or the box.

Jen's comparison between Plunket and Ora Toa's WCTO approaches show that they are grounded in two different constructions of care. Plunket provides biomedical healthcare to women and their infants, focusing on physical measures of health, as Jen experienced when her son's slow weight gain was presented as her personal failing and a problem she needed to solve. When Jen transferred her son's WCTO care to Ora Toa, the nurse took a holistic approach to his slow weight gain, assessing his overall development, and bringing Jen along as a partner in his care.

Jen is now ambivalent about this decision, on one hand she is happy she could give her son breastmilk, and on the other hand, she says it was "such hard work." She continues, "I was kind of at the point where it was really getting to me, it wasn't helping me get better mentally, just the seven or eight times a day," an infant is fed on average over a 24-hour period (Plunket, 2024a). However, she also reasons that because of her mental state at the time, if she had stopped express feeding, she would have felt like she was "failing as a mother, because surely one of the most natural things of being a mother is that you, if you've given birth to the child, is you then feed the child from your breast because that's what your body does." The feeling of failure was also a sentiment shared by Pippa, and documented by Ryan et al. (2010) who conclude that when a mother does not enjoy in breastfeeding their infant "she has few other discourses to call upon but the one that says, I failed, I feel guilty, I've let them down" which causes a crisis in her sense of self" (p. 957), Símonardóttir & Gíslason (2018) analysed the narratives of 77 women who struggled with breastfeeding in Iceland, a country that strongly promotes gender equality and where breastfeeding represents a strong moral and social norm, with high expectations that mothers breastfeed their infants. The mothers interviewed in this study went through similar difficulties breastfeeding as both

Pippa and Jen and were also encouraged to express breastfeed to enhance milk production. Moreover, the mothers reported being surprised that breastfeeding could be difficult, and not being able to breastfeed affected their sense of self-worth. However, also like Pippa and Jen, after trying everything they could do breastfeed successful, making the decision to stop breastfeeding provided a sense of relief to the mothers and marked a new phase of their motherhood (Símonardóttir & Gíslason, 2018).

When Jen gave birth to her second son, she hoped for a different experience with breastfeeding, however after two weeks his tongue tie began preventing him from latching and he was not getting enough milk, "and he would just be fussing and screaming and on and off and on and off. And so, he had a couple of [tongue tie] releases, but it didn't really help, and I pumped for a bit while we were trying to figure stuff out. So, he had breast milk until he was about three months." Although she had been through this process before with her first son, Jen found the decision to stop express feeding and start her son on formula, difficult to make. She remembers being persuaded by different providers that with time and a lot of work she would be able to breastfeed her second son:

> So, there must've been about four or five midwives and lactation consultants that had seen [second son] feed, and Ora Toa that thought that it all looked fine. So, they were kind of feeding this hope that no, we just need to get through this little blip, and we'll be able to figure that out.

However, she says her Ora Toa nurse was "straight up" with Jen, acknowledging her intention to breastfeed, and balancing that with the reality of her situation:

> She was like, "you can [breastfeed], but it's going to be a lot of hard work." She saw what was going on, she saw exactly what everybody else perhaps hadn't quite seen and she just told me straight up about it and was honest.

Jen agonized about this decision for weeks, but with the help of her mum she was able to make the decision to stop express feeding and start exclusively formula feeding her son. She quips, “at the end I was like, well, I’m just obviously really good at growing boys with tongue ties.” Jen needed to get to the point where she could believe it was not a moral failing that she was not able to breastfeed her sons; it was something that she had no control over. Jen reflects, “it was subconscious and not realising how much I’d been influenced pre-children around, well, if you feed your baby, you just breastfeed, it’s there.” Jen says often notices breastfeeding promotion in public spaces:

> Everywhere you see breastfeeding, breastfeeding, breastfeeding, you go into the malls and you go into the bathrooms and it’s like breastfeeding posters and then things, anything in the hospital, it’s all breastfeeding friendly and so nobody talks to you about formula, how to do a bottle, whether it's breast milk or formula, how to do it, how to do it safely, and anything. If you do go looking as to how to do [formula], it's kind of like, maybe this is a bit harsh, but kind of scare tactics of there's so much bacteria that you can introduce and you have to be so careful and you have to have water at this temperature and it's made to be really intimidating and scary if that's the option that you choose.

Jen is reflecting on the pervasiveness of the "breast is best" campaign, attributed to the World Health Organisation (2024). The campaign has been readily embraced by governments and health systems, contributing to the moralising of breastfeeding, and villainising of formula feeding in many countries, including Aotearoa New Zealand (Símonardóttir and Gíslason, 2018)

Perinatal Depression and Recovery

Jen says she knew soon after her first son was born that what she was feeling was more than baby blues and what she was likely experiencing was postnatal depression. She remembers:

> I didn't feel any immediate sense of like, oh my goodness, I love this guy. So, I didn't feel that, and to be honest, I didn't really have a really strong bond with him for quite a few months, which kind of probably added to and didn't really help the depression side of things.

Jen was referred to the Plunket Perinatal Adjustment Programme (PPNAP) by her Plunket nurse. She said the programme helped her with strategies to connect with her son, such as narrating their day-to-day activities. She remembers her mental health began to improve when she started to bond with him, chatting with him and admiring him at around six months old. Jen also reached out to some of the new mothers she met during the antenatal course, she remembers:

> It took me a couple of days to build up the courage to be like, I'm feeling a bit lonely. I just wondered if anybody wanted to go for a walk or a coffee. And they were like, oh my god, yes, . . . we feel the same way. And that kicked off quite a tight little kind of group.

Through the group, Jen began to feel less lonely and was relieved to connect with other mums with similar experiences of new motherhood.

With her second son she said she experienced a brief bout of baby blues but because she was aware of the signs of postnatal depression, Jen was able to create a support system around her which included her midwife and her GP. She describes her second midwife as “amazing” and explains that she felt much more connected to her than to her first midwife. Jen says she “was very aware, knew kind of where I was at with breastfeeding and that I was worried about postnatal depression.” After her second son was born and they had returned home from the hospital, her midwife or a member of her team conducted five home visits in the first week to support Jen and her son and assess her mental health. Reflecting on both midwife experiences she says:

> Even when [second midwife] was not able to do it, one of her team did it. They'd say, "I need to check with you, how's feeding going and how you feeling? [Second midwife] said, these are two things that I specifically need to check." So that was really, really good. I didn't see [first midwife] until about day four or five. And even though I would've had more problems feeding first time around, I just didn't get that level of support. [First midwife] did say, "oh, there's the breastfeeding clinic, why don't you go in?

Jen surmises that if she had received earlier postpartum support from her first midwife, they may have identified that she was starting to develop postpartum depression which affected the first six months of her first son's life. From her experience with her first son, Jen was able to call on her second midwife for support during the first days and weeks of his life, "they just kept checking and they kept checking with how feeding was going. So, they knew the kinds of things that might get to me, so, they were really kind of checking for that." Aotearoa New Zealand midwives provide continuity of care up until the infant is six weeks old, and during this time, one of their roles is to "support with the transition into motherhood" (New Zealand College of Midwives, 2024b). Leahy-Warren (2018) explains "ultimately, perinatal social support as perceived by women needs to be individualised, so that it is aligned with their needs and expectations; available and provided by the right person" (p. 220). New Zealand midwives are trained to provide PCC to mothers, however based on Louise and Jen's experiences, this is dependent on individual providers.

Chapter Conclusion

Jen's experiences are reflective of many women who become mothers, from deciding whether to have a child, to struggling with the lack of control that seems to come along with the role. Breastfeeding is positioned and widely promoted by government, the health system, and clinicians as the only safe way to feed an infant, causing women who are not able to breastfeed, like Pippa and Jen, to feel like they are putting their babies at risk if they use formula. Moreover, when Jen engaged clinicians and providers who have implemented PCC and Māori constructions of care her experiences were overwhelmingly positive, when compared to those who provided biomedical healthcare. Her medical outcomes did not differ, her sons were both delivered safely, and she was not able to resume direct breastfeeding, showing it is how providers and clinicians deliver care is paramount.

Chapter Six: Sarah

Sarah is bubbly, thoughtful, and generous; she welcomes me into her home, and offers me a coffee and prepares a tray of morning tea for us to share. Her home is full of toys and activities for her two-and-a-half-year-old daughter, who is at preschool. Sarah, now in her early thirties, says she fell pregnant with her daughter soon after she and her husband made the decision to start their family. She says she "had a loose idea of motherhood" and when she learned she was pregnant, she remembers feeling "excited and nervous. I think the idea of being a parent versus the actual in your face, I'm going to be a parent; reality is a lot different. I definitely still questioned my ability to parent, but I was excited." Sarah reflects the parenthood paradox, a term coined by Baumeister (1991) to highlight the discrepancy between one's expectation of parenthood and the reality of being a parent. Research is mixed about the parenting paradox's effect on mental health outcomes, with some studies showing an increase in negative mental health outcomes (Baumeister, 1991; Evenson and Simon, 2005) and others showing positive mental health outcomes for parents (Nomaguchi & Milkie, 2003).

Nelson and Kushlev (2014) developed a model to identify the specific circumstances as to why and how parents may experience more or less happiness. They then applied this model to explain when parents are more likely to experience more or less happiness, using three primary methodological approaches: studies comparing parents and non-parents, studies tracking the changes in well-being during the transition to parenthood, and studies comparing parents' experiences going about their daily activities with and without their children. They found:

> . . . parents are unhappy to the extent that they encounter relatively greater negative emotions, magnified financial problems, more sleep disturbance, and troubled marriages. By contrast, when parents experience greater meaning in life, satisfaction

> of their basic needs, greater positive emotions, and enhanced social roles, they are met with happiness and joy (p. 888).

Sarah describes her experience of motherhood as similar to Nelson & Kushlev's (2014) findings:

> I'm less stressed being a mum. I just got really weighed down being in an office full time and being a mum; while I have some of that short-term stress of just the battle of wills, I enjoy being a mum a lot more than I enjoyed being an office worker.

She identifies the role of mother as both stressful and more fulfilling than her previous paid work.

Pregnancy and Childbirth

Like Louise and Jen, Sarah also struggled to find a midwife; she too started reaching out to private midwives at six weeks pregnant. She remembers sending out 20 to 30 emails and only hearing back from one midwife, a new graduate:

> She sent an email being like, "we'll have a meeting and if you like me, you can choose to go with me, but no pressure if you decide to go with someone else." And I was like, "there isn't anyone else . . ." She was really lovely, but I definitely think personality wise, a different midwife would've been better for me, but I didn't really feel like we had the option to, I guess, shop around.

Sarah encountered the health system for the first time when she was pregnant; she says navigating the unfamiliar system was difficult and she struggled to understand "hospital talk." There was also limited access to healthcare due to the emergency state of the COVID-19 pandemic. Sarah remembers, "all of our hospital appointments and whatnot were really odd." She says she was required to attend all her antenatal appointments alone, without her husband or a support person, including her 20-week scan when she found out the sex of their baby. During her pregnancy she encountered several complications such as, low foetal movement, her baby measuring large, and a possible diagnosis of gestational diabetes, for which she required guidance and support from her midwife. However, her midwife was at times unreachable and often missed their scheduled appointments. Sarah says the stress of the complications was exacerbated by her midwife being unavailable to her at critical times during her pregnancy:

> It was like, well, “what's actually happening? Where are my results? What do they mean? What can I be doing?” And so, it just felt like there was just that little bit of lack of guidance. . . . there was just a little bit of that back of the mind being like, well, “what's actually happening? Who do I talk to if I can't reach my midwife? What are the supports in place?”

Sarah recalls at one point during her pregnancy when she was worried about low foetal movement, she took herself to the hospital and requested a check to confirm that her baby was okay; a request the hospital midwives were happy to accommodate.

This issue with her midwife was likely compounded by the government’s mandated COVID-19 restrictions (COVID-19 Public Health Response (Requirements for Close Contacts) Order 2022). Crowther et al. (2021) conducted a systematic scoping review of Aotearoa New Zealand maternity and midwifery services and the COVID-19 response; they found that guidance provided to maternity healthcare providers during the first months of the pandemic was inconsistent and mainly focused on hospital-based services. The guidance overlooked midwives who provide continuity of care across community and maternity facilities. This created ambiguity and caused additional stress as they tried to keep themselves and their whānau safe, while still caring for pregnant women, new mothers, and newborn babies (Crowther et al., 2022). Furthermore, during the COVID-19 pandemic many patients, including pregnant women were required to advocate for themselves within the health system (Ryan and Barber, 2022). Patients who self-advocate are shown to have better health outcomes (Hagan et al., 2017); however, Sarah explains she did not have a thorough enough understanding of the health system at the time to challenge the practices of her providers, including her midwife (Wiltshire et al., 2006). Moreover, women who have a support person available to them throughout their perinatal care are shown to have lower rates of postnatal depression and anxiety and higher satisfaction with birth (Campbell et al., 2007). In Sarah's case, her midwife should have fulfilled the support person and advocate roles, as whānau and other support people were restricted from attending appointments during this period of the pandemic.

As her due date approached, Sarah wondered if her midwife would be present during her labour and birth, or if she would have a midwife with her who she had not met before, like Jen experienced. However, she says her midwife met Sarah and her husband at the hospital and was with them as Sarah began to push. She recalls that by then, she was exhausted and wanted to sleep rather than push, and felt she needed firm instructions on how to birth her baby safely. She reflects:

> I'm a personality that definitely needs someone maybe a little bit more hard-nosed . . . When I got to labour, she wasn't quite the right fit for me. And that was kind of where it really came out that maybe a different personality would've been better."

Fortunately for Sarah, a hospital midwife with two students in tow, asked if they could attend her labour. The teaching midwife ended up providing the guidance that Sarah needed:

> She came in and she was straight up, knew that I probably at that point, wasn't trying as hard as I should be. And she was like, "right do it, push now," and just gave me that real firm guidance, which I personally needed, I wasn't responding to any of the niceties that everybody else was giving.

Sarah, like Louise, Pippa, Jen, demonstrates the need for providers to build trusting relationships with their clients. During labour Sarah's midwife did not know what she needed from her to be able to persevere to birth her baby. She says, if it was not for the hospital midwife, she would have likely had to undergo an emergency CS.

What Sarah experienced is an aspect of the biomedical healthcare and an outcome of managerialism, in which her midwife could not invest in a relationship with her. As a result, (1) they may not have known that Sarah had gaps in her knowledge of the health care system, maternal and foetal health, and needed information and reassurance; (2) Sarah did not feel included and able to participate in her own care, and felt she had to seek information and reassurance from a hospital midwife (Alharbi et al., 2014). Sarah repeats the sentiment that her midwife was “really lovely,” three times during our interview, a testament to her generosity. She sums up her experience with the health system, identifying a systemic issue facing the midwifery profession and their clients. “This is a problem I think with the system, not with my midwife, is that she was always so busy with other people or with deliveries or whatever, that often our scheduled appointments would be missed.” She suggests how the health system could better support midwives and their clients:

> I think it's kind of a common complaint from midwives is that they are under resourced. So, I can understand why they struggle to keep up in the same way, but there needs to be systems in place so that they have backup people they can call on. So that a missed appointment is like, okay, I might not see you, but can I see someone else?

Sarah says that if she has another baby, she will opt for the CMT instead of trying to find a private midwife with whom she might form a better connection. She seeks the consistency of care a hospital-based CMT can provide, as opposed to a singular point of contact, common for community-based midwifes, which she found to be too inconsistent. Sarah reflects, “I think as well as once you've had a child, you can make a lot more informed decisions because you know what your own journey's going to look like.” A sentiment shared by Louise and

Jen who both chose different midwives for their second pregnancy with whom they had stronger connections.

Breastfeeding

Sarah’s experience of breastfeeding was much the same as for Pippa and Jen; she was provided guidance for breastfeeding in the postnatal ward, however by the time they were discharged, her baby was struggling to latch, and Sarah’s milk production was limited. When Sarah and her husband brought their baby home, their midwife took some personal leave and organised for another midwife to conduct their home visits. Sarah describes this midwife as “really helpful” particularly with breastfeeding. She explained to Sarah that “fed is best” and if her daughter needed formula, that was okay. “Fed is best,” trademarked by The Fed is Best Foundation (2024), challenges the dominant breastfeeding narrative “breast is best:”

> Fed is best means that a baby must be *fully* fed to have the *best outcomes,* and that can’t always be achieved with breast milk alone. Therefore, parents who choose to feed formula either partially or fully to ensure their child is fully fed, whether out of necessity or choice, are, by definition, providing their child the “best” (The Fed is Best Foundation, 2022).

The Fed is best movement recognises that although many babies and mothers can breastfeed, not all babies can thrive by consuming only breastmilk. This may be due to multiple factors including low milk production as Sarah describes, or difficulty latching as Pippa and Jen experienced. Kent et al. (2016) found that there may be a significant number of women that do not produce enough milk to exclusively breastfeed their babies, even when controlling for factors like skin to skin contact between mother and infant and milk removal within one hour after birth, which is associated with higher rates of breastfeeding beyond six weeks for term infants (Hill et al., 2005). The researchers weighed term infants before and after each feed over a 24-hour period in the first four weeks of lactation. They found that by between days 11 and 13, two-thirds of the mothers produced less than 440ml of milk per day, the adequate daily milk production for established lactation usually reached by day 11. And between days 14 and 28, nearly one-third of the mothers produced less than 440ml of breastmilk per day. This study contributes to the conversation that breastfeeding may not always provide the nutrition needed for a baby to thrive. Going forward, Sarah and her husband decided to mix feed their baby breastmilk and formula until she was around four months old, when they decided to exclusively feed her formula. At that point, her baby was losing weight, and they were concerned for her health.

> We did eventually decide, actually she's losing weight. We can't keep going with this, she needs what's going to help her build it back on. Especially as she was born so small, so we went for the formula journey, and it was really good, it was a lot less stressful.

This sentiment is shared by both Pippa and Jen. As like all the participants of this study, Sarah intended to exclusively breastfeed her baby and expresses her own internalisation of the breast is best narrative:

> It was really hard because obviously everything you hear is just breastfeed, breastfeed, breastfeed, like breastfed is best. And it feels like one of those things that people should just do. It should just happen. You don't feel like it's something that, I mean obviously it's something you have to learn, but when it's talked about it as a child, you're just like, this is just what happens, it's just natural. And it didn't happen for me, so that felt a bit hard.

Even now Sarah says she would try to breastfeed again if she and her husband decided to have another baby. However, she says she "would be a lot less hard on myself still wanting to try and still giving it a go, but being a lot probably quicker to accept that, hey, maybe this just isn't a thing."

Healthcare

Māori Healthcare

Sarah’s midwife recommended that she transition to Ora Toa for her daughter’s WCTO care. Sarah doesn’t drive and Ora Toa attends the family’s home for all appointments, unlike Plunket which requires parent and baby to attend their clinics following the initial home visit. The family’s Ora Toa nurse was a new to the role which worried Sarah following her experience with her midwife. WCTO providers should have the expertise to help parents manage their baby’s care, in Sarah’s case, her Ora Toa nurse should have been able to support Sarah with breastfeeding issues, including transitioning to mixed feeding and formula feeding (Te Whatu Ora, 2024c). However, Sarah recalls that she was advised by her Ora Toa nurse to make an appointment with her GP:

> She actually sent us to our GP and our GP was the one who did that for us. And that was fine, but it was just another person to do it . . . We didn't have to pay for the service anyway, but it was just one of those things that should have been a seamless process, but we ended up adding in another loop.

Sarah reflects, that although the Ora Toa nurse’s care was “a little bit shaky at first,” she values the knowledge and experience the nurse has gained over the two years she has been visiting their family. Moreover, she appreciates that their Ora Toa nurse knows their history and provides consistent advice specific to their family, an essential feature of PCC. An aspect of the Ora Toa service that differed from the other participants’ experiences of Plunket and was similar to Jen’s experience of Ora Toa, is their approach to infant milestones. Sarah remembers when her daughter was not gaining weight as quickly as her growth chart predicted, her Ora Toa nurse explained that this was concerning but that Sarah could speak to her GP about strategies to help her gain weight. She says:

> “I didn't feel like I was in trouble because of the milestones not being met. . . . It was more holistic: so, this and this are happening, but this isn't happening well, we need to do something, but this is normal.”

The Ora Toa nurse normalised Sarah's daughter's slow weight, reducing her stress and finding practical strategies to support her and her whānau.

Perinatal Depression and Recovery

When their daughter was just a few weeks old, Sarah and her husband both contracted COVID-19 and during this time there were strict isolation procedures for anyone who tested positive with the virus. Sarah recalls that first her husband contracted the virus and when he was nearing the end of his isolation period, she too tested positive. This means that the new parents were isolated from their external support network, including healthcare providers, whānau, and friends, for close to one month putting Sarah as risk of postnatal depression and anxiety (Ryan & Barber, 2022). “Being physically distanced from others breaks the natural ties and culturally embedded traditions that typically have new parents surrounded and held by family, community, and professional supports” (Ryan & Barber, 2022, p. 5). Sarah reflects, “I don’t know if they didn’t really think about supports systems for young mums going through that or just anyone.” Ryan and Barber (2022) interviewed Auckland-based mothers and healthcare providers out about the needs and experiences of women with postnatal mental health conditions within the pandemic condition. They found that the lack of emotional and practical social support, increased the participant’s feelings of isolation. Their findings were consistent with similar studies in a range of countries including, Canada, United Kingdom, and United States, that show there was an increased risk of postnatal mental health conditions during the COVID-19 pandemic, with depression rates at high as 40 percent and anxiety rates of 72 percent (Davenport et al., 2020).

Sarah was not diagnosed with postnatal depression; however, she reflects now over two years on, “I probably had a little bit of depression. I didn’t ever diagnose it, and I didn’t do anything about it. But definitely coming out of it, I look back and I’m like, “I was in a black hole.” Rates of undiagnosed and untreated perinatal depression are thought to affect as many as 50 percent of mothers, and both are associated with poor outcomes for both mother and child (Cox et al., 2016). Sarah attributes her poor mental health to several factors: her difficulty breastfeeding, lack of sleep, and her experience of feeling uninformed and unsupported through her pregnancy, labour, birth, and early postpartum period. “I think it just all kind of culminated into me just not really being happy, just being a bit depressed.” When I asked Sarah how she eventually recovered, she reflects that when her daughter started putting on weight, her mood started improving. This is the point in which she switched from express breastfeeding with formula top-ups, to exclusively feeding her daughter formula.

Social Support

Sarah values the support she receives from her and her husband’s families, however, shares that when her daughter was born, and as she settled into motherhood, she felt she needed to put boundaries in place for one key relationship. Sarah and her husband live in a house his parents helped him buy before they were married. Before Sarah moved in, her husband had flatmates living with him; given their stake in the house, Sarah’s in-laws particularly her mother-in-law, spent a lot of time at the house, helping with chores and checking on the property. When Sarah moved in after she and her husband married, her mother-in-law continued to spend a lot of time visiting their home. At the time Sarah was working and did not mind, however when the couple came home with their baby and her husband returned to work, Sarah said she now needed “space to learn how to become a mother.” Sarah decided to initiate scheduled visits for her mother-in-law to visit their home instead of arriving unannounced. This process took time as they settled into their new roles as mother and grandmother:

> I think when you have a new member of the family, you suddenly have to juggle things differently. And they're learning as much about becoming grandparents as you are learning about becoming a mother. So, it's a process, I think. I am not going to say it was all great, but we learned together.

This desire for space may be reflective of the neo-liberal value of self-reliance, transmitted through intensive mothering.

Although Sarah put in place boundaries with her whānau to have better control over her and her daughter's routine, loneliness is shown to contribute to perinatal depression. Loneliness in pregnant mothers and those with children under five years old may be as high as 40 percent (Kent-Marvick et al., 2022). Small et al. (1997) conducted a population-based study of depressed mothers; when asked why they thought they were depressed, the participants most common responses were, ‘‘lack of support’’ and ‘‘feeling isolated." Furthermore, research shows that high levels of parent stress from the demands of caregiving, and childcare stress due to lack of available childcare support, are risk factors for postpartum depression (Yim et al., 2015; Hahn-Holbrook & Haselton, 2014). Bost et al. (2002) found that social support is an important predictor for parents’ wellbeing, less parent depression, and an easier psychological adjustment to parenthood. Sarah says, “as [daughter] got older, we'd kind of settled on a routine where her *nana* and *great grammy*, because great grandma's still alive, would come over once a week and we had a day that they'd come.” She felt more comfortable leaning on her for support. Sarah does not drive, and she says her mother-in-law would drive her and her daughter to and from GP visits:

> It was one of those things that I guess also allowed me to kind of connect better with my mother-in-law because it's like, well, hey, “actually you're really willing to do

> these things and jump in where I need you. I need to be a bit more flexible as well around actually allowing you time to visit."

Sarah is very considered when reflecting on her relationship with her mother-in-law; she passed away between our interviews and she speaks about her with a great amount of warmth.

Like Louise and Jen, Sarah attended the Parents Centre Antenatal course and describes gaining a supportive network of new mothers at its conclusion. She also says she found the information provided during the course useful, she says she did not know much about pregnancy, birth, or newborns prior to the classes. She reflects:

> Even if you don't get a lot out of the course, even just knowing some of the things you might want to Google is a good thing. I'm not a pre-planner, I was like, "I want a kid." I didn't do any research so having that course and knowing places I maybe should look or things I should know was really helpful . . . But definitely the networks been the most valuable thing. My antenatal group, we're still in touch.

Sarah identifies the validation that the other participants also felt in having mum friends with children around similar ages, "just knowing that other people are facing the same things makes you feel like you're not doing as bad a job." When Sarah started working part time from home when her daughter was three months old, her antenatal peers reassured her of her decision:

> My antenatal group were really accepting of it. A lot of them are career focused mums, and they're like, "yeah, I get it." I think they started going back at about six months, a lot of them, but they understood it. They were like, "oh, that's really tough, but good on you for balancing career and mum life."

However, Sarah says that working from home while caring for her daughter eventually started to affect her mental health.

> But I do think it took a bit of a toll on my mental health. It was like, well, when she's down, am I juggling work? Am I juggling housework or am I getting some respite myself? So, I had the time, but definitely I was probably a little bit more of a stressed mum. But then she dropped the naps, and it got a little bit harder for a while. And then we started at preschool and suddenly actually my time's opened up a lot. So, I feel like I've kind of come out of a rocky road and we are getting into our new normal.

The dual roles of mother and paid worker without access to childcare seem to have contributed to Sarah's poor mental health.

Chapter Conclusion

Sarah's experiences of early motherhood were overshadowed by the global COVID-19 pandemic, which upended the health system and isolated people from their support networks. Like Louise and Jen, Sarah did not connect with her midwife and was disappointed by their lack of PCC. Furthermore, because she did not have adequate support during pregnancy, she had to manage her pregnancy complications on her own, without prior knowledge of health system. Sarah was fortunate in that her midwife recommended her and her daughter to be transferred to Ora Toa for postnatal care; their WCTO nurse has provided continuity of care for the family for over two years. However, during a critical time for her baby's development, their then inexperienced nurse outsourced much of their care to her GP, adding to the new mother's load. As COVID-19 restrictions eased, Sarah's social support increased and her mental health improved, this also coincided with she and her husband's decision to exclusively formula feed their daughter, a decision Sarah is happy she made.

Chapter Seven: Discussion

Within this thesis I have explored four experiences of motherhood and matrescence in Aotearoa New Zealand. These documented experiences foreground factors that contribute to the wellbeing of new mothers. By focusing on the experiences of four participants we can see how the dominant constructions of neoliberalism and managerialism, motherhood, disease and repair, and health and illness, transmitted through public organisations, influence the identities and experiences of these mothers (Somers, 1994). Neoliberalism and managerialism often go hand in hand, as I have shown, and as Komersaroff (2015) articulates, "the radical cost cutting and privatisation of social services that followed the adoption of neoliberal principles became a public policy strategy rigorously embraced by governments around the world" (p. 519). Furthermore, I wanted to ascertain whether the Aotearoa New Zealand health system is serving the economically privileged, Pākehā women who have historically had more positive health outcomes than Māori women (Hays, 1996). I found that not only is the health system not serving the Pākehā mothers, but what they described is a Kafkaesque bureaucracy which obstructs the provision of quality healthcare and may have negatively contributed to their mental health during the perinatal period (Clegg et al., 2016). Through their interactions with the Aotearoa New Zealand health system, we can identify the inherent power imbalances which exist between mothers and clinicians, and the influence this can have on a mother's self-efficacy and help-seeking. We can also see how mothers challenge the valuing of individualism in the current system, which arose as a result of neoliberalised managerialism, and which permeates other constructions, including intensive mothering, disease and repair, and health and illness. Participants in this research do this by rejecting the service providers which fall short of their expectations and instead opt for midwives with whom they have a connection, peers and whānau, and Māori Well Child Tamariki Ora providers.

In this final chapter, I return to my central concerns in this thesis, neoliberalism, managerialism, disease and repair, health and illness, and intensive mothering, expanding on these constructs in relation to my findings from the four cases. As I have done so above, I will present the key findings from each case comparatively. The first presents the demands of intensive motherhood, specifically, self-reliance and perfectionism and how these factors may have negatively contributed to the participants maternal mental health (Hays, 1996). In the second section I explore the Aotearoa New Zealand health system, specifically midwifery, hospital, and specialist care, and the WCTO programme. The system appears fragmented to participants; clinicians appear overworked; missing appointments, neglecting vital health information, and are not focused on the wellbeing of the mother/baby dyad in context, but on checkboxes. I contrast this reported situation of fragmentation in the system interactions, the participants report having with select clinicians, who appear to them to practice person-centred care with a Māori WCTO provider. In my concluding statement, I postulate that the current health system is not fit for purpose for new mothers. Embedding a relational construction of health, illness, and motherhood may contribute to a decrease in poor maternal health outcomes for both Pākehā and Māori mothers. I will conclude with the importance of conducting feminist narrative research to co-construct emancipatory approaches to challenge the primacy of harmful constructs on healthcare for mothers.

Mothering in Aotearoa New Zealand

The four cases presented in this thesis, reveal commonalities in the lived experiences of motherhood and matrescence for participants. Louise, Pippa, Jen, and Sarah are all economically privileged, Pākehā women, who live in single-family homes with the fathers of their children. They are all university educated; Sarah is in paid employment, Louise and Pippa are on parental leave, and Jen left paid employment when she had her first baby. These mothers expressed relatively little access to support and are the primary adult responsible for child rearing in their whānau. All four women described the pressure they felt to meet the demands of motherhood and reported experiencing both diagnosed and undiagnosed perinatal depression. There are two factors that I think contributed to the pressure they described feeling during the initial postnatal period: self-reliance and perfection. As Das (2020, p. 22-23) explains:

> Intensive mothering fits perfectly into heavily gendered, neo-liberal visions of individual responsibility and self-management, where overworked mothers must remain tied to the priceless child. . . this discourse has been mobilised at various private and public institutional levels placing a strong imperative in the hands of mothers to invest high amounts of physical and emotional energy into specific activities and practices with children, without which they might themselves be putting their children's interests last or undertaking enormous risks.

In this quote, Das (2020) evokes the neoliberal value of self-reliance, to illustrate the social expectation that a woman must sacrifice herself when she becomes a mother to adequately care for her child. Moreover, the discourse Das (2020) invokes in the second part of the quote demonstrates the social pressure mothers may feel to be perfect, all-encompassing caregivers to their children, even to the detriment of their own wellbeing. However, given what we can extrapolate from studies of contemporary hunter-gatherer groups, self-reliance was not valued in our evolutionary past. In hunter-gatherer societies mothers have large networks of allomothers to help them care for their baby (Bridgers & Fox, 2024). Furthermore, in pre-colonial Māori cultures, childrearing was shared across the whānau by both women and men. As the Ritchie's (1997) observed, Māori who lived in urban settings during the mid to late twentieth century continued to practice multiple parenting by building peer networks around their homes. Without access to an extensive social support network, mothers are forced to become self-reliant and be one of the sole providers to their children's wants and needs.

Self-Reliance

Self-reliance is a hallmark of intensive mothering (Scott et al., 2004). However, the participants of this study did not seem to want to be self-reliant mothers, in fact they all reflected that when they received social support, there was an increase in their self-efficacy and wellbeing, and reduced feelings of loneliness and isolation. As Leahy-Warren (2018) describes, "social support frequently refers to the process through which social relationships promote health and wellbeing" (p. 219). Social support has been shown to be a protective factor for new mothers against perinatal depression (Leahy-Warren, 2018; Schobinger, 2022; De Sousa Machado et al., 2020; Ministry of Health, 2021; Dennis, 2010). This was evident throughout the cases. For example, Louise lent on her "critical friends' for support; some of which provided her with practical parenting support, whereas others provided emotional support. Similarly, Pippa credits her mum-friend in helping her make the decision to stop express feeding her baby, when she disclosed that she was feeling overwhelmed by the task. For Jen, the first six months following the birth of her first baby were difficult, as she struggled to bond with her son, and the profound difficulties she experienced establishing breastfeeding. When she reached out to a few new mothers she met through her antenatal class, she found that they too were finding the postnatal period difficult and were able to support one another and validate their experiences. Sarah also values the friendships she made with other new mothers through her antenatal class. She reflected that having friends with children of similar ages improves her self-efficacy as a mother because she can see their experiences reflected in her own.

During the first few weeks of her baby's life, Sarah was isolated from her whānau and wider support network. During the COVID-19 pandemic, the Aotearoa New Zealand public health restrictions contributed to the privileging of self-reliance by restricting people’s physical access to one another, to prevent spread of the virus. Sarah remembers being a new mother, struggling to establish breastfeeding, isolated from her social network which she says took a toll on her mental health. This situation exemplifies how different health initiatives can impact one another. Research into the influence of pandemic public health restrictions on maternal mental health during the pandemic substantiates this point. For example, Yan et al.'s (2020) quantitative study found that the rates of postnatal depression were higher during the COVID-19 pandemic than before its emergence. Abdul-Fatah et al.'s (2024) qualitative scoping review bore similar results, finding that public health restrictions that limited social contact had a negative influence on new mothers' mental health, related to lack of social and community support. Following this experience, Sarah set boundaries with her mother-in-law to manage her visits to her home, until she had established a routine with her baby. However, when she did allow her mother-in-law to provide practical support to her and her baby, Sarah spoke about how grateful she was for her help.

Although Louise valued her social network and recognised the positive influence they had on her wellbeing, she also spoke often about the importance of raising independent children. At the time we met, she was working to ensure her son became an independent sleeper. Louise was implementing a strict sleep schedule for her son, learning from experiences with her daughter at a similar age; she also wanted him to be an independent sleeper, not dependent on her or her husband to settle him to sleep. Unfortunately, adhering to the strict schedule contributed to Louise becoming socially isolated, and the times when she would feed him to sleep, made her feel like she had failed as a mother. Consequently, Louise was experiencing several weeks of depressed mood and was concerned that she had perinatal depression. She was in the process of seeking help from her general practitioner (GP) and support network, knowing that she would not simply recover on her own. Sleep training first arose around the 19th century during the industrial revolution when younger people moved to more urbanised areas in search of work.

With new parents living away from family and lacking access to allomothers, and the standardisation of longer workdays, parents have to figure out how to get more sleep. At the same time there is growing cultural emphasis on individualistic values, like self-reliance, even in babies (Rosier & Cassels, 2020). Presently, sleep schedules and sleep training are popular among Millennial parents; there are no shortage of regulated and unregulated infant sleep experts, sleep advice, and sleep schedules available through a simple internet search or through social media. Like the new parents of the industrial revolution, Pippa wanted her baby to be an independent sleeper so that she and her partner could get an adequate amount of sleep. Though they had a difficult time making the decision to sleep train their baby. Pippa wrestled with the idea of letting her cry, a common technique of sleep training, however, she was also suffering psychological effects of sleep deprivation and wanted her baby to be able to fall asleep on her own without Pippa or her partner rocking her to sleep. In contrast, Pippa's partner was happy to rock her to sleep through the night. Ultimately, Pippa made the decision that they would hire the services of a sleep trainer, as her mental health was declining. She credits sleep training with her baby being able to soothe herself to sleep and sleep through the night without the aid of her parents, and Pippa's improved wellbeing.

Public constructions of mothering and health and illness appear to influence the ways these participants think and act. This was evident in the experiences of the mothers who sought the social support of whānau and friends during their postnatal period, and reported increased wellbeing, and decreased feelings of isolation, and low mood. However, when Sarah put in place boundaries with her mother-in-law, to manage her visits until her and her baby established a routine, and Louise and Pippa sought to train their babies to become independent sleepers, we can see that they are enacting the neoliberal value of self-reliance.

Perfectionism

Like self-reliance, perfectionism in new mothers may contribute to poor mental health outcomes. A study on the relationship between postpartum depression and beliefs about motherhood and perfectionism during pregnancy found a positive association between depression, beliefs about perfectionism and poorer social support (Wittkowski et al, 2017). A study on the mental health consequences of idealised motherhood similarly found that the standards of perfection inherent to intensive mothering may have a negative effect on mothers despite their beliefs about motherhood (Henderson et al, 2016). Likewise, perfectionism emerged in all the mother's accounts, not that I believe that they were all striving to be perfect mothers, but it was prominent in some of the experiences they shared, particularly when it came to breastfeeding. For example, Louise called out her ambivalence about perfectionism, as an unachievable standard for any mother. She described her then mental state as two people trying to take the wheel of a car, two competing narratives, one striving for perfection, and the other recognising it is futile. Perfectionism was linked in participant accounts to the ideal mother engaged successfully in activities such as breast feeding.

Like many women in Aotearoa New Zealand, Louise, Jen, Pippa, and Sarah all intended to exclusively breastfeed their babies until they began eating solid foods at six months, at which time they would continue to supplement their diets with breastmilk. All four women described breastfeeding as "natural," and "innate," and what a women’s body is designed to do. This is in part due to how the meaning attributed to breastfeeding has been constructed. Some feminist advocates for breastfeeding have framed the act as empowering and inherently feminine (Anders et al., 2022). In doing so they have left unchallenged oppressive and highly gendered elements of infant feeding that trap women in an idealised vision of motherhood (Símonardóttir & Gíslason, 2018). There has also been a highly successful marketing campaign attributed to the World Health Organisation (2024) known as "Breast is best". Símonardóttir and Gíslason (2018) propose that the associated promotion of breast feeding is now so entrenched in culture that the primacy of breastmilk has been internalised as part of our collective understanding, and therefore is difficult, if not impossible to resist or counter. The discourse is such that if a mother does not breastfeed their baby from birth to two years old, they are put at a disadvantage both in health and intelligence. Furthermore, the discourse around formula feeding is constructed as a risky approach to infant feeding. If you feed your infant formula, you are denying them the benefits of breastfeeding which puts them at risk of certain illnesses, adding to a mother's guilt and shame when they cannot provide it for their baby. For example, if one was to look at formula feeding and wanted to conduct research on the formula brand that would best suit their baby, every website for formula available in Aotearoa New Zealand, requires you to read a message on the superiority of breastmilk for your infant, before you can access information about the product (Scherer, 2017). This further perpetuates the internalised fear that feeding your baby anything other than breastmilk is the wrong choice. Nevertheless, on average, Aotearoa New Zealand babies are breastfed for much less than two years.

The Growing Up in New Zealand study, presently being conducted by Auckland University, follows the lives of 6000 children and their families. This is the country's largest contemporary longitudinal study of child development which includes a unique insight into breastfeeding in Aotearoa New Zealand. The study found that the average rate of breastfed babies is 97 percent, though at six months of age only 15.3 percent of babies in Aotearoa New Zealand are reportedly exclusively breastfed, without supplements of formula or water (Castro et al., 2017). The experiences of the women in this study follow the trends in the Growing Up in New Zealand Study; three of the four women had profound difficulties breastfeeding.

Pippa and Jen experienced difficulties with latching their babies when attempting to direct breastfeed; they both decided to exclusively express breastfeed to preserve their milk supply until their babies were able to feed through direct breastfeeding. Pippa exclusively fed her baby expressed breastmilk for three months, during which time she disclosed to her Plunket nurse that she was finding the process distressing and wondered if both her and her baby would be better off transitioning to exclusive formula feeding. When Pippa made the decision to stop express feeding her baby, she reflected that both her mental and physical health improved. Sarah had a similar experience to Pippa's, she had low milk supply and decided to express breastfeed and supplement with formula. She also reflects that around the time she stopped express breastfeeding, her mood started to improve. Jen's two boys were born with tongue ties and although they received a medical procedure to release the ties, they were not able to latch to direct breastfeed. Jen exclusively express breastfed her first son for six months and her second son for three months. She found the decision to stop express feeding and move her boys on to formula difficult, she reported feeling like she had failed in her job as their mother. It should be noted that even though they waited, hoping their babies would learn to latch in Pippa and Jen's cases, or in Sarah's case her supply would increase, they were never able to exclusively direct breastfeed their babies.

Express breastfeeding is common, but the experiences of women who exclusively express feed their babies has not been widely researched (Anders, Robinson, Ohlendorf, & Hanson, 2022). Anders, Robinson, Ohlendorf, & Hanson’s (2022) study explores the experiences of women who practice exclusive express breastfeeding from a feminist perspective by exploring their infant feeding goals and intentions, and the factors that influence their experiences of feeding their babies. They found that mothers who exclusively express breastfeed feel “unseen and unheard” (p. 4) by health care professionals whose focus is on mothers who direct breastfeed (by latch) and even feel judged for express breastfeeding their infants. The participants in this study had positive and negative experiences with this method, some describe feeling “tied to the pump,” others said that it gave them more freedom to leave and return to work as their baby could be fed breastmilk by other caregivers. As with Pippa and Sarah, some women worried that they were not producing enough milk to feed their baby by expressing, and they decided to move their infants onto formula.

There is numerous research into the physical benefits of breastfeeding for the mother/child dyad; for example, breastfeeding results in fewer allergic rashes (Kramer et al., 2011) and gastrointestinal disorders for babies (Schnitzer et al., 2014) and lowered risk of breast cancer for mothers (Chowdhury et al., 2015). There is also research that shows the sociodemographic factors associated with breastfeeding, such as maternal age, education, parity, and pregnancy planning which all contribute to breastfeeding duration and exclusivity (Castro et al., 2017). However, there is little research into the psychosocial factors that facilitate or prevent women from breastfeeding for the recommended timeframes (Davie et al., 2021), and little acknowledgment of the disbenefits of breastfeeding for the mother (Anders, Robinson, Ohlendorf, & Hanson, 2022). Davie et al.'s (2021) grounded theory study of healthy women who gave birth to healthy infants, in which the researchers sought to understand women’s perceptions and practices of infant feeding behaviours in the early postpartum period, found that women with negative experiences of breastfeeding felt that they were not well prepared for the challenges of breastfeeding. Moreover, for breastfeeding to be a positive experience, it must work for both the mother and child. This aligns with Schmied et al.'s (2011) qualitative meta-synthesis of women's perceptions and experiences of breastfeeding support, in which women reported receiving unrealistic information about breastfeeding, rather than individualized support to establish breastfeeding or to identify difficulties such as latch (Schmied et al., 2011). Moreover, Fox et al.'s (2015) qualitative study of women's experiences of breastfeeding in the UK found that antenatal resources provided to first time mothers set unrealistic expectations of breastfeeding which led to feelings of failure when they encounter difficulties.

After Pippa had stopped express breastfeeding and started exclusively feeding her daughter formula, she reflected that the pressure that mothers face to exclusively breastfeed their babies is unrealistic, and there should be more awareness of the difficulties women may face when attempting to establish breastfeeding. Similarly, Jen decried the breast is best campaign that she says she sees in many of the public places she frequents, as having played a role in influencing her understanding about infant feeding, prior to having her babies. She further argues that the information available about formula feeding is negatively biased and led her to think it could be an unsafe product to feed her babies.

For Louise, Pippa, Jen, and Sarah direct breastfeeding was an indicator of a good mother; a narrative they internalised from health promotion marketing campaigns, and health providers and clinicians which will be addressed in the subsequent section. When Pippa, Jen, and Sarah were unable to establish direct breastfeeding, they had feelings of failure, that led to them to make the decision to express breastfeed. For the mothers, providing breastmilk to their babies was achieving the idealised version of motherhood they had internalised prior to having their babies. They all reflect that express breastfeeding had a negative influence on their mental health, and when they ceased, they experienced an improved sense of wellbeing.

Perinatal Healthcare in Aotearoa New Zealand

In this section, I identify the functions of the Aotearoa New Zealand health system with which the participants most often interacted: midwifery; hospital and specialist care; and Well Child Tamariki Ora. In doing so I consider how constructions of mothering, disease, health, and illness are enacted in these functions and how these guide the practices of providers and clinicians. I also seek to unpack the influence they have had on the women's experience of matrescence and motherhood, and their feelings of self-efficacy.

Community-Based Midwives

The New Zealand College of Midwives (2024c) describes the philosophy of Aotearoa New Zealand midwifery as grounded in principles of person-centred care:

> Midwifery is holistic by nature: combining an understanding of the social, emotional, cultural, spiritual, psychological, and physical ramifications of women's reproductive health experience, actively promoting and protecting women's wellness; promoting health awareness in women's significant others; enhancing the health status of the baby when pregnancy is on-going.

In sum, midwives have a significant influence on a women's perinatal experience and outcomes. It has been estimated that 95 percent of women in Aotearoa New Zealand are under the care of a private, community-based midwife or team of midwives during their pregnancy, labour, birth, and six weeks postnatal (New Zealand College of Midwives, 2024b). The community-based model is meant to ensure continuity of care throughout the perinatal period. Midwives support women's transitions into motherhood by providing information, helping with decision making, supporting mothers and their whānau with social stress, referring mother and baby to specialist care if required, and helping to establish breastfeeding and resolve feeding issues (New Zealand College of Midwives, 2024b).

Research shows that primary and community-based health systems can produce better outcomes (Starfield, 2011). Community-based midwives in Aotearoa New Zealand have a public health role which has been shown to reduce social inequality through health promotion; parenting education and coordinating care through the health system for vulnerable groups (McNeill et al., 2010). Furthermore, the community midwife model has been shown to produce better outcomes for women and babies, and is cost-effective compared with other models, partly as women under the care of midwives are less likely to receive interventions, like caesarean section delivery (Callander et al., 2018). In relation to perinatal mental health, a systematic review conducted by Caird et al. (2010) found that the community-based approach allows for more flexibility; when midwives can provide additional appointments to women, it has a positive effect on reducing postnatal depression.

As Louise, Jen, and Sarah attest when the community approach works, it works well. The midwife who stepped in to support Sarah when her and her husband arrived home with their baby, provided the person-centred support needed to establish breastfeeding. When she observed that Sarah was struggling to direct breastfeed her baby, the midwife assured Sarah that her baby would be safe if she needed to feed her formula instead of breastmilk. This relieved some of the pressure that Sarah felt to breastfeed her baby, despite the difficulties they were experiencing. Similarly, Louise and Jen had positive experiences with their midwives during their second pregnancies. Louise's midwife made her feel safe throughout her pregnancy, labour, and birth, and coordinated her elective caesarean section so she did not have to repeat her story, a factor that exacerbated Louise's fear of childbirth during her first pregnancy. Jen's midwife was proactive, setting an appointment to discuss her birth plan, and provided her examples of different scenarios to ensure she understood how her labour and birth may proceed. She was also present at Jen's labour and birth, and when she was unavailable for some postnatal appointments, she ensured that her team member was prepared to assess Jen's mental health, knowing that she experienced postnatal depression after her first baby was born. These community-based midwives provided an integral service which contributed to the wellbeing of the mothers and their whānau.

It is also important to note here that Louise, Jen, and Sarah also expressed vastly different experiences with their first midwives. The experiences they shared exposes a system under pressure. Despite starting their search for midwives in the early weeks of their first pregnancies, Louise, Jen, and Sarah were all unable to find a midwife that they connected with, and with whom they felt safe. Louise reached out to Wellington Hospital and was referred to their Community Midwifery Team, where she saw several midwives throughout her pregnancy, with no one point of contact that she felt like she could depend on, particularly when it came to coordinating her care with the surgical team who would deliver her baby. Whereas Jen and Sarah were both able to secure the services of a private community-based midwife but expressed disappointment with the care they were provided. Jen had to advocate for herself to her midwife to ensure that she had a birth plan that she was comfortable with, and then her midwife failed to attend her labour and birth, as she was not on-call that weekend. Jen was put in the position where she met the midwives that would assist in her labour and birth for the first time while she was already in labour. Sarah's midwife missed appointments and failed to provide critical information about the health of her and her baby while she was pregnant. She took herself to the hospital during her pregnancy when she was worried about foetal movements, a situation for which her midwife should have been available to her. Moreover, during her labour and birth, Sarah did not receive the type of support she needed to birth her baby. She spoke about how grateful she was that a hospital midwife was available to step in when she needed encouragement. For both Jen and Sarah, their midwives did not provide continuity of care, or build rapport and, more critically, trust with their patients; facets of person-centred care that could have made a positive difference to their experiences.

There are structural or systemic issues that contributed to the inadequate care the mother's experienced. While the community-based midwife model is person-centred, midwives work in a health system, administered by the government of the day, which increasingly features financial restraints and managerialism. Midwives who work within the community-based midwife model manage their own caseloads, and 40 cases per year is considered standard full-time equivalent. This number is based on low complexity cases. However, as Homer et al. (2019) illuminate, many midwives work in high deprivation areas, where midwives are likely to provide additional support for women, including additional appointments to help manage health issues, and social barriers women may be facing, such as transport, housing, and childcare. They argue that midwives working in areas of high deprivation should have reduced caseloads. Moreover, McRae et al. (2018) found that compared to physician-led perinatal care models, midwifery care can reduce the prevalence of low birth weight and preterm birth for women in low socioeconomic positions. However, these positive outcomes are predicated on midwives being adequately resourced and having effective referral mechanisms with the wider health system (Renfrew et al., 2014). A study conducted by the Ministry of Health and New Zealand College of Midwives (2017) found that community-based midwives' workload is 17 to 26 percent higher than standard full time equivalent. Lowering the caseload to 40 cases per year, from upwards of 50 cases per year, would require 150 to 200 additional community-based midwives. Moreover, their fees are set through regulation and are fixed meaning that they are paid the same fee for low and high complexity case and have no mechanism to recover fees for additional work (Bealing, 2020). Bealing (2020) argues this is a disincentive for midwives to take on complex cases and a workforce sustainability issue. They propose a marginal cost pricing model which links payments to the demand for and length of consultations, or a special fee for midwives who work in high-deprivation areas, or with women who have highly complex needs.

Furthermore, community-based midwives cannot collect fees until a woman reaches 28 weeks of pregnancy, or completion of services, putting them in a situation where they have to self-fund their work for approximately seven months before they can claim payment from the Ministry of Health. Bealing (2020) suggests a milestone payment approach would be more in-line with government contractors for other industries, like construction and infrastructure. Nevertheless, Suleiman-Martos et al. 2020 conducted a systematic review of burn-out in midwives, finding low salary and lack of professional recognition are sited as potential causes for burnout, and increased pay is not going to lessen their work loads.

There is a dichotomy between the neoliberal constructions enacted by the health system and the New Zealand College of Midwives. Community-based midwives face resource constraints, a compensation system that is not fit for purpose, and a growing population with highly complex needs, whom they do not have capacity to adequately support, is putting the industry, midwives, and pregnant women at risk.

Hospital and Specialist

All four women in this study gave birth at Wellington Regional Hospital, part of the Te Whatu Ora Capital, Coast and Hutt Valley which oversees three hospitals in the region. Te Whatu Ora Capital, Coast and Hutt Valley (2025a) sight three values that underpin the service, *manaakitanga* (the process of showing respect, generosity, and care for others), *kotahitanga*, (connection and unity), and *rangatiratanga* (leadership and authority), which align with what the Ritchie's sited as the most dominant aspects of valuing in Māori culture (Nikora, 2007). Wellington Hospital Maternity has 12 self-contained labour and birthing suites, a postnatal ward, and a range of outpatient services, called Pēpe Ora, which are organised holistically according to Mason Durie's (1986) Te Whare Tapu Whā Māori model of health. The model depicts four walls of a *wharenui* [meeting house] each representing an element of health, which when all in balance allows us to thrive.

Furthermore, the Orthopaedic Service, where Pippa's daughter was cared for, and other outpatient clinics are situated in Te Wao Nui child health service, adjacent to Wellington Hospital, a children-centred space that draws on Māori metaphors, "derived from Te Wao Nui a Tāne, the name translates as 'The Great Forest' and reflects the ecosystem of integrated health services designed for tamariki, rangatahi and whānau of central New Zealand" (Capital & Coast District Health Board, 2025b). Put together, the services espouse

Māori health and wellbeing constructions, and it would be reasonable to expect person-centred care when engaging with the clinicians who provide care there.

Under Wellington Hospital's Community Midwifery Team, Louise saw a team of midwives throughout her pregnancy, labour, birth, and six-week postnatal period. Louise suffered from severe fear of childbirth during her pregnancy, labour and birth stemming from her history of child sexual abuse. Although she accessed the support of two perinatal mental health services, who she credits with helping her through her anxiety, her midwifery care was fragmented and lacked continuity of care, which meant every time she met a new midwife, she had to repeat what she needed to help her feel safe. Furthermore, when she received the referral to an obstetrician for an elective caesarean section (CS), she understood from the referring midwife that she would have to make a case for her choice of birth plan and the obstetrician could deny her request; neither of which occurred when she met with her obstetrician. Finally, Louise explained to the surgeon and anaesthetist what she needed to feel safe, leading up to and during the CS. However, when she entered the operating theatre, they had not communicated her needs to the surgical team and Louise became distressed. In addition to community-based midwives, hospital midwives are an integral part of perinatal healthcare in Aotearoa New Zealand (Bealing, 2020). Hospital midwives, share the same values espoused by the New Zealand College of Midwives (2024c) as community-based midwives, and experience many of the same structural issues within the health system. Dixon et al.'s (2017) survey of 473 midwives found that midwives employed in the Aotearoa New Zealand health system worked less hours than community-based midwives but had higher levels of burnout and anxiety. This was associated with under-resourcing and lack of support from management. They also reported lower levels of autonomy, empowerment, and professional recognition. These issues and the team-based structure the hospital midwives work under in which women do not have one point of contact throughout their perinatal period, may have contributed to the experiences Louise described.

Another struggle between managerialism and person-centred care occurred when both Pippa and Jen were attempting to establish breastfeeding in the postnatal ward after delivering their babies. Pippa was not provided any individualism feeding support during the first 12 hours, until a paediatrician arrived to examine their baby and asked them why they were requesting minimal amounts of formula, when their baby should have been receiving five times the amount by that point. In Jen's case, she was asked to sign a consent form prior to being provided formula, which put her in a position where they had to choose between putting her newborn at risk by feeding him formula or letting him be hungry until she established breastfeeding. These examples illustrate that person-centred care needs to be implemented at all levels of the health system. The midwives that neglected to provide Pippa and her baby individualised feeding support, and had Jen sign the consent form, were doing their job as dictated by the health organisation where they are employed. The hospital has embedded a one-size-fits-all approach to infant feeding, forgoing the needs and preferences of individual mothers and their babies.

Pippa and her partner, both clinicians, working at Wellington Regional Hospital, came across the structural issues that prevent clinicians from providing person-centred care in both the postnatal ward and Te Wao Nui Child Health Service. Pippa felt safe in the operating theatre during the emergency caesarean section and credits the surgical team with providing her and her baby with exceptional care. However, when they were transferred to the postnatal ward after birth and then the orthopaedic outpatient service to treat their baby's hip dysplasia, there were several incidents that led Pippa and her partner to question the quality of the care they were receiving. In the postnatal ward, it was a paediatric registrar that diagnosed their baby's hip dysplasia and had to request the orthopaedic register that had cleared her hips just hours before, return to conduct a subsequent assessment. Pippa also reflected on the impersonal care they received in the outpatient service, when clinicians would walk in and out of the examination room to examine their baby, without introducing themselves to Pippa or her partner or requesting consent to assess their daughter. Pippa described the clinicians as being on "autopilot," which is known symptom of burnout (Smith, 2021).

The Aotearoa New Zealand health system has been experiencing systemic issues for decades, instigating recent system-wide reforms. One of the legacies of the previous health system is significant workforce shortages (Te Whatu Ora and Te aka whai ora, 2023). Workforce shortages can result in a lack of access to quality health services; and cause a number of issues for health workers, including fatigue, burnout, illness, and workforce retention. Workforce shortages have plagued the sector for years. Demands on healthcare workers during the COVID-19 pandemic exacerbated these issues. Hodkinson et al. (2022) conducted a systematic review and meta-analysis to examine the association of physician burnout with the career engagement and the quality of patient care globally; they found an association between physician burnout and poor function of healthcare organisations, contributing to high physician turnover and reduction in quality of patient care.

Louise, Pippa and Jen's experiences of services under the Te Whatu Ora Capital, Coast, and Hutt show a workforce hampered by managerialism, providing services and care that fall short of the values espoused by the public organisation.

Well Child Tamariki Ora

Plunket and Ora Toa are private organisations contracted to deliver the Well Child Tamariki Ora (WCTO) programme across the Wellington region. Their clinicians are experts in child health and development, who work with women and their whānau to assess and support child health, growth, and development, whānau health and wellbeing, provide early childhood education, and assess and support readiness for school (Plunket, 2024b). Plunket "believes in partnership and walking alongside whānau. We’re here to listen and to support you with what you need – not to judge, or to tell you what you 'have' to do" (Plunket, 2024b).

Pippa and Jen both had profoundly negative experiences when they sought support from their Plunket nurses about their difficulty breastfeeding. Pippa, who had been exclusively express breastfeeding her daughter, shared with her Plunket nurse that her mental health was declining. When the Plunket nurse told Pippa that providing some breastmilk for her baby is better than exclusively feeding her formula, they failed to assess Pippa and her baby as a mother-baby dyad, wherein, for the baby to thrive the mother also needs to thrive. Jen also met with her Plunket nurse when she was having difficulty direct breastfeeding her first baby, and he was losing weight. The Plunket nurse's implication that Jen was not feeding him enough on purpose, had a lasting effect on her self-efficacy.

For mothers to feel empowered to make their own feeding choices they need to "receive accurate, independent information covering a wide set of social and support issues relevant to the decision-making process, with well-explained epidemiological evidence recognised as just one factor impinging on decision-making" (p. 81). Moreover, during the antenatal period women should be delivered education normalising different breastfeeding experiences, including difficulties that women may face initiating and continuing breastfeeding and how they may be resolved; and raise awareness that the first few weeks after a baby is born is an adjustment period during which additional support may be required as breastfeeding is established. In the postnatal period, individualised feeding support should be provided with no agenda other than to enable mothers' feeding preferences and decisions.

For mothers to feel comfortable seeking help with breastfeeding, models of support should be developed that are mother-centred and proactive (Trickey and Newburn, 2012). This aligns with person-centred care principles of relationship and trust building between providers and clients. Relatedly, Schmied et al.'s (2011) metasynthesis on women's perceptions and experiences of breastfeeding support sums up the best practice approach to infant feeding support:

> . . . it is important for supporters to achieve a balance in their approaches: positive but realistic, not over idealistic; encouraging, proactive, and focused on the benefits, but not creating pressure on women to breastfeed and making them feel inadequate or failing if they do not. If women felt they were listened to with empathy and given detailed, realistic information that was centred on their needs, given encouragement, and affirmation, they felt supported (p. 58).

Pippa and Jen were not alone in their experiences with Plunket; Massey University collected 420 stories of families' experiences with the WCTO programme around Aotearoa New Zealand. They found that parents' experiences of Plunket were similar to Pippa and Jen's, in that they felt like they were using a tick box approach, focused on the baby's physical health, and not taking time to connect with the parents and whānau (Clapham 2024).

In contrast, Jen subsequently transferred her WCTO care to Ora Toa Pōneke. The latter provides a Māori-centred relational model of health, grounded in principles of *whakawhanaungatanga* (building trusting relationships), *tikanga* (cultural protocols and processes); and informed by cultural values of *aroha* (compassion and empathy), *manaakitanga* (kindness and hospitality), *mauri* (binding energy), and *wairua* (spiritual wellbeing). Jen's Ora Toa nurse assessed her baby's weight, as well as other developmental factors and determined that although her baby's weight was a concern, he was thriving in all other areas. Most importantly, they framed the weight loss as a problem they would solve together, and it was neither Jen's fault nor her responsibility to remedy alone. When Jen was having the same difficulties breastfeeding her second baby, the Ora Toa nurse was honest with Jen, telling her that she could continue to try and direct breastfeed her son, but it would be a lot of hard work.

Similarly, Sarah, who was referred to Ora Toa by her midwife, was under the care of a new Ora Toa nurse. When they first started working together, Sarah was surprised when her Ora Toa nurse kept referring her to her general practitioner when she did not know answers to the issues when they arose. This included Sarah's concern over her baby not gaining enough weight; although she encouraged Sarah to bring her daughter to her GP, her Ora Toa nurse also took a holistic approach and advised Sarah on how her baby was thriving. As she kept returning for home visits over the next two years, Sarah appreciated the continuity of care, and because her Ora Toa nurse knows her whānau's history and can provide individualised support and advice. The approach of the Ora Toa nurse is described by Schmeid et al. (2011) in their meta synthesis of women's perceptions and experiences of breastfeeding support, as achieving an important balance to ensure their clients feel supported: "positive but realistic, not over idealistic; encouraging, proactive, and focused on the benefits, but not creating pressure on women to breastfeed and making them feel inadequate or failing if they do not" (p. 58).

The differences between the women's experiences with Plunket and Ora Toa, which both are contracted to provide the same service within the same region, are stark. Plunket and Ora Toa are private organisations, not subject to the same constructions of health and illness or hampered by managerialism in public organisations. Although Plunket's states that it is an organisation which believes in partnership with women and whānau, in practice they are providing a one-size-fits-all approach that does not account for the whole person in context. Ora Toa on the other hand has found a way to provide the same service that is grounded in Māori relational values, making the mother's feel supported and understood, and respecting that for the whānau to thrive, mothers also need to thrive.

Concluding Statement

This study has documented how four mothers' experiences of matrescence and early motherhood were influenced by the social constructions that are enacted by governments, public and private organisations, and clinicians. The values that shape intensive mothering, such as self-reliance and perfectionism, are at different times enacted by the mothers and rejected by them. However, what continued to emerge from their experiences was their need for social support. I reflected on their experiences in relation to Aotearoa New Zealand's health system. I show that even when the principles of person-centred care are espoused, the system appears to be driven by managerialism. This can create ambivalence for clinicians who, under the strain of limited resources and cost-cutting measures, are at times unable to provide quality healthcare. I used the example of two WCTO, Plunket and Ora Toa, both private organisations which espouse similar person-centred values, but only Ora Toa provides that way of caring.

Knowing that the Aotearoa New Zealand health system was already letting down Māori mothers and whānau, I questioned whether it is serving Pākehā women during a vulnerable time in their lives. I contend it is not. During encounters with providers and clinicians whose practices are grounded in relational values, their experiences and wellbeing improved. Therefore, if the Aotearoa New Zealand government is committed to providing better care for new mothers and whānau, they cannot merely espouse person-centred and Māori health constructions, they must also implement them throughout the health system.

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Appendix 1: Interview Schedule

Interview 1: Personal story of motherhood and social groups

- Preliminary engagement and consent
    - *Go through consent process, participant signs consent form.*
- **Start recording**
- Spend some time learning about participant and their background (tone is casual, friendly, reciprocal).
    - Did you grow up in NZ, where? What brought you here?
    - What do you like about it?
    - How long have you been in Wellington?
    - Do you have family close by?
- Confirm they have a clear idea of the project.
- Provide an overview of the interview process and what we will cover in the first and second interviews.
- Focus of interview 1:
    - Eliciting their personal story of motherhood from conception to present.
    - Exploring how their social group memberships influence how they experience motherhood.
- Questions/prompts:
    - I'd like to start by hearing your story –
    - When did you know you wanted to be a mum? *Can you tell me more about that? How did you know you were ready? Was there anything that worried you about becoming a mum?*
    - Did you fall pregnant quickly, or did it take time? *Can you tell me more about that? Did you seek advice about becoming pregnant? Books, blogs, social media accounts, google, healthcare professionals, friends? What was helpful? What was not so helpful?*
    - How did feel when you found out you were having a baby? *How did your partner/family/friends react?*
    - What was pregnancy like for you? *Did you enjoy being pregnant, or parts of pregnancy? Did you have any physical discomfort? How did you prepare for your baby? What changed for you when you were pregnant?*

- How did you find out information about pregnancy? *Books, blogs, social media accounts, google, healthcare professionals, friends? What was helpful? What was not so helpful?*
- Did you know women that were pregnant at the same time? *Did you join any groups? Antenatal, online pregnancy forums, Facebook groups, etc.? What was helpful? What was not so helpful?*
- Tell me about the lead up to labour and delivery. *How did you feel? Did you have a birth plan? What arrangements did you make with your partner? Lead maternity carer? Family?*
- Tell me about your labour. *Was it as you imagined? Was your partner present? Anyone else? Did it go to plan? How did you feel about that at the time? How do you feel now?*
- Do you remember holding your baby for the first time? *How did you feel? What did your baby look/feel like? Do you remember anyone else being in the room with you? What was it like seeing your partner become a parent for the first time?*
- How long were you in the hospital? *What was it like for you? Did you get what you needed from hospital staff? Did you recover quickly from the birth, or did it take time to heal? Was it what you expected?*
- What was it like taking your baby home? *What was that first night/week/month like for you? Did your midwife/Plunket visit your home? Did you look forward to these visits? Did they answer your questions/provide reassurance/make appropriate referrals? Was your partner home with you? For how long? Was this enough time or would you have liked them to be home for longer? Did you have support from family and/or friends? Was it helpful?*
- Was there anything you found particularly hard about having a newborn? *Feeding, sleeping, settling? Did you seek advice from books, blogs, social media accounts, google, healthcare professionals, friends? What/who helped the most? What/who helped the least?*
- Can you remember how you felt during those early days of motherhood? *How did your body feel? How do you think you changed when you became a mother? How did you feel emotionally, were you happy, sad, anxious, lonely, bored, all the above? Did you feel close to your partner? Did they act as you expected?*

    - Did you have a group of new mum-friends when your baby was born? *Can you remember the first time you met up with your new mum-friends? How did you feel engaging with your new-mum friends versus your other friends? Did you feel supported by your mum-friends? Did you feel like you could offer them support? Did you spend much time together during the early months of motherhood? Was this important to you?*
    - Do you ever have any opposing views to mothering as your new-mum friends or other support people? *How do you navigate this?*
    - When you have a question or concern about your baby/child now, where do you seek advice? *Books, blogs, social media accounts, google, healthcare professionals, friends? Are they helpful? Are they unhelpful? Can you give me an example?*
    - Do you feel different now that you're a mum? *Physically, emotionally, socially? Have your priorities changed? Can you give me an example?*
- Closing
    - Signal the end of the interview.
        - Is there anything else you would like to add that we haven't explored?
        - Do you have any questions for me?
    - **Stop recording**
    - Confirm interview 2.
    - Take time to say goodbye and express gratitude.

Interview 2: Health and social services and social media

- Preliminary engagement
- **Start recording**
- Reflecting on Interview 1:
    - How did you feel after our last interview?
    - Did anything unexpected come up for you?
    - Is there anything you would like to add to our previous discussion?
- Focus of interview 2:
    - Mapping engagements with social groups and health and social services to support recollections and better understand their influence on the participant's experiences.

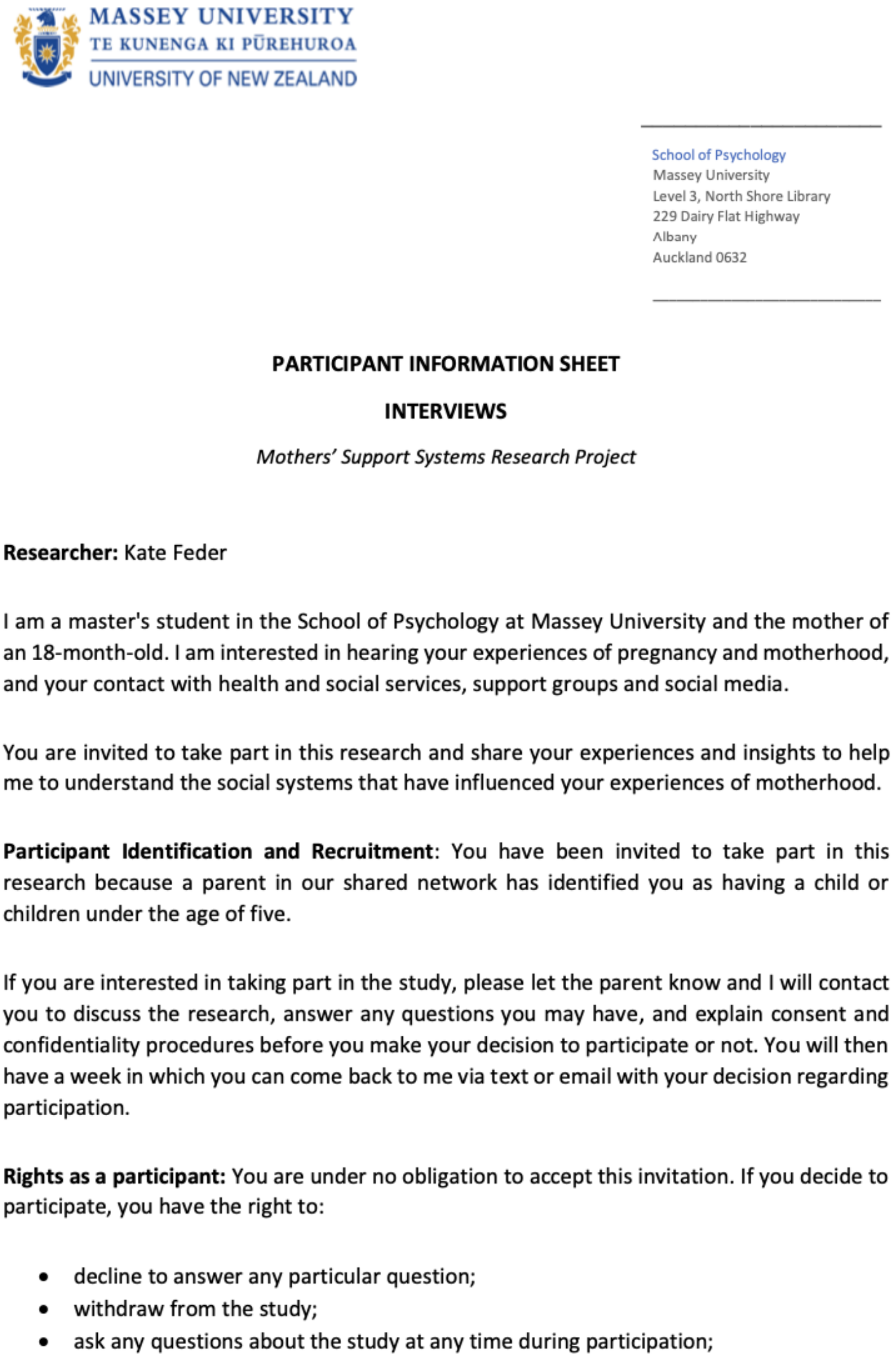
    - Exploring how their social media engagement influences their experiences.
- Explain diagramming process (provide paper, pens and example diagram):
- Start by drawing a small circle that represents yourself, your partner, and your baby in the middle of the paper, followed by two concentric circles which radiate outwards.
- Make a list of the social groups and health and social services that you engaged with for pregnancy, labour and delivery, and your and your baby's health and wellbeing.
- Arrange the services on the diagram.
    - The services which you think had the most influence on your experiences should be represented closer to the inner circle, and those with least influence in the outer circles.
- Finally, use different coloured pens to draw spokes through each service to your inner circle representing whether they were negative and/or positive experiences.

Allow time for participant to construct their diagram, encourage them to describe what experiences arise for them as they draw.

- Diagramming questions/prompts:
    - In our last interview, you told me about.../you described your interaction with... Can you tell me more about that?
    - How did you feel during that interaction? *Afterwards? What did you do next?*
    - Did you take their advice? *Were they helpful? Looking back, would you do anything differently?*
    - Did you see them again? *Why/why not? Did you share your experience of the service/practitioner with your new mum-friends? Would you not engage with a service/practitioner if a new mum-friend told you about a negative experience of their own?*
    - *When participant has completed diagram and they are ready to move on, put diagram aside.*
    -
    - Social media questions/prompts:
    - Do you use social media? *Which platforms do you use the most? Do you look at content every day? When are you most likely to look at content? Do you notice times when you are more likely to look at social media? How do you feel during those times? Can you describe a particular situation?*

  - Have you noticed that the content in your feeds have changed overtime? *Have you noticed any particular topics or points of view have popped up in your feeds, related to fertility, pregnancy, labour, breastfeeding, BLW, sleeping, behaviour? Provide personal examples, if needed.*
  - Have you ever had your mind changed because of something you've seen on social media? *Can you tell me more?*
  - Have you ever searched social media for answers to your parenting/baby related questions? *Did you find the answers you were looking for? How do you know what content to trust? How do you know when a content creator is genuine? Is it how they speak, look, the types of content, the products they endorse, their personal stories?*
  - Have you ever searched search engines for answers to your parenting/baby related questions? *Did you find the answers you were looking for? How did you feel? Better? Worse? What did you do next?*
  - Do you share social media content between your new mum-friends? *How do they respond? Do you like/follow the same content?*
- Closing
  - Signal the end of the interview.
    - Is there anything else you would like to add that we haven't explored?
    - Do you have any questions for me?
  - **Stop recording**
  - Confirm next steps.
  - Take time to say goodbye and express gratitude.

Appendix 2: Information Sheet



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PARTICIPANT INFORMATION SHEET

INTERVIEWS

Mothers' Support Systems Research Project

Researcher: Kate Feder

I am a master's student in the School of Psychology at Massey University and the mother of an 18-month-old. I am interested in hearing your experiences of pregnancy and motherhood, and your contact with health and social services, support groups and social media.

You are invited to take part in this research and share your experiences and insights to help me to understand the social systems that have influenced your experiences of motherhood.

Participant Identification and Recruitment: You have been invited to take part in this research because a parent in our shared network has identified you as having a child or children under the age of five.

If you are interested in taking part in the study, please let the parent know and I will contact you to discuss the research, answer any questions you may have, and explain consent and confidentiality procedures before you make your decision to participate or not. You will then have a week in which you can come back to me via text or email with your decision regarding participation.

Rights as a participant: You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study;
- ask any questions about the study at any time during participation;

- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

What this study involves: You will be invited to participate in two interviews over a two-week period. These interviews will take place at a mutually agreed location. Before we begin with the first interview you are required to sign a consent form.

You will be asked questions about your experiences of pregnancy and motherhood. I am particularly interested in how health and social services, support groups, and social media have influenced your experiences.

Each interview will take approximately one hour. Each interview will be audio-recorded and later transcribed into a written text. You have the right to ask for the recorder to be turned off at any time during the interview. You will be provided with kai for each interview.

Eligibility: You can participate in this study if you:

- Are over the age of 18 years;
- Reside in Wellington;
- Have a child or children under five years of age, who were born in New Zealand.

Confidentiality and privacy: Your participation in this study is confidential**.** The information will be shared between yourself and the researcher. I will ensure that the principles of confidentiality are maintained. I will not share any information about what we discuss in the interviews in any way that would identify you to anyone.

Information you provide will be kept anonymous in any reports or publications from this research. All interview information will be transferred into electronic data files that will be backed up and stored on a secure University computer. Hard copies will be destroyed as soon as they are converted to digital copies.

Risks and Benefits: Participation in this research carries few direct risks to you. Participating in this research will contribute to a growing body of literature pertaining to women's' experiences of motherhood and related supports.

After discussing the study with the researcher, if you decide to participate: Please sign the attached consent form and return it to the researcher.

If you would like to keep a copy of this information, please keep this in a safe place.

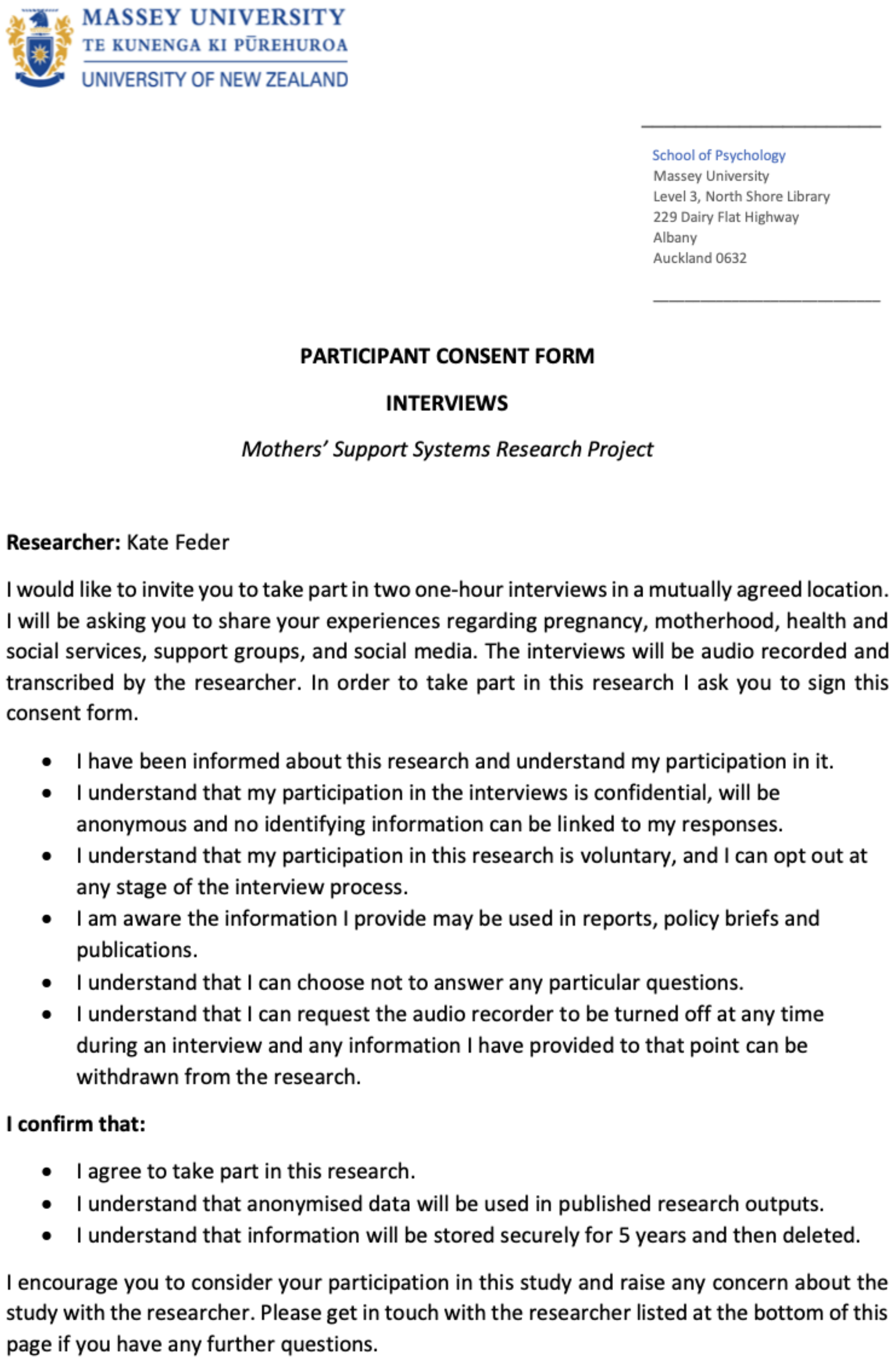
Thank you for the time you have taken to read and consider this invitation. If you have any questions, please do not hesitate to contact me:

Kate Feder
School of Psychology, Massey University Wellington
Email: katherinefeder@gmail.com

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz".

Appendix 3: Consent Form



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

School of Psychology
Massey University
Level 3, North Shore Library
229 Dairy Flat Highway
Albany
Auckland 0632

PARTICIPANT CONSENT FORM

INTERVIEWS

Mothers' Support Systems Research Project

Researcher: Kate Feder

I would like to invite you to take part in two one-hour interviews in a mutually agreed location. I will be asking you to share your experiences regarding pregnancy, motherhood, health and social services, support groups, and social media. The interviews will be audio recorded and transcribed by the researcher. In order to take part in this research I ask you to sign this consent form.

- I have been informed about this research and understand my participation in it.
- I understand that my participation in the interviews is confidential, will be anonymous and no identifying information can be linked to my responses.
- I understand that my participation in this research is voluntary, and I can opt out at any stage of the interview process.
- I am aware the information I provide may be used in reports, policy briefs and publications.
- I understand that I can choose not to answer any particular questions.
- I understand that I can request the audio recorder to be turned off at any time during an interview and any information I have provided to that point can be withdrawn from the research.

I confirm that:

- I agree to take part in this research.
- I understand that anonymised data will be used in published research outputs.
- I understand that information will be stored securely for 5 years and then deleted.

I encourage you to consider your participation in this study and raise any concern about the study with the researcher. Please get in touch with the researcher listed at the bottom of this page if you have any further questions.

Name: ___________________________________

Signature: ________________________________

Date: ____________________________________

Kate Feder
School of Psychology, Massey University Wellington
Email: katherinefeder@gmail.com

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz".