Exploring Mothers' Experiences of Perinatal Mental Distress in Rural Aotearoa New Zealand

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Arts

in

Psychology

At Massey University, Te Whanganui-a-Tara, Aotearoa

Natalie Thiele

2025

ABSTRACT

The World Health Organisation (WHO) has identified perinatal mental distress as a global health priority, estimating that one in five mothers experiences some form of mental health difficulty during this period (World Health Organisation, 2022). In Aotearoa New Zealand, this concern is particularly acute, with suicide now recognised as the leading cause of maternal death. Perinatal mental distress, spanning conception through the first 12 months postpartum, affects mood and daily functioning, with consequences that can perpetuate cycles of distress across generations. Despite the seriousness of this issue, there remains a lack of qualitative research in Aotearoa New Zealand that includes the voices of mothers and situates their experiences within the country's unique sociocultural context. This study employed an Interpretative Phenomenological Analysis (IPA) approach, drawing on semi-structured interviews with five mothers in Central Otago who had experienced perinatal mental distress. Findings and analysis revealed three superordinate themes: Identity: The Fragmented and Reformed Self, Psychological: The Storm and Calm Inside, and Sociocultural: The Weight of Expectation and Strength in Numbers. Each theme comprised several subordinate themes, which together traced a journey from hardship to healing. The findings highlight the need for a more inclusive understanding of perinatal mental distress, one that acknowledges the full emotional spectrum of mothers' experiences and situates them within both individual and sociocultural contexts.

Ko te whaea te takere o te waka

Mothers are like the hull of a canoe, they are the heart of the family

Māori proverb

ACKNOWLEDGMENTS

First and foremost, I would like to thank the participants who so generously gave their time and trust in sharing their deeply personal stories. The interviews were profoundly moving, both in the moment and as I wove your voices into this thesis. Without your openness and willingness to speak about your experiences of perinatal mental distress, this project would not have been possible. I would also like to acknowledge the many mothers across Aotearoa New Zealand who have taken part in previous research. Your contributions have laid the groundwork for a deeper understanding of this important topic and continue to inform the development of future research and practice.

A huge thank you to Dr. Elle Brittain, the primary supervisor for this thesis. From our very first video call through to the final push to completion, you have been a steady, encouraging presence. You took a chance on me and on this topic, a subject rarely explored at Massey University, and guided me with patience, expertise, and reassurance even during the times I doubted myself. Your knowledge and experience in qualitative research, combined with your calm and supportive nature, have shaped this thesis in ways I could not have achieved alone. I feel truly privileged to have had your supervision.

I am also deeply grateful to the support networks for mothers in the Central Otago region. Thank you not only for the invaluable work you already do with mothers and families, but also for the generosity you showed me - taking the time to talk with me at various stages of this project and assisting with participant recruitment. In particular, I would like to acknowledge Central Lakes Family Services, Precious Beginnings, the Plunket team, and my dear friend who serves as a midwife in this community. Your kindness and support were instrumental in making this research possible.

Finally, to my friends and family, thank you for being by my side throughout this journey. Your support has taken many forms - phone calls, meals, shared knowledge, encouragement, and countless reminders to keep going when I felt I might not make it. I feel incredibly fortunate to be surrounded by such a special network of people who steadied me and gave me the confidence to see this project through to the end.

TABLE OF CONTENTS

CHAPTER 4: FINDINGS AND ANALYSIS

CHAPTER 5: DISCUSSION

LIST OF TABLES AND FIGURES

CHAPTER 1: INTRODUCTION

1.1 Chapter Overview

In this chapter, I provide a brief introduction to the topic of perinatal mental distress, drawing on a collection of findings that call for increased awareness and action to support mothers, whānau, and communities. I use the term perinatal mental distress to capture the full range of mothers' experiences during this vulnerable time, rather than limiting the discussion solely to diagnostic terms such as depression and anxiety. I begin by highlighting global discussions on the topic before situating the discussion within the context of rural living in Aotearoa New Zealand. I conclude the chapter by outlining the aims of this research and my own research positionality.

1.2 Introduction

The perinatal period, spanning from conception through to the first 12 months after birth, represents a transitional stage in the life cycle. While it can be a time of great joy, it can also be marked by challenges. This period is often met by mothers with role strain, identity confusion, sleep deprivation, financial stress, and hormonal fluctuations (Radesky et al., 2013; Wenzel, 2013). These factors can lead to a buildup of stressors and heighten the risk of adverse health outcomes, particularly in the absence of adequate support. The importance of effective identification and early intervention for perinatal mental distress cannot be overstated. Perinatal mental distress can disrupt mother-infant bonding, child development, and increase the risk of emotional, behavioural, and cognitive challenges in children, highlighting an intergenerational cycle of distress (Stein et al., 2014). For many mothers, this transition unfolds within the pervasive expectations of ‘idealised motherhood’, a heavy Western construct that places the wellbeing of the child above all else, often at the cost of maternal mental health (Ennis, 2014). These ideals force unrealistic expectations on mothers and can have a silencing effect when their realities are at a mismatch, often leading to underdiagnosis and needs which go unsupported. Without early intervention, these challenges can snowball into more severe cases that influence both short and long-term health outcomes of the mothers, children, and whānau.

Perinatal mental distress is common and has been associated with high rates of morbidity and mortality, as well as being linked to far-reaching adverse outcomes that extend well beyond maternal wellbeing (Metlzer-Brody & Rubinow, 2004). The World Health Organisation (WHO) has identified perinatal mental health as a global priority, with estimates that one in five mothers experiences some form of mental health condition (World Health Organisation, 2022). This pattern is especially pressing in Aotearoa New Zealand, where maternal suicide is now recognised as the leading cause of death (Wilkinson et al., 2022). Poor perinatal mental health affects a significant proportion of the country's population, with estimates suggesting that 12-18% of mothers experience depression or anxiety during this period (The Ministry of Health, 2021). Rates of distress are disproportionately higher across certain groups, specifically Māori, Pacific, and Asian peoples, suggesting inequitable outcomes that exist within the wider system (The Ministry of Health, 2021).

The Maternal Care Action Group NZ (2022) reports that approximately 75% of affected mothers are excluded from publicly funded maternal mental health services becaue their symptoms are not deemed ‘severe enough’. Mothers often report being dismissed or misdiagnosed, having their distress reduced to ‘baby blues’. Even mothers with moderate to severe symptoms frequently encounter fragmented care pathways, where referrals are made but not acted on, or services are simply unavailable due to resource constraints (Perinatal and Maternal Mortality Review Committee (PMMRC), 2022). The Mothers Helpers Survey (2015) further supports these findings, showing that two-thirds of mothers who face perinatal mental distress experience delays in diagnosis and treatment due to low screening rates and a lack of education. Multiple reviews and public submissions have called for urgent reform, with recommendations, including universal screening during pregnancy and the postnatal period, conducting a national stocktake of perinatal mental health services to identify gaps, developing coordinated national pathways for treatment, and addressing the funding shortfall for mild to moderate perinatal mental health support.

While there is excellent work being done to increase awareness of perinatal mental distress, the current model of care in Aotearoa New Zealand is struggling to meet the needs of a large population of those affected. Without system-wide change, the gaps identified will continue to

drive inequitable outcomes and preventable harm. It is important to understand and make a conscious effort to address these gaps to improve wellbeing for mothers and promote healthy development for children. Research focusing on perinatal mental distress has traditionally prioritised quantitative methods, which, while crucial, often do not include the voices of those most affected. This is particularly true for individuals living in rural communities, where unique structural and geographic barriers introduce unique challenges to accessing support. Increased isolation and access to specialist healthcare services, particularly in areas such as Central Otago, can compound stress and heighten the risk of developing more severe mental health outcomes. Qualitative research provides a necessary lens through which to understand the lived experiences of those who face perinatal mental health challenges, in working towards addressing current gaps and informing more responsive care for all mothers.

1.3 Research Aims

In this study, I aimed to explore the lived experiences of perinatal mental distress among mothers living in rural Central Otago, Aotearoa New Zealand. Grounded in an Interpretative Phenomenological Analysis (IPA) framework, the research sought to understand how factors shape the experience of mental distress during the perinatal period and how mothers make meaning of their experiences.

In exploring the research question, *How do mothers living in rural Aotearoa New Zealand experience perinatal mental distress?,* I aimed to uncover rich, detailed insights into the internal and external mechanisms that influence maternal mental health during this time.

I hope to contribute to the existing literature by centring the voices of mothers in a rural Aotearoa New Zealand context. By exploring the psychosocial and environmental factors that influence experiences of perinatal mental distress, this research has the potential to inform mental health screening practices, professional care, and policy development with a more nuanced and contextualised understanding. Ultimately, I hope this study raises awareness of the realities of mothers, reduces stigma, and empowers individuals and their support networks to recognise distress patterns and seek timely support.

1.4 Researcher Positionality

My name is Natalie Thiele, and I am a 34-year-old female living in Wanaka, New Zealand. I currently work in youth mental health and addiction services, where I have witnessed firsthand the impact that maternal mental health can have on mothers, children, and the wider whānau. Living with a midwife has further deepened my understanding of the complexities surrounding motherhood. I am both fascinated and saddened by the challenges that many mothers face, many of which could be mitigated through greater awareness, compassion, and more robust support systems. I am deeply passionate about supporting mothers through this fundamentally transitional period in their lives. Throughout my academic journey, I have developed an appreciation for the transformative potential of qualitative research, an approach that centres the lived experiences of individuals and offers meaningful insights that can help to shape more responsive care from the ground up.

1.5 Structure of the Thesis

1.5.1 Chapter 1: Introduction

The introduction provides an overview of the background information related to the topic of perinatal mental distress and presents a rationale for this research project. I outline the very urgent need for awareness and action to better support mothers and whānaua by situating existing literature within the context of Aotearoa New Zealand. I also attend to the research aims and present my research positionality.

1.5.1 Chapter 2: Literature Review

This chapter gives an overview of the existing literature surrounding perinatal mental distress. I present its conceptualisation, factors related to biological, psychological, and socio-cultural levels of health and implications for mother and child. This chapter introduces qualitative research in the area, before a discussion of the topic within the local setting of Aotearoa New Zealand, particularly with reference to the unique challenges faced by rural living.

1.5.2 Chapter 3: Methodology

I present the methodological rationale for the project by outlining qualitative inquiry and its theoretical position. I explore the foundations of Interpretative Phenomenological Analysis (IPA) and discuss the use of semi-structured interviews. The research design is explained in detail, including participant sampling, the inclusion criteria, the recruitment process, data collection, ethical considerations, and researcher reflexivity.

1.5.3 Chapter 4: Findings and Analysis

Here I share the voices and stories of mothers who generously offered their time for the research project. These are presented as narrative accounts, followed by my interpretation of their experiences, moving beyond what they described and towards what their experiences reveal within the broader context of perinatal mental distress. Three superordinate themes are presented, which represent a journey from hardship towards healing: ‘Identity: The Fragmented and Reformed Self’, ‘Psychological: The Storm Inside’, and ‘Sociocultural: The Weight of Expectation and Strength in Numbers’.

1.5.4 Chapter 5: Discussion

Finally, I offer a more detailed look at the research findings and weave them through the broader literature of perinatal mental distress, linking them to both convergences and divergences. I discuss the study’s implications for practice, its strengths and limitations, and recommendations for future research, before presenting my final reflections as the researcher**.**

CHAPTER 2 LITERATURE REVIEW

2.1 Chapter Overview

I begin this chapter by conceptualising perinatal mental distress, examining its representation in the literature with a particular focus on the most frequently cited disorders, namely depression and anxiety, and their typical onset. I then provide an overview of the biomedical model and biopsychosocial models of health and illness, before exploring factors associated with the biological, psychological, and social-environmental levels of health. Next, I offer an in-depth consideration of the implications of perinatal mental distress on pregnancy and birth, maternal health, fetal and infant development, and attachment development. This is followed by a literature review focusing on qualitative research related to perinatal anxiety and depression, as well as findings from within the Aotearoa New Zealand context. I conclude the chapter by presenting the topic within this local setting, including relevant statistics and the role of early screening and intervention. I also outline the particular challenges faced by rural populations, with a focus on Central Otago, where this research is set. Throughout this chapter, the language used to reference research will be consistent with the terminology employed by the respective authors.

2.2 Conceptualising Perinatal Mental Distress

The current study will focus on the perinatal period, spanning from conception (pregnancy) through to the first 12 months postpartum (after birth). This period represents a transitional stage in the life cycle that impacts maternal, infant, and family wellbeing. Perinatal mental distress is distinguished by the expression of symptoms as well as the timing of their onset. This is particularly relevant as it differentiates perinatal health outcomes from other mental health conditions at different stages in life. Despite the importance of timing, the literature surrounding maternal mental health highlights inconsistency in how the perinatal period is defined, with various interpretations affecting when symptoms are expected to emerge (Meltzer-Brody & Rubinow, 2021). The lack of an agreed-upon definition complicates the ability to pinpoint and

report on perinatal mental health challenges, the consequences of which may influence early diagnosis, symptom recognition, and treatment. The World Health Organisation (WHO), for example, defines the perinatal period as beginning at 22 weeks of gestation and ending seven days after birth (World Health Organisation, 2022). More commonly, literature in this space refers to the perinatal period as the time from conception through pregnancy and up to 12 months after birth (O'Hara & Wisner, 2014; Meltzer-Brody & Rubinow, 2021). While research has historically separated postnatal or postpartum experiences categorised by specific disorders, more recently, there has been a shift towards using the term perinatal distress to describe the full spectrum of a mother's journey.

The journey from conception, through pregnancy, and into motherhood can be a time of incredible joy, while it can also be marked by difficult challenges. This transitional period brings with it major physiological, psychological, social, and economic changes. These can lead to a build-up of stressors and contribute to heightened risks of adverse mental health outcomes. Broadly speaking, perinatal mental distress is defined by the presence of mood and anxiety disorders either during pregnancy or postpartum (O'Hara & Wisner, 2014). These disorders can present at varying levels of intensity, from mild to more severe, and can impact a mother's capacity to function and care for the baby (Meltzer-Brody & Rubinow, 2021). Literature in this space highlights a range of adverse mental health outcomes, including perinatal depression, anxiety, obsessive-compulsive disorder (OCD), postpartum stress disorder (PTSD), and, in more acute cases, postpartum psychosis (O'Hara & Wisner, 2014). A full review of all mental health conditions during the perinatal period falls outside the scope of this research. Instead, the aim is to focus on perinatal mental distress, specifically in relation to the two most robustly researched disorders, perinatal depression and anxiety.

Research into perinatal mental distress has traditionally focused on either antenatal onset (during pregnancy) or postnatal onset (after childbirth). Again, there are inconsistencies in what defines these periods. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) refers to 'postpartum symptoms' as occurring within four weeks of birth (American Psychiatric Association, 2000), whereas WHO describes 'postpartum' as any time during the first 12 months post-birth (Fisher et al., 2012). In the DSM-5, 'postpartum' is defined by

symptom onset at any time during pregnancy, up until four weeks after birth (American Psychiatric Association, 2013). This expanded definition, from DSM-IV to DSM-5, is likely influenced by the recognition that at least one-third of cases involving postpartum depression cite onset during pregnancy (Wisner et al., 2013). These definitions call to attention the importance of recognising different descriptions and the impact they have on research outcomes. As a result, it can be challenging to agree on prevalence rates and descriptive statistics (Meltzer-Brody & Rubinow, 2021). That said, the following is a broad review of perinatal depression and anxiety, including prevalence, definitions, and symptom presentations.

2.2.1 Perinatal Depression

Perinatal depression (PND) is the most extensively researched of all perinatal mood and anxiety disorders to date. Typically, symptoms develop gradually, with varying onsets relative to childbirth (Meltzer-Brody & Rubinow, 2021). As such, symptoms may emerge before or during pregnancy and persist after birth, or they may only present after childbirth. The variability in symptom onset highlights the complex nature of PND. Historically, research has focused on either antenatal onset (during pregnancy) or postnatal onset (after birth), illustrating again the absence of an agreed-upon understanding of perinatal mental health disorders. Nonetheless, prevalence studies indicate that PND affects 10-20 % of mothers in high-income countries and up to 26% in low- to middle-income countries (Roddy Mitchell et al., 2023). The differences in rates are likely influenced by factors which differ across cultures, such as perceptions and stigma surrounding mental illness, the ways mothers report symptoms and socio-economic disparities (Parkash, 2021). Regardless of these variations, the prevalence of PND affects a considerable portion of the global population who are at increased risk for adverse outcomes associated with maternal and infant well-being.

The diagnostic criteria for perinatal depression closely mirror those for Major Depressive Disorder (MDD). However, for perinatal depression, healthcare professionals consider symptoms in light of hormonal and physical or environmental changes associated with pregnancy. MDD is characterised by several symptoms, including persistently depressed mood, loss of interest or pleasure, psychomotor agitation, fatigue or loss of energy, significant weight loss or gain,

insomnia or hypersomnia, feelings of worthiness or inappropriate guilt, decreased ability to concentrate, and/or recurrent thoughts of death, suicidal ideation, or suicidal attempt (American Psychiatric Association, 2013). When these symptoms emerge during pregnancy or within the first four weeks postpartum, the DSM-5 includes a "peripartum onset" specifier to the MDD diagnosis. Similarly, the International Classification of Diseases, Tenth Revision (ICD-10) does not recognise PND as a separate diagnosis. Instead, it applies an additional 'puerperium' code to indicate symptoms that arise within six weeks post-birth (World Health Organisation, 2019). As with MDD, PND differs in the presentation of symptom frequency, duration, intensity and onset, which adds to the complications of appropriate diagnosis and treatment. Despite this being the most researched perinatal mental health disorder, PND remains one of the most under-recognised experiences of the perinatal period (Meltzer-Brody et al., 2018).

2.2.2 Perinatal Anxiety

Perinatal anxiety (PNA) is an umbrella term that encompasses a spectrum of anxiety disorders, including generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) (Meltzer-Brody & Rubinow, 2021). Symptoms of PNA often begin in pregnancy and continue after childbirth; however, symptoms can exist before conception or arise exclusively in the postpartum period. PNA has received considerably less attention than PND in research despite evidence suggesting that anxiety disorders may be more common than depression during the perinatal period (Rallis et al., 2014). One possible explanation is that anxiety has traditionally been viewed as a component of depression rather than as a distinct disorder (Gorham, 2018). This overlap is understandable as the emotional and psychological transitions into motherhood can make it challenging to distinguish 'normal' reactions from signs of a mental health concern. Anxiety disorders frequently co-occur with PND (Meltzer-Brody & Rubinow, 2021), with some studies indicating comorbidity rates as high as 50% of PND cases (Fairbrother et al., 2016; Gavin et al., 2005). However, it is important to make clear that many mothers experience anxiety independently of depression. Given this complexity, it is unsurprising to find significant variations in prevalence studies. As an indication, studies suggest that PNA affects 25 – 45% of mothers (Rallis et al., 2014; Faisal-Cury & Menzes, 2007).

Understanding the distinct yet overlapping nature of PNA and PND is a crucial step towards comprehensive support for maternal mental health.

The DSM-5 does not currently recognise PNA as a distinct disorder. However, symptoms observed during the perinatal period are similar to anxiety disorders experienced at different stages of life. Healthcare professionals consider these symptoms in light of the unique biopsychosocial context of pregnancy and birth. Common symptoms include excessive anxiety and worries about various topics and a struggle to control worry. Additionally, the worry and anxiety symptoms are associated with at least three of the following: restlessness or feeling on edge, easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbance (American Psychiatric Association, 2013). Although the DSM-5 includes a 'peripartum onset' specifier to diagnose perinatal depression, it does not directly address PNA. As such, professionals may diagnose a mother with a specific anxiety disorder (such as GAD, OCD, or PTSD) and note its occurrence in relation to the perinatal period. Many professionals advocate for greater attention towards PNA as a distinct concern, with more precise diagnostic criteria, arguing that the current framework may fail to capture the full scope of perinatal anxiety. For example, typical diagnostic 'cut-off' scores may incorrectly classify mothers with transient anxiety as having sustained anxiety, leading to inappropriate treatment or support (Dennis et al., 2013). Given the high prevalence rates and the vast emotional transitions involved in motherhood, it is important to distinguish between what may be considered 'normal' experiences of anxiety during the perinatal period versus 'clinical' levels of perinatal anxiety. Developing a deeper understanding of these experiences and implementing appropriate screening tools will help ensure that mothers receive timely and accurate care.

2.3 Different Models of Understanding Health and Illness

To better understand the topic of perinatal mental distress, it is helpful to look at different models for understanding health and illness, specifically the biomedical model and the biopsychosocial model. The biomedical model was the primary paradigm for understanding illness until the late twentieth century. This model is grounded in reductionism, seeking to identify physical or somatic causes for an illness and offering interventions that 'correct' biological imbalances

(Rocca & Anjum, 2020). The biomedical model attributes perinatal mental distress symptoms to factors such as hormonal fluctuations and neurochemical imbalances, and prioritises treatment solutions like antidepressants or mood stabilisers. While this lens has been highly effective in many respects, it has also faced criticism. One of the main limitations is its narrow focus, which tends to overlook the 'whole person' and the broader context in which illness occurs. This approach has the potential to treat symptoms without addressing the underlying cause of the problem (Rocca & Anjum, 2020). Additionally, it assumes a uniform experience in the transition to motherhood, which overlooks individual variability and cultural diversity (DeSouza, 2004).

To address the limitations of the biomedical model, Engel (1977) introduced the biopsychosocial model, a framework that has since gained prominence in the field of psychology. In addition to biological factors, this model highlights the role of psychological and social factors when understanding the development of illness (Lugg, 2022). Applied to perinatal mental distress, the biopsychosocial model allows for a broadened exploration of health and illness through consideration of factors such as individual cognitive biases and coping mechanisms alongside social determinants such as relationship dynamics and cultural expectations of motherhood. This holistic approach allows for treatment plans that consider the broader context of a mother's life, rather than focusing solely on biological factors (Bergunde et al., 2022).

In Aotearoa New Zealand, the biopsychosocial model more accurately reflects the Indigenous Māori view of health, which is inherently relational and holistic. This worldview is often seen through a whānau-centred lens where the well-being of the individual is deeply connected to that of the whānau and the community (Raweti, 2023). Durie's (1984) Te Whare Tapa Whā offers an understanding of health that highlights four interconnected pillars of hauora (health and well-being): taha wairua (spiritual), taha hinengaro (mental and emotional), taha whānau (family and social), and taha tinana (physical). When these dimensions are in balance, they promote overall well-being; however, when any of the pillars are missing or damaged, adverse health outcomes can occur for an individual or collective. This model offers a more comprehensive perspective on health, providing a broader understanding that extends beyond the limitations of the biomedical model. Te Whare Tapa Whā is particularly relevant to the topic of perinatal

mental distress in acknowledging that a mother's well-being cannot be viewed in isolation from her relational and cultural context.

2.4 Correlates Influencing Perinatal Mental Distress

Due to the complex and multifactorial nature of mental health conditions, as well as the limited focus on perinatal-specific mechanisms in existing studies, there is no single pathway known in the development of perinatal mental distress. Notably, much of our current understanding of depression and anxiety is based on research conducted outside of the perinatal period, often involving male subjects in preclinical studies (Will et al., 2017). However, epidemiological studies indicate that women are more prone to these disorders (Scott et al., 2010). The following is a summary of the correlates that have been shown to influence the onset and maintenance of perinatal mental distress. Understanding these factors and how they relate to one another enhances opportunities for improved awareness, prevention and treatment of perinatal mental distress.

2.4.1 Physiological Factors

Genetic factors are commonly cited as a significant factor in the development of depression and anxiety, with research highlighting certain genetic combinations which can contribute to greater susceptibility (Levison & Nichols, 2017). Specific genes involved in serotonin regulation and adrenal responses have been identified, impacting internal coping mechanisms for stress and mood fluctuations (Uher & McGuffin, 2010). Genetic predispositions can contribute to what is referred to as neurobiological kindling, a process where individuals who have experienced multiple episodes of depression become more vulnerable to future occurrences (Uher & McGuffic, 2010). Differences in gene expression related to stress and hormone regulation have also been found in women with perinatal depression. Research has linked perinatal depression to specific genetic variations related to serotonin, oxytocin, and brain-derived neurotrophic factors (Doornbos et al., 2009; Sanjuan et al., 2008). Twin studies have shown that genetics can explain nearly half of the variability in perinatal depression, indicating a strong heritability component (Viktorin et al., 2016). Additionally, a family history of mental health disorders has been shown

to increase the likelihood of individuals developing depression and anxiety. In a recent systematic review and meta-analysis, Zacher Kjeldsen et al. (2022) found that of 100,877 women across five continents, the risk of developing postpartum depression was almost twofold for mothers with a family history of psychiatric disorders. While research indicates the likelihood of a genetic component linked to perinatal mental distress, understanding of this is complicated by the role of epigenetics and gene-environment interactions.

Given the prominence of the biological model in healthcare, the following paragraph delves into neurobiological influences which have been linked to the development of depression and anxiety more generally. In doing this, the hope is to ensure a more robust understanding of psychological distress, which can then be understood within the context of the perinatal period. Neuroimaging studies have identified structural and functional differences in the brains of individuals with depression, observing anomalies in the medial prefrontal cortex, the amygdala, and the striatum and thalamus (Drevets, 2000). Imbalances in key neurotransmitters, such as serotonin, dopamine, and norepinephrine, have also been shown to influence mood regulation and internal coping mechanisms (Uher & McGuffin, 2010). Research has also identified structural differences in individuals with anxiety disorders, with studies consistently showing increased amygdala activation in situations which are anxiety-provoking (Holzschneider & Mulert, 2011). Alongside the amygdala, which has been closely linked to fear and anxiety, the insula and anterior cingulate cortex have also been linked to anxiety disorders and form what is commonly referred to as the "fear network" (Holzschneider & Mulert, 2011).

Although fewer neuroimaging studies focus specifically on mothers during the perinatal period, emerging research has brought forward important insights. Some studies have been able to demonstrate changes in brain structure and function associated with anxiety and depression during pregnancy and postpartum. For example, a study by Silver et al. (2018) found structural brain differences in mothers with depression, highlighting evidence of white matter abnormalities. Specifically, the results indicated reduced fractional anisotropy (FA), a marker of white matter health, in regions such as the left anterior limb of the internal capsule and the right retrolenticular part of the internal capsule of the corpus callosum. White matter is crucial for communication between different brain areas, and disruptions may influence mood disorders. As

such, these findings suggest that reduced white matter may contribute to the emotional and cognitive symptoms experienced by mothers with postpartum depression (Silver et al., 2018). Another study by Moses-Kolko et al. (2010) was able to indirectly explore anxiety symptoms within the context of perinatal mental health through the use of functional MRI (fMRI). The researchers investigated brain activation patterns in response to emotional stimuli and found abnormal activity in the dorsomedial prefrontal cortex, as well as connectivity anomalies with the amygdala. These findings suggest that mothers with perinatal anxiety may experience increased emotional reactivity, indicating overactivity in fear-related brain circuits and highlighting potential neural mechanisms linked to perinatal anxiety.

The endocrine system, often referred to as the body's messenger system, is shown to present biological risk factors for perinatal mental distress. This system consists of hormones produced by internal glands that are released into the circulatory system and regulate specific mechanisms through feedback loops (Wenzel, 2024). Dramatic hormonal shifts occur during pregnancy, particularly in estrogen, progesterone, and cortisol levels. Research suggests that some women are more sensitive to these hormonal changes, increasing their risk of developing perinatal depression or anxiety (Wenzel, 2024). Dysregulation of the hypothalamic-pituitary-adrenal axis (HPA), the body's primary stress response, has also been associated with perinatal depression (Kammerer et al., 2006). When the body is under stress, the brain triggers a sequence of hormone releases, starting with corticotropin-releasing hormone (CRH) from the hypothalamus, which stimulates the pituitary gland to release adrenocorticotropic hormone. This, in turn, signals the adrenal glands to release cortisol, a hormone that helps to manage stress. During pregnancy, however, the placenta begins producing its own CRH, which is not regulated by the usual feedback system, leading to higher levels of cortisol that peak after childbirth (Wenzel, 2024). Research suggests that some women may have an overly sensitive or under-sensitive stress response, indicating an association between the HPA axis and perinatal depression (Kammerer et al., 2006). A study by Hannerfors et al. (2015) supports this, showing that CRH levels during mid-pregnancy were lower among severely depressed women compared to healthy pregnant women. Additionally, premenstrual syndrome (PMS), which causes aggravated mood symptoms due to changes in sex hormones during the menstrual cycle, is noted as a risk factor for perinatal depression. The hormonal fluctuations during PMS are similar to those experienced during

pregnancy and postpartum (Gastaldon et al., 2022). These findings suggest that individual sensitivity and imbalances in systems impacted by hormone changes may contribute to the development of perinatal depression or anxiety.

2.4.2 Psychological Factors

Research into psychological factors highlights mental processes which are linked to perinatal mental distress. These factors play a critical role in an individual's mental health, emotional well-being, and overall level of functioning (Wenzel, 2024). One of the most commonly cited correlates for depression and anxiety relates to cognitions, whereby maladaptive thinking patterns and cognitive biases influence the way information is processed. A study by George et al. (2013) found that anxious mothers were more likely to exhibit maladaptive coping responses such as self-blame and denial. Their findings also reveal that anxious mothers used significantly fewer adaptive strategies, like acceptance and positive reframing, than non-anxious mothers. Similarly, Coates et al. (2014) explored cognitive processes in mothers experiencing postnatal distress. Their findings highlight issues such as self-blame, guilt, avoidance, and difficulties adjusting to motherhood

Beck's (1967) Cognitive Triad of Depression can be used to highlight three negative thought patterns which commonly reflect the belief system of a person experiencing depression. From this perspective, individuals are seen as automatically harbouring pessimistic views about 1) themselves, 2) others and the world, and 3) the future (Hammar & Ardal, 2009). A good example of this is research by Onyemaechi et al. (2017), which demonstrates that low self-esteem (i.e., negative views about oneself) is a well-established risk factor for mental health challenges across the perinatal period. Similarly, a cognitive triad can be identified for anxiety, whereby negative thought patterns contribute towards and sustain feelings of anxiousness. From this perspective, individuals are seen as 1) viewing themselves as vulnerable, 2) viewing others and the world as vulnerable, and 3) viewing the future as predominantly filled with threats (Miranda & Mennin, 2007). Both cognitive triads emphasise negative anticipation as a central feature and highlight the role of cognitions in processing information. Additionally, a low threshold for uncertainty has also been linked to poor mental health in the perinatal period, where individuals with a low

tolerance for unpredictability found it more challenging to manage negative thoughts and emotions (Sbrilli et al., 2021).

A history of mental health challenges is another strong predictor of perinatal anxiety and depression, with individuals who have previously experienced mental health issues at greater risk for similar struggles during the perinatal period (Jeong et al., 2013). This relationship highlights the cumulative effect of past conditions on perinatal mental health. Symptoms of depression or anxiety which arise during pregnancy often act as precursors to ongoing mental health issues postnatally, potentially triggering a cycle where initial symptoms are aggravated by stressors such as reduced sleep and the demands of infant care (Räisäen et al., 2014). The nature of anxiety and depression is highly comorbid, suggesting that the presence of one may increase the risk of developing the other. For example, research indicates that high levels of anxiety during pregnancy can increase the risk of postpartum depression up to threefold (Biagga et al., 2016). Additionally, a history of disordered eating has been shown to increase the risk of anxiety and depression throughout the perinatal period (Micali et al., 2011). This correlation may be due to increased body image concerns, physical discomfort, and disruptions to existing coping mechanisms. Similarly, a history of trauma has been linked to perinatal anxiety and depression, with unresolved trauma being shown to resurface in the face of increased vulnerabilities (Biaggi et al., 2016; Yang et al., 2022).

The psychological transition to motherhood is often fraught with challenges and requires a redefinition of identity. Gruen (1990) describes this transition as a period of profound change, during which mothers must renegotiate their roles, relationships, and established patterns. For many, this journey can be emotionally draining and overwhelming, primarily as mothers reflect on previous parts of themselves, such as professional or social identities (Kauppi et al., 2012). The exploration of identity is a key factor which has been linked to perinatal mental distress. Kauppi et al. (2012) found that some mothers experience a disconnect between the idealised, fulfilling view of motherhood perpetuated across cultures and lived experience. An example of idealised motherhood is the expectation that mothers should experience constant joy and selflessness. This gap can be confronting for mothers, highlighting a complex mix of losses such as autonomy, independence, social identity, and their physical selves. Further supporting these

findings, Laney et al. (2015) conducted a qualitative analysis that examined how motherhood impacts the sense of identity and personal development. They identified themes such as a temporary loss of self as mothers worked to integrate their new maternal identity, tension between the role of mother and other aspects of their lives, and a tendency to focus on familiar roles. These experiences were accompanied by shifts in how mothers perceived themselves and their sense of self-worth. This shift in self can lead to increased self-consciousness and self-criticism, ultimately contributing towards poor mental health outcomes.

Attitudes towards motherhood play an important role in predicting perinatal depression and anxiety. Beliefs around motherhood, for example, feelings that one should have a stronger bond with their baby or concerns about being judged by others, or fearing that others will think they are “bad mothers” for specific actions, can negatively impact perinatal mental health (Wenzel, 2024). A study by Sockol et al. (2014) explored attitudes toward pregnancy and motherhood. Their findings showed a correlation between negative maternal attitudes and poor mental health outcomes, particularly during the postpartum period. While pregnancy-specific anxieties, such as fear of childbirth or concerns about the baby’s health, were linked to higher levels of anxiety, postpartum attitudes were a stronger predictor of depression. This aligns with broader literature, where positive or realistic attitudes about motherhood are associated with better adjustment and lower levels of anxiety and depression (Coleman et al.,1999; Green & Kafetsios, 1997). Further supporting these findings, Harwood et al. (2007) explored the discrepancy between idealised expectations and actual experiences of motherhood, showing higher levels of depression and poorer relationship adjustment when experiences were negative relative to expectations. Together, these studies emphasise the importance of preparing mothers with realistic education about the challenges of motherhood. Fostering a balanced, realistic view of motherhood can help mothers navigate the inevitable challenges while embracing the positive aspects of motherhood. It is also important to move beyond education alone and challenge the broader social structures that uphold these norms, which are discussed in more detail in the following section.

2.4.3 Social and Environmental Factors

Single motherhood is frequently cited as a significant factor, due to the overwhelming nature of the emotional and practical demands of managing childcare, finances, and household responsibilities without a partner (Shenoy et al., 2014; Cairney & Wade, 2002; Angel & Worobey, 1988). Moreover, several studies have identified a lack of social support as one of the most significant predictors of perinatal anxiety and depression. Biaggi et al. (2016) noted that a lack of emotional or practical support can contribute towards feelings of isolation, stress, and helplessness. Similarly, positive interpersonal relationships can serve as a psychosocial protective factor, helping to ease the pressures of motherhood (Antoniou et al., 2021). Kay et al. (2024) examined how social support and psychosocial stimulation influence a mother's mental health during the perinatal period. They found that emotional support, such as encouragement and empathy, and practical support, including help with household tasks or parenting advice, are strong protective factors against mental distress. The partner relationship has also been shown to play an important role, with relationship conflict, poor communication, and partner tension exacerbating mental health challenges (Leach et al., 2015; Dennis et al., 2017). Research by Bayrampour et al. (2016) further illustrates the impact of partner tension, showing it to be a powerful predictor of anxiety symptoms during pregnancy and the postpartum period. Taken together, these findings reinforce that supportive relationships and nurturing family environments promote improved maternal mental health during the perinatal period. This has significant implications for the need to strengthen social support systems.

Socially constructed gender roles are shown to shape beliefs, attitudes, and expectations about motherhood. These gender roles stem from the idea that women are inherently wired for maternal instincts, often leaving mothers feeling pressured to live up to idealised standards. The ideal mother is seen as constantly available and deeply invested in their children's wellbeing, often at the expense of their own emotional needs (Ennis, 2014). In Western individualistic societies, there is increasing pressure on mothers to engage in 'intensive mothering', which describes the expectation that mothers should dedicate exhaustive time and resources to raising their children. Sharon Hays (1996) argues that this creates a tension between the expectation for mothers to devote themselves to their children and the demands of modern life. This

contradiction can heighten levels of stress and contribute towards adverse mental health outcomes. Henderson et al. (2016) support this view through their findings, which show that internalising feelings of guilt and the pressure to embody the ‘perfect mother’ can harm a mother's mental health. Additionally, societal expectations often discourage mothers from openly discussing their struggles. When mothers feel unable to share their difficulties, it can lead to social isolation and increased feelings of loneliness and helplessness, ultimately increasing the risk of anxiety and depression. Furthermore, stigma surrounding mental health in many communities can also hinder access to support and worsen perinatal mental health (Byatt et al., 2015). These findings bring forward the potential negative impact that social constructs can have on mental health and call for a critique of the dominant motherhood ideologies.

Modern society has seen an overwhelming presence of social media, which plays a complex role in shaping mental health. While it can offer valuable opportunities for connection, support, and the sharing of experiences, it has also been shown to contribute to mental health challenges through an environment of information overload and unrealistic expectations. Nowadays, mothers may turn to parenting apps, websites, and social networks for support. However, these resources often offer incomplete, irrelevant, or inaccurate information (Buultjens et al., 2012). Social media platforms often portray highly romanticised and unattainable standards of motherhood, heightening social comparison and potentially increasing feelings of inadequacy (Tate, 2023). An online study by Kirkpatrick and Lee (2022) supports this point, which found that Instagram’s idealised portrayals of motherhood can be harmful through increased comparison to what mothers see on social media, as well as increased envy and state anxiety. In contrast, Price et al. (2017) showed that first-time mothers highly valued the use of social media as both a form of connection and a means for developing real-world connections. In this way, platforms such as Facebook and Instagram become a way to connect with other mums, ask questions, or even organise in-person catch-ups. They argue that the use of online engagement is purpose-driven, shaped by broader social expectations which influence perceptions of what is acceptable and accessible support.

Another important social and environmental factor influencing maternal mental health is ethnic identity. Research shows that mothers from minority groups face a heightened risk of anxiety and

depression due to a range of sociocultural factors such as racism, economic stress, and limited access to healthcare (Gennaro et al., 202). The intersection of ethnicity, gender, and class creates unique stressors that can contribute to mental health challenges (Andrea, 2024). Social determinants of health are incredibly influential in shaping mental health outcomes, particularly among minority populations (Crear-Perry et al., 2021). Social determinants of health are broadly defined as the conditions in which people are born, live, work, and age, as well as their access to power, money, and resources (World Health Organisation, n.d.). Mistrust of healthcare systems due to historical racial discrimination, cultural stigma surrounding mental health, and a lack of culturally responsive care act as systemic barriers that further exacerbate these disparities (Huggins et al., 2020). Research by Valdez et al. (2018) suggests that cultural sensitivity interventions can improve mental health outcomes for minority mothers. Their study found that group-based interventions, which provided a culturally safe space for mothers, helped reduce feelings of isolation and improved mental health.

A wide range of environmental factors have been identified as contributing to perinatal mental distress, primarily through the cumulative stress for mothers and the limited resources mothers have to cope with these stressors. For example, low socioeconomic status, inadequate healthcare, housing instability, food insecurity, community violence, and stressful occupations have all been linked to perinatal depression and anxiety (Meghani et al., 2024). When there is a cumulative stress related to these factors, and this co-occurs with limited or no support systems, mothers' resources to cope can then be overwhelmed. Additionally, the stress created by these conditions can be compounded by the absence of support systems, such as affordable and accessible childcare or paid family leave, both of which can ease the transition into motherhood (Crear-Perry et al., 2021). When resources are limited, unavailable, or already overwhelmed, mothers may feel stretched too thin and unable to seek or access appropriate support, further impacting symptoms of anxiety and depression.

Lastly, the pregnancy experience itself can heighten the risk of anxiety and depression for mothers. Blom et al. (2010) found that certain perinatal complications, such as pre-eclampsia, emergency caesareans, fetal distress, or the need for the baby to be admitted to the hospital, were associated with postnatal depression. Another study by Ahmadpour et al. (2023) concluded that

both postpartum depression and anxiety are related to childbirth experiences. They noted factors such as emergency caesarean, mid-pregnancy problems, fear of childbirth, neonatal intensive care, and long-term labour as relating to negative birth experiences. These complications can leave mothers feeling a loss of control or guilt related to their birth experience, ultimately contributing towards ongoing psychological stress

2.4 The Ripple Effect

The literature on perinatal health highlights a range of negative sequelae related to mental distress, ranging from short-term to long-term consequences (Folliard et al., 2020). This body of research shows how its effects extend far beyond the individual. It is clear to see the direct impact on a mother's wellbeing; however, the consequences can also have enduring consequences on child development. This intergenerational impact underscores the importance of research into the topic of perinatal mental distress and foregrounds its potential to inform interventions that support both maternal and child wellbeing (Glover, 2007). The following sections will discuss the current literature focusing on the implications of perinatal mental distress on pregnancy and birth, maternal well-being, fetal, infant and child development, and attachment issues.

2.4.1 Implications for Pregnancy and Birth

One of the most comprehensive studies on this topic is a systematic review and meta-analysis exploring the implications of pregnancy and childbirth for perinatal distress (Grigoriadis et al., 2018). Findings point to a clear association between antenatal anxiety and multiple adverse outcomes, including preterm birth, lower infant birth weight, earlier gestational age, and smaller head circumference. Ding et al. (2014) support these findings through their work, which found a link between maternal mental health and two major birth complications: low birth weight and preterm birth. They concluded that healthcare professionals should be particularly vigilant when addressing mental health concerns during pregnancy.

Perinatal depression has also been linked to complications such as preterm birth, low birth weight, and earlier gestational age. Accortt et al. (2014) conducted a systematic review of the relationship between prenatal depression and various adverse birth outcomes, revealing a strong link between prenatal depression and preterm birth. Their review also found an association between experiences with prenatal depression and an increased risk of low birth weight and earlier gestational age. Furthermore, the study explored potential mechanisms through which depression might influence birth outcomes, such as increased cortisol levels, poor nutrition, and reduced prenatal care. Grigoriadis et al. (2013) further support these findings, reporting an association between antenatal depression, increased risk of preterm birth, low birth weight, earlier gestational age, and neonatal complications. They also explored the role of potential mechanisms, including increased cortisol levels and inflammatory processes, reduced physical activity, poor nutrition, and lower levels of prenatal care.

Research into the effects of antenatal anxiety and depression suggests that its influence extends beyond birth outcomes. High levels of anxiety during pregnancy are associated with an increased risk of miscarriage and preterm labour (Mulder et al., 2002; Staneva et al., 2015). These findings indicate that antenatal anxiety not only impacts the course of pregnancy but also increases the likelihood of complications that can influence early delivery. Antenatal anxiety has also been shown to affect a mother's preference for birthing style. Rubertsson et al. (2014) found that heightened anxiety symptoms during pregnancy were linked to an increased fear of childbirth, which in turn was associated with a stronger preference for caesarean birth. Grigoriadis et al. (2013) found that mothers who experienced antenatal depression had an increased likelihood of caesarean deliveries, which they concluded could be related to both physical complications during labour and the impact of depression on decision-making. These findings suggest that maternal mental distress not only affects birth outcomes but also shapes the way mothers perceive and approach childbirth, potentially altering birth plans in response to heightened stress or fear.

A retrospective study by Dowse et al. (2020) found that women who self-reported anxiety during pregnancy were more likely to have birth complications. They were also more likely to be admitted to a neonatal unit, have longer hospital stays, and have lower Apgar scores, which

indicate the infant's health state in the first 10 minutes. Similarly, Martini et al. (2010) observed that maternal distress was associated with preterm birth and an increased likelihood of caesarean delivery. Both of these studies relied on self-report measures, introducing a potential for reporting inaccuracies and a lack of diagnostic precision. Despite this, the findings highlight a critical gap in mental health care for pregnant women, as self-reported mental distress may often go undetected without more thorough screening protocols.

2.4.2 Implications for Mother

Research consistently demonstrates that mild to moderate perinatal anxiety can significantly impair a mother's functioning. Furber et al. (2009) interviewed 24 pregnant women who self-reported moderate levels of psychological distress, much of which stemmed from past difficulties and concerns about their pregnancy. Mothers experienced disruptions to their daily lives, including changes in eating habits, work routines, and overall lifestyle. Similarly, Highet et al. (2014) completed research with mothers who self-reported postnatal depression or anxiety, showing that moderate distress resulted in excessive worry and a decline in social functioning. These studies demonstrate that mild to moderate levels of mental distress can have a significant impact on a mother's functioning and ability to engage in day-to-day activities. This point emphasises the need for early, normalised and proactive mental health screening throughout the perinatal period, as addressing mild distress during this critical period could have significant implications, such as improving maternal well-being and health outcomes for both mother and child.

Razurel et al. (2013) investigated the relationships between perceived stress, social support, and coping strategies, and examined how these factors impact maternal well-being during the perinatal period. Their review found a clear link between perceived stress and the onset of anxiety and postnatal depression. Notably, the study highlighted the critical role that social support plays in mitigating the impact of stress, particularly by managing feelings of isolation and supporting the capacity to cope. Active coping strategies, such as seeking help or engaging in problem-solving, were associated with better mental health outcomes. In contrast, passive coping strategies, such as avoidance and denial, were linked to poorer mental health outcomes.

The review points out that while perceived stress is an essential factor in maternal mental health, support and coping strategies can play a significant role in how stress is experienced and managed.

Another important factor influencing mental health outcomes in the perinatal period is breastfeeding, which can play both protective and challenging roles depending on individual experiences and circumstances. Research has shown that the benefits of exclusive breastfeeding extend well beyond the immediate postnatal period. Women who breastfeed exclusively have been found to have improved health outcomes, including achieving pre-pregnancy weight, reduced risk of developing type II diabetes, reduced risk of depression, and a lower likelihood of developing hormone-related cancers such as endometrial, ovarian, and breast cancer (Del Ciampo & Del Ciampo, 2018). In contrast, several studies have referenced the adverse effects of anxiety and depression on breastfeeding initiation, duration, and enjoyment. Coo et al. (2020) completed a prospective study and found that high levels of distress were associated with a lower likelihood of exclusive breastfeeding. Fallon et al. (2018) found that mothers who reported high levels of anxiety were less likely to initiate breastfeeding, had shorter durations, and reported lower levels of enjoyment. These findings underscore how mental distress can disrupt not only the physical act of breastfeeding but also a mother's emotional connection to the experience, potentially affecting long-term breastfeeding outcomes.

Lastly, postnatal depression has also been shown to impact a mother's ability to bond with her infant. A qualitative study by Keefe et al. (2016) found that mothers who have experienced postnatal depression had intense feelings of worry, anxiety, and self-doubt, particularly concerning their ability to care for their children. Reupert et al. (2015) point out that with appropriate support and intervention, it is possible to reduce the adverse effects of perinatal mental distress and improve outcomes for both mothers and children. This highlights the need for early identification and intervention for mothers experiencing mental distress, as well as providing support to families.

2.4.3 Implications for Fetal, Infant, and Child Development

Infants born to mothers who experience mental distress during the perinatal period may face a range of physical, cognitive, and behavioural challenges. A review by Atkar et al. (2019) explored the impact of perinatal depression, anxiety, and other psychological conditions on fetal and infant development, highlighting how maternal stress and elevated cortisol levels can affect fetal growth and brain development. These conditions not only influence immediate infant health but can lead to long-term developmental difficulties, including physical, cognitive, emotional and behavioural issues. Furthermore, the effects of maternal mental health issues can extend across generations, with children becoming more susceptible to developing mental health issues themselves.

The physical effects on infant and child development are well documented, with several studies examining the implications of perinatal mental distress. Let et al. (2014) found that high levels of antenatal anxiety, particularly during late stages of pregnancy, were linked to an increased risk of bronchiolitis in infants. This suggests that maternal stress can impact an infant's immune system, potentially making them more vulnerable to respiratory illnesses. A study by Greene et al. (2018) indicates that maternal anxiety, particularly during neonatal hospitalisation of low birth weight babies, is associated with lower fine motor skills at 20 months. Glasheen et al. (2010) found strong links between postnatal anxiety and somatic symptoms in children, such as colic and abdominal pain, as well as psychological outcomes for infants and children, such as difficult temperament. While there were many factors related to infant health, their findings suggest that early maternal anxiety, in particular, can influence a child's developmental trajectory, including motor coordination and physical independence.

Perinatal mental distress has been consistently linked to adverse outcomes in children's cognitive development. Barker et al. (2011) found that both antenatal and postnatal anxiety and depression were associated with emotional and cognitive disorders in adolescents. Their large-scale study of mother-infant dyads reinforces that maternal mental health has long-lasting implications, extending well beyond the postpartum period. Further evidence supporting this comes from Telgae et al. (2007), who found that high levels of maternal anxiety during pregnancy were

associated with an increased risk of language delays in infants. Similarly, Davis and Sandman (2010) found that anxiety during early pregnancy was linked to lower cognitive development in infants. Buss et al. (2010) demonstrated that anxiety in mid-pregnancy was associated with decreased grey matter volume in children, a critical marker of healthy brain development. Van der Berg et al. (2005) found that infants of mothers with high levels of antenatal anxiety demonstrated impulsivity and lower cognitive scores. These findings indicate that early maternal distress can affect children's attention span, ability to regulate their responses, and cognitive function.

Perinatal mental distress has also been linked to adverse emotional and behavioural outcomes in children. O'Connor et al. (2002), in an extensive study, found that antenatal anxiety predicted emotional and behavioural problems in children at both four and eight years of age, even after controlling for obstetric risks, postnatal depression, and other psychological factors. Similarly, Davis and Sandman (2010) reviewed a body of literature and found a strong link between anxiety during pregnancy and an increased risk of Attention Deficit Hyperactivity Disorder (ADHD) in children. However, they noted that many studies in this area failed to account for attachment style, which can play an important role in emotional and behavioural outcomes. Prenoveau et al. (2017) examined the impact of postpartum Generalised Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) on child outcomes. Their findings demonstrated that both anxiety and depression symptoms in mothers were associated with higher levels of reported behavioural problems and emotional negativity in children. Importantly, in observational assessments of children in this study, only children of mothers with MDD showed significantly higher levels of emotional negativity. This nuance underscores the complexity of the relationship between maternal mental health and child development, suggesting that the effects of perinatal distress may vary depending on the specific nature of the maternal mental distress.

2.4.4 Attachment Theory

The significance of Attachment Theory in the context of perinatal maternal health is vast. It has led to significant developments in mental health policy, including the provision of a framework

for understanding early child behaviour (Galbally et al., 2020). A comprehensive review of the literature and research in this area would exceed the scope of this thesis. However, the following is an overview of the development of this theory, along with the current research exploring the relationship between perinatal mental distress and attachment theory. This focus is not meant to imply that parents are neglectful or to blame for their children's challenges, but rather to acknowledge and emphasise the importance of the caregiver-infant relationship and highlight that many parents may need additional support or guidance at times.

Attachment is a foundational framework in understanding parenting and the parent-child relationship. Attachment theory posits that the emotional bonds formed between infants and their primary caregivers serve as an outline for future relational and emotional functioning. The innate need for attachment influences almost every aspect of early development and is shaped by the caregiver's environment during pregnancy and infancy. More than just a theory of behaviour, attachment theory emphasises the profound psychological and physiological impact of early relationships, particularly the role of the caregiver in providing safety, responsiveness, and emotional regulation. Secure attachments, formed when caregivers are responsive to their infants' needs, promote healthy social and emotional development. In contrast, insecure or disorganised attachments have been linked to social and emotional difficulties later in life.

In tracing the development of attachment theory, Winnicott (1953) introduced the concept of the 'Good Enough Mother', a notion which has influenced understandings of the necessary emotional environment for healthy infant development. This work demonstrates the role of early caregiving in the development of the self, proposing that consistent and responsive care fosters a genuine sense of self. In contrast, neglectful or intrusive caregiving may lead to the development of a false self as a coping mechanism. Bowlby (1969) extended Winnicott's ideas by viewing attachment as an evolutionary mechanism and arguing that behaviours are biologically programmed to ensure survival. From this perspective, infants naturally form attachments to their primary caregivers, who ideally provide a secure base for the child to explore the world. Bowlby proposed that early bonding experiences shape the Internal Working Model, which influences how infants and children interpret social interactions. The Internal Working Model also has impacts on emotional and social development throughout the lifespan. These mental

representations of the self are understood as guiding future relationships and responses to emotional experiences in adulthood. Ainsworth (1978), who worked alongside Bowlby, later empirically tested his theory, which has been foundational in the fields of maternal mental health and child development. Ainsworth's work identified distinct attachment behaviours in children, as related to the role of caregiver relationships. Ainsworth developed an influential method known as the Strange Situation Procedure, which involved observing children's reactions to separations and reunions with their caregivers. This approach identified four main attachment patterns: secure, insecure-avoidant, insecure-ambivalent, and insecure-disorganised. Ainsworth's research emphasises the importance of caregiver responsiveness, suggesting that variations in parenting sensitivity are key to whether a child develops a secure or insecure attachment.

During the Stranger Situation Procedure, children with a *secure attachment* display distress when separated from their caregiver but are quickly comforted upon return, with the caregiver serving as a 'secure base' from which to explore their environment (Ainsworth et al., 1978). As such, children with secure attachments develop positive working models of relationships, expecting that support is available when needed. In contrast, children with an *insecure-avoidant attachment* show little to no signs of distress during separation and actively avoid their caregiver upon return, reflecting a lack of trust in the caregiver's ability to meet their needs. These children often 'down-regulate' their attachment behaviours, managing distress independently rather than seeking comfort. *Insecure-ambivalent attachment* is characterised by distress during separation, followed by ambivalence or resistance when the caregiver returns. This suggests the child is uncertain about the caregiver's availability and responsiveness, leading them to 'up-regulate' their attachment behaviours, through increased or intensified behaviour in response to perceived threats. Finally, *insecure-disorganised attachment* is marked by conflicting behaviours such as simultaneously approaching and avoiding the caregiver, freezing, or displaying fear or distress upon reunion. In some cases, the child may also exhibit repetitive behaviours, such as rocking or jerking. This attachment style typically reflects an internal conflict, where the child is unable to resolve their distress within the context of their relationship, often because the caregiver is a source of both comfort and fear (National Collaborating Centre for Mental Health (UK), 2015). Attachment patterns observed in infancy and childhood tend to persist into adulthood in

approximately 70% to 80% of individuals, influencing their interactions in romantic partnerships, friendships, and social contexts (Fraley, 2002).

Maternal mental distress can also impact attachment between mother and infant and, therefore, the attachment style of the infant, contributing to intergenerational cycles of attachment patterns. Mothers with insecure attachment styles are at increased risk of mental health disorders due to the activation of internal working models related to negative representations of self and others (Freeney et al., 2003). Warfa et al. (2014) support this by highlighting a link between maternal attachment style and postnatal depression, with ambivalent attachment being more strongly associated with postnatal depression than avoidant attachment styles. Mothers with insecure attachment styles generally may struggle with emotional availability or feel heightened anxiety about their infant's needs, which can increase the risk of developing perinatal depression or anxiety. A study by Reck et al. (2013) found that mothers with anxiety disorders during the postpartum period engage in interaction styles that lead to increased infant distress in novel situations, especially when the mother has an avoidant attachment style. Similarly, Stein et al. (2012) found that anxious mothers tend to be more controlling and less likely to follow their child’s lead. In this way, the attachment dynamics within the family can reinforce cycles of insecure attachment, impacting emotional regulation and relationship patterns across generations. These mental health challenges can disrupt the caregiver environment, making it harder for the mother to respond sensitively and consistently to her infant's cues. As a result, the infant may develop an insecure attachment style, which mirrors the mother's attachment style, thus perpetuating an intergenerational cycle of insecure attachment.

2.5 Insights from Qualitative Research

Traditionally, research on maternal mental health has focused on the topic from a clinical or quantitative perspective. However, qualitative research offers a valuable opportunity to delve deeper into the lived experience of mothers, fostering a more collaborative approach that centres on the voices of those directly impacted. This approach prioritises the subjective experiences of mothers during the perinatal period, allowing for an exploration of their unique mental health struggles. Through the use of interviews and focus groups, qualitative research helps to uncover

the nuanced aspects of lived experiences, providing a richer understanding that emphasises meaning-making and interpretation. As noted at the outset, there has been a shift in the literature towards using the term *perinatal distress*, reflecting a desire to capture the broader and more fluid nature of lived experiences, experiences that are often less confined by controllable variables. The following section provides a summary of qualitative research on perinatal mental distress, using the same language as the respective researchers in relation to symptomatology and onset.

2.5.1 Depression

Kauuppi et al. (2012) conducted a comprehensive descriptive study involving mothers with postnatal depression, their significant others, researchers, and interdisciplinary providers. The researchers focused on mothers' expectations of motherhood, their perceptions of postnatal depression, and their specific needs. The findings revealed a central theme of stigma, with many mothers feeling labelled as 'crazy' when discussing their mental health struggles. The initial postpartum period was marked by negative emotions such as fear, guilt, loss, isolation, and being overwhelmed. Many mothers sought support from their social or professional networks, with attempts often leading to further disengagement, as they felt judged as 'bad' or 'unfit' mothers. The study concluded that when mothers' expectations of motherhood clash with their lived reality, their experiences can feel disorientating, often contributing to increased emotional distress. The study highlights the need for more supportive and non-judgmental approaches to maternal mental health, to encourage openness and reduce the stigma mothers may face.

Iturralde et al. (2021) conducted a study with pregnant or postpartum mothers from diverse racial and ethnic backgrounds, including Asian, Black, Latina, and White, as well as clinical experts. The study explored barriers that mothers from diverse backgrounds face in engaging with treatment for perinatal depression, with their findings highlighting that mothers encounter challenges at individual, social, and clinical levels. Individually, factors such as social stigma, difficulty recognising symptoms, limited understanding of treatment options, and the constraint of time hindered their ability to seek support. Socially, culturally specific discourses that discourage treatment, low social support, a history of trauma, and the difficulty of taking time off

work were further barriers. Clinically, mothers reported that a lack of knowledge and skills among healthcare providers, coupled with a lack of cultural competence and language barriers, prevented effective treatment engagement. This research draws attention to the complexities of addressing perinatal depression in diverse populations and calls for a more culturally sensitive and accessible approach to care.

O'Mahen et al. (2012) explored the perinatal-specific needs of mothers experiencing depression to inform modifications to cognitive behavioural therapy (CBT) to make it more relevant. The study sought to gain insight from mothers into their individual experiences during pregnancy and the postpartum period. Three key themes emerged: self, motherhood, and interpersonal. 'Self' revealed that mothers internalised 'motherhood myths', feeling pressured to meet idealised standards of motherhood and prioritising their child's needs over personal self-care. 'Motherhood' highlighted the challenges of managing social support, as mothers struggled to accept help or navigate relationships with family and friends. There was a sense of perceived inadequacy in their ability to fulfil the role of motherhood, which contributed to depressive symptoms. 'Interpersonal' speaks to strains in partner relationships and feelings of social isolation from peers and the community. The findings were consistent with a CBT perspective, which suggests that negative thinking patterns can impact behaviour, and the lack of engagement in positive, reinforcing activities can exacerbate these negative cycles. The researchers emphasise the need for CBT interventions relevant to mothers to address unhelpful thinking patterns and to integrate strategies for improving social support, self-compassion, and relationship dynamics, thereby promoting wellbeing for mothers during the perinatal period.

2.5.2 Anxiety

Arfaie et al. (2017) explored pregnancy-related anxiety and risk factors, including fear of childbirth, through semi-structured interviews with mothers referred to healthcare centres. The analysis identified four categories of fear: the process of delivery (e.g., pain, competency, loss of control), delivery (e.g., late arrival, preterm labour), delivery complications (e.g., bleeding, death, delivery accidents), and healthcare quality (e.g., hospital facilities, trust in staff). The study highlighted the need for supportive and informative environments for mothers, with a key

focus on information about the delivery room, labour, and strategies for navigating fear and pain. Similarly, Eriksson et al. (2006) investigated the intensity of fear experienced during childbirth. The study interviewed 20 mothers using a grounded theory approach, finding that intense fear of childbirth fluctuates and is influenced by judgments based on perceptions of self and others. The researchers noted that while some mothers reported finding it helpful to discuss their fears, all mothers highlighted the difficulty of doing so. Their findings stressed the importance of understanding healthcare professionals, particularly midwives, in facilitating these conversations.

Cóté-Arsenault et al. (2006) conducted an extensive qualitative study involving mothers who had experienced previous pregnancy loss. Five key themes emerged: growing confidence, fluctuating worry, interpreting signs, managing pregnancy, and having dreams. The first four themes reflected the unstable nature of pregnancies for these mothers, while the ‘managing pregnancy’ theme included subthemes of being hypervigilant, seeking reassurance, and relying on internal beliefs. The study highlighted that mothers with previous pregnancy loss experience constant worry and anxiety, seeking reassurance that their babies are safe. In a similar study, Moore and Cóté-Arsenault (2018) analysed the diary entries of mothers with histories of miscarriage, stillbirth, or neonatal death. Six themes emerged: staying alert, dealing with uncertainty, dreaming of the destination, connecting with others, and reflecting on self. These themes intertwine in the overarching theme of ‘staying on track, navigating the pregnancy’. The findings portrayed the pregnancy journey as a challenging and uncertain path towards the destination of a healthy baby.

Wardrop and Popadiuk (2013) conducted a qualitative study using a feminist biographical approach to explore first-time mothers' experiences of anxiety in the postpartum period. Six in-depth interviews were completed, with questions designed to delve into personal experiences of anxiety and the challenges of transitioning to motherhood. The study identified five main themes: experiences of anxiety, expectations of a new mother, issues of support, societal scripts of motherhood, and the transition. The authors concluded that there is a need for healthcare professionals to broaden their understanding of postpartum distress to include anxiety, recognising its significance in the maternal experience.

Evans et al. (2017) completed a qualitative study to explore the experiences of anxiety during pregnancy and the views of mothers on the use of screening measures in antenatal care. The study included two focus group discussions: one with mothers in a community setting and another with mothers in a hospital setting, all of whom had received additional support for anxiety during pregnancy. Three main themes emerged: sources of support, administration of anxiety instruments, and the use of instruments to prompt discussion. The researchers concluded that while the introduction of anxiety instruments could be beneficial in identifying anxious feelings, participants voiced concerns about their administration and their ability to access follow-up support. Their findings raise an interesting discussion about measuring anxiety to understand emotional well-being, while taking care not to oversimplify the nuanced experiences of pregnant mothers.

2.5.3 Perinatal Mental Distress

Mothers can experience a range of psychological problems across the perinatal period, with symptoms and vulnerabilities of disorders often seen as overlapping, evidenced by high rates of co-occurring disorders. Coates et al. (2014) advocate for a transdiagnostic approach to understanding postnatal mental health, which focuses on identifying common underlying causes of distress, rather than categorising mental health issues based on specific disorders. This approach aims to guide more holistic treatment strategies. Their qualitative study sought to explore how mothers conceptualise their postnatal distress. Using Interpretative Phenomenological Analysis (IPA), four main themes were identified: living with an unwelcome beginning (unwanted negative emotions), relationships within the healthcare system, the shock of the new (adjusting to the demands of motherhood), and permanent changes to one's life post-birth. Psychological processes such as guilt, avoidance, and adjustment difficulties were present across different types of distress, with mothers highlighting the importance of social support in managing their new needs. These findings indicate the importance of exploring the psychological processes that contribute to postnatal mental health challenges and the need for more comprehensive, supportive care.

A study by Highet et al. (2014) sought to gain qualitative insights into mothers' personal experiences of perinatal depression and anxiety. The study aimed to explore the experiences of mothers who had experienced perinatal depression or anxiety, focusing on the specific factors related to these conditions during this stage of life. Participants were women from both urban and rural settings across Australia. The research used a grounded theory perspective, with findings indicating that the wide range of symptoms experienced by mothers could be understood as part of a broader phenomenon of loss and frustration. These symptoms were often linked to the numerous changes inherent to the transition to motherhood and were frequently associated with a sense of dissatisfaction with personal experiences of motherhood. The study highlights the need for greater, more accurate and comprehensive information about perinatal depression, and emphasises the importance of raising awareness about anxiety disorders during this period.

Jones et al. (2022) completed a study examining the feelings and experiences associated with perinatal distress during the COVID-19 pandemic, a period marked by a global increase in mental health challenges. Drawing on a realist approach, five key themes were identified: family and well-being, lack of support, mothering challenges, loss of control due to COVID-19, and work and finances. The findings revealed that while the participants showed high rates of depression, their descriptions were more indicative of anxiety and general distress, suggesting that perinatal mental health may be more nuanced than previously recognised. The study points to the complex and multifaceted nature of maternal mental health. It stresses the need for future research and healthcare to consider the full range of emotions and symptoms expressed by mothers. Given the broader implications of the pandemic on societal support structures, these findings challenge the notion that perinatal distress can be solely categorised into specific diagnoses and call for a more inclusive understanding of maternal wellbeing.

2.5.4 Aotearoa New Zealand Specific Research

In Aotearoa New Zealand, qualitative research focusing on perinatal mental health has provided valuable insights into the unique challenges faced by mothers. A study by Holden et al. (2019) engaged with maternity carers and mothers who identified as Māori and Pacific to explore gaps

in screening practices and potential access pathways for mothers experiencing mental health concerns. Their findings revealed that both mothers and carers perceived maternal mental health screening as inconsistent and ad hoc, with multiple barriers impacting screening and access to support. Notably, while lead maternity carers felt that mothers were often unreceptive to screening, mothers expressed a strong desire to discuss their mental health concerns. The study concluded that gaps in maternal mental health services exist and that improvements are needed at the patient, provider, and system levels to ensure more equitable and effective care. Another study by Clapham et al. (2024) expands on these findings by utilising their online story-sharing platform to gather stories from mothers who experienced unmet needs while accessing the Well Child Tamariki Ora (WCTO) service. The study identified three key themes: 'making it seem that I'm coping', 'I wish I had connected with my WCTO nurse', and 'beyond the baby'. Their findings underscore multiple missed opportunities for WCTO providers to address mental health concerns and offer necessary support, stressing the importance of a relational approach to care that considers the needs of families and whānau.

A study by Ryan and Barber (2022) conducted interviews with eight Auckland-based mothers and three healthcare providers to explore the impact of the COVID-19 pandemic on postnatal mental health. The findings focused on five themes: uncertainty and anxiety, financial work stress, the importance of the 'village' (community support), inner resilience, and the feeling that "no one cared for mum". The study illustrated a lack of focus on maternal healthcare appointments, coupled with limited support services for mothers seeking help. These findings underscore the need for greater importance on mental health training for healthcare providers, especially during the postnatal period when mothers may be particularly vulnerable.

Job (2022) utilised a mixed-methods approach to examine the experiences of mothers regarding their birth experiences and subsequent mental health. Qualitative content analysis identified four key themes: expressing myself, appraisals into the unknown, the reality of the experience, and the impact on future birth experiences. The study found that Māori mothers often had negative birth experiences linked to communication breakdown and obstetric interventions. Whereas non-Māori mothers reported contrasting expectations versus reality, it is unclear how modern ideals of motherhood could influence this discrepancy. This discrepancy highlights that birth

experiences, particularly those involving interventions, contribute towards postnatal mental distress.

Finally, Reid et al. (2018) completed a qualitative study using Kaupapa Māori methodology to explore the experiences of Māori mothers living in rural New Zealand with gestational diabetes. The study highlighted that gestational diabetes not only posed physical health risks but also led to psychological stress and emotional challenges, ultimately contributing towards an increased risk of anxiety and depression. Their findings indicated intergenerational beliefs that gestational diabetes was an inevitable heritable illness, for example, "it just runs in the family", and identified missed opportunities for health services to address psychological concerns. There was an identified need for a more holistic approach to healthcare that recognises both the physical and emotional impact of gestational diabetes, particularly in the context of intergenerational poverty and disadvantage.

2.6 Aotearoa New Zealand Context

Aotearoa New Zealand's population was estimated at 5,308,500 as of December 2023, with an annual growth rate of 2.87% (Stats New Zealand, n.d). In the year ended June 2024, there were 57,006 live births, a slight decrease from 57,534 in the previous year (Stats New Zealand, 2024). Perinatal mental health issues affect a significant proportion of the population, with estimates suggesting that 12-18% of mothers experience depression and anxiety during this period (The Ministry of Health, 2021). Tragically, for some women, their mental distress can become so overwhelming that they experience suicidal ideation and behaviours, with suicide now identified as the primary cause of maternal death in Aotearoa New Zealand (Wilkinson et al., 2022). Furthermore, rates of distress are disproportionately higher across certain groups, specifically Māori, Pacific, and Asian peoples (The Ministry of Health, 2021), highlighting inequities and social determinants linked to perinatal mental health (Dawson et al., 2022). A study by Signal et al. (2017) found that 22% of Māori mothers met criteria for depression during late pregnancy, compared to 15% of non-Māori mothers. Similarly, 25% of Māori mothers met criteria for anxiety versus 20% of non-Māori mothers.

Globally, and in Aotearoa New Zealand, there is increasing evidence that suggests that supporting babies during the first 1,000 days of life (from conception to their second birthday) is crucial for their lifelong physical, emotional, and psychological well-being (Helen Clark Foundation, 2022). However, maternal mental health challenges are often under-recognised due to several factors, such as inadequate screening methods, limited data, insufficient mental health services, and education (Clapham et al., 2024). In 2012, the Ministry of Health released *Healthy Beginnings* (2012), aimed at improving the availability, quality, and national consistency of perinatal and infant mental health services in Aotearoa New Zealand. This initiative has led to the expansion of services, including personalised care packages, community-based respite care, and enhanced clinical responsiveness. Nonetheless, more work is needed to achieve better outcomes for mothers, children, and their families. The Perinatal and Maternal Mortality Review Committee (2022) has called for evidence-based approaches to support younger mothers, identify modifiable risk factors for all mothers, and develop Kaupapa Māori models of care. Central to these recommendations is the recognition that future mental health services must place patients, families, and whānau at the heart of care. To achieve this, healthcare providers must focus on building strong relationships and understanding the experiences of those they support, considering their individual, familial, whānau, and community contexts (Te Whatu Ora, 2022).

2.6.1 Screening and Early Intervention

Maternity care in Aotearoa New Zealand, like many Western nations, has a history deeply rooted in hospitalisation and medicalisation, leading to a loss of control for mothers in their experience of birthing (Grigg & Tracy, 2013). The focus on physical care has often overshadowed the need for comprehensive mental health support and care that centres on mothers' needs. While there has been a slow shift toward integrating psychological aspects of care, this change is still emerging in legislation and practice. At present, publicly funded services remain inadequate to meet the diverse mental health needs of mothers, which should be accessible to all mothers experiencing distress and not just those severely affected (Wilkinson, 2022). Early interventions for maternal mental health are crucial, as they have been shown to positively influence prenatal development, enhance the bond between caregiver and child, improve maternal mood, and boost parental self-efficacy (Clapham et al., 2024). The importance of universal screening for perinatal

mental health cannot be overstated. Screening, when done correctly, should be implemented for all pregnant women during their first lead maternity care visit, repeated in mid-pregnancy, and again postnatally (Wilkinson, 2022).

The early identification and treatment of perinatal mental distress is essential, with maternal anxiety recognised as both a key risk factor and strong predictor of depression (Fairbrother et al., 2015). While a formal diagnosis of a mood or anxiety disorder requires a clinical assessment and interview with a qualified professional, a range of self-report and psychometric tools are available (Goldman et al., 1999). In Aotearoa New Zealand, the most commonly used screening tool is the Edinburgh Postnatal Depression Scale (EPDS), which was developed to identify women who may require further clinical assessment (Cox et al, 1987). The scale is also sensitive to anxiety and can detect symptoms across the broader spectrum of perinatal mental distress (Matthey, 2008). Evidence suggests that postnatal depression responds well to various treatment modalities, particularly psychological interventions. However, pharmacological and combined approaches may also be appropriate depending on the severity, duration, and complexity of symptoms (O'Hara & McCabe, 2013).

The EPDS has limitations in its cultural application. While it has been validated for Tongan and Samoan women living in Aotearoa New Zealand, its relevance for Māori women has not been assessed (Wilkinson, 2022). Research shows that Māori mothers may be more likely to express perinatal distress through physical symptoms rather than emotional or mood-related complaints (Merrit, 2005). This highlights the need for culturally sensitive screening tools that reflect the diverse ways in which stress can be experienced and communicated. A recent report by Wilkinson (2022) calls for greater awareness of these cultural variations and the development of an inclusive screening approach. One that moves beyond narrow diagnostic labels like 'perinatal depression' or 'perinatal anxiety' and instead recognises the full spectrum of perinatal mental distress.

2.6.2 Rural Living

Rural and remote communities in Aotearoa New Zealand face unique challenges that are often overlooked at the national level (Crowther, 2016). Rural and maternity services are defined by proximity to obstetric and pediatric hospital care, with rural areas requiring at least a 30-minute drive and remote rural areas requiring more than 60 minutes (Kyle & Aileone, 2013). Geographic isolation and limited access to specialised healthcare services, particularly in areas like Central Otago, can increase stress for pregnant mothers. Long travel times to specialist services often mean mothers must leave their families, lose continuity of care with their lead maternity carer, and bear financial burdens, which can exacerbate mental health challenges (Whitehead et al., 2022). Furthermore, research indicates that greater exposure to stress during pregnancy can increase the likelihood of perinatal mental distress (Waldie et al., 2015). In rural areas, healthcare services are typically located in larger towns, leaving remote communities with limited access to maternal care, including midwifery, prenatal, and postnatal support. Studies show that many rural mothers choose to travel to base hospitals for specialised care like epidural anaesthesia and to avoid labour transfers (Grigg et al., 2015). Travel for birth and specialist antenatal care due to pregnancy complications presents financial and logistical challenges, which urban mothers also face, but to a lesser extent (Low et al., 2005). These barriers contribute to poorer mental health outcomes, highlighting a need for increased focus and support for rural populations to address the adverse impacts that rural living can have on maternal healthcare.

2.8 Chapter Summary

The current study focuses on the perinatal period, spanning from conception through to the first 12 months postpartum. This period is marked as a transitional time that shapes the wellbeing of mothers, infants, and families. Despite the topic's importance, literature reveals a lack of an agreed-upon definition of perinatal mental distress, further complicating recognition, diagnosis, and treatment. Historically, perinatal depression has taken priority in research; however, more recent work has called for the inclusion of anxiety due to its high comorbidity and distinct clinical profile. Furthermore, there is a shift observed where researchers are moving towards the use of perinatal mental distress to capture the full spectrum of experiences in this period.

Mental distress during this period does not follow a single pathway; instead, it is multifactorial, shaped by physiological, psychological, and socio-environmental influences. These challenges can have both short-term and long-term consequences, with research highlighting intergenerational effects that extend far beyond the individual. Attachment theory reinforces this, illustrating how maternal mental health can shape early relational and emotional development in children. The biopsychosocial model of health offers a vital lens through which to understand these complexities, highlighting the need for holistic and integrated care. Exploring how these factors interact presents meaningful opportunities for enhanced awareness, prevention, and treatment. However, research has traditionally isolated these influences, failing to account for the nuanced, lived realities of mothers. Interpretative Phenomenological Analysis (IPA) offers a unique approach, allowing for contextualised, experience-driven explorations of how factors interweave.

In Aotearoa New Zealand, research has identified substantial gaps in perinatal mental health screening and support, with services described as ad hoc and fragmented. Mental health concerns are often under-recognised due to inadequate screening, limited data, and underresourced services. Additionally, suicide has now become the leading cause of maternal mental death in the country. There is a very real need for relational, culturally responsive care that supports not only individuals but whānau as a whole. Research into perinatal mental distress often overlooks the voices of those most affected, particularly mothers in rural communities, who face unique structural and geographic barriers to accessing support. Understanding the lived experience of perinatal mental distress through qualitative research is an essential step in addressing current gaps and informing more responsive, equitable care.

CHAPTER 3: METHODOLOGY

3.1 Chapter Overview

This chapter begins by outlining the methodological rationale, situating the research within the broader context of qualitative inquiry and its underlying ontological assumptions. I introduce the meta-theoretical foundations of Interpretative Phenomenological Analysis (IPA), offering insight into the study's philosophical and epistemological commitments. I then explore the use of semi-structured interviews in depth, highlighting how this method aligns with the core principles of IPA and supports the exploration of my research question: *How do mothers living in rural Aotearoa New Zealand experience perinatal mental distress?* I follow with a detailed account of the research design, including participant sampling, inclusion criteria, recruitment process, and data collection procedures. The data analysis is described with reference to Smith et al.'s (2009) six-step IPA framework. To demonstrate rigour, I draw on Yardley's (2000) four criteria for evaluating research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. I also outline the ethical considerations, detailing how ethical principles were upheld throughout the study. Finally, I present a reflexivity statement, in which I express my position as a researcher and the influence I exert throughout the research process.

3.2 Rationale for Choosing the Methodology

Scientific inquiry has historically prioritised empirical, quantitative methods as the gold standard for producing objective knowledge (Brinkmann et al., 2020). A rise in social justice movements throughout the 1960s and 1970s led to significant changes in the academic landscape, advocating for the inclusion of diverse voices in research. This shift prompted critiques of dominant positivist approaches that upheld the idea of universal truths and instead emphasised a new perspective that views knowledge as produced in relation to social, cultural, historical, and economic contexts (Leavy, 2020). In this framework, subjectivity is valued, with the understanding that people build their own realities based on personal beliefs, perceptions, experiences, and so on (Vaprio, 2017). As a result, qualitative methods have re-emerged as a valid and increasingly popular approach to research, offering richer, more contextualised

understandings of human experiences. Within this framework lies an opportunity to challenge taken-for-granted assumptions about the research topic by focusing on how meaning is constructed at the individual level (Bishop & Yardley, 2014).

To address the research question, an Interpretative Phenomenological Analysis (IPA) methodology was chosen. IPA is a qualitative research approach that is particularly well-suited for this study, as it enables an in-depth exploration of the participants' lived experiences (Smith et al., 2009). IPA values the participants' voices, offering a more nuanced understanding of their experiences (Sofaer, 1999). IPA research, by nature, values subjectivity in the production of knowledge and is based on the assumption that realities are co-constructed between the 'object' in the world and the 'subjective' processes involved in perceiving it. Here, human beings can perceive internal and external phenomena through a social, cultural, and historical framework built from one's experience of 'being in the world' (Packer, 1985). The 'being' is seen as embedded in the world, and the world is embedded in the being. Heidegger (1963) refers to this as 'Dasein' or being in the world. In contrast, methodologies built within quantitative frameworks tend to value an objective reality, viewing the subject and the object of study as separate entities, emphasising controlled measurements to ensure validity.

IPA is particularly valuable in exploring experiences of mental distress during the perinatal period, as it allows for detailed descriptions and interpretations of the emotional and psychosocial nuances. This approach is especially important in the context of rural Aotearoa New Zealand, where there is a paucity of qualitative research focusing on mothers' lived experiences of perinatal mental distress. As such, IPA offers a unique and essential lens through which to explore these often under-researched experiences.

3.3 Adopting Interpretative Phenomenological Analysis

IPA focuses on understanding the everyday experiences that hold particular importance or significance for individuals and prioritises participants' perceptions and experiences (Smith & Osborn, 2015). In other words, when using IPA, researchers aim to understand what it is like to 'walk in the shoes' of their participants and make meaning of their experiences (Pietkiewicz &

Smith, 2014). This methodology offers a robust framework for exploring mothers' psychological and emotional experiences during the perinatal period, thanks to its focus on lived experiences, its interpretive approach, and its idiographic perspective.

IPA derives directly from the meta-theoretical principles of hermeneutic phenomenology, phenomenology, hermeneutics, and idiography. *Phenomenology* draws on several philosophical principles, including those of philosophers such as Hesser, Heidegger, and Merleau-Ponty (Smith et al., 2009). It prioritises individuals' inner worlds, focusing on their thoughts, feelings, and memories (Laverty, 2003). Participants are viewed as experiential experts, and researchers strive to understand the meanings individuals attribute to their experiences. In phenomenological research, the world is understood as perceived by the individual, through their lived experience, in that specific context. Therefore, phenomenology calls for a first-person description of how people experience phenomena, rejecting the notion of 'value-free' or 'context-free' research.

The second meta-theoretical principle, *hermeneutics*, highlights that all knowledge and understanding are mediated through interpretation. Originally a technique for interpreting biblical texts, hermeneutics recognises that analysis always involves an interpretative element. This interpretation occurs on two levels, often referred to as the double hermeneutic. In this process, participants interpret their personal and social world while the researcher interprets how participants make sense of their experiences (Smith & Osborne, 2004). The researcher assumes a dual role: on one hand, engaging with the participant, and on the other hand, interpreting the participant's experiences within the broader context of the phenomenon. The phenomenon is there, ready to "shine forth, but the researcher requires detective work to facilitate the coming forth, and then to make sense of it once it has happened" (Smith et al., 2009, p. 35). Central to this detective work is reflexivity, which plays a pivotal role in IPA; researchers must acknowledge and critically reflect on their own preconceptions and biases, which inevitably influence interpretation (Heidegger, 1962). Language is key in this process, as it is through language that we express and understand 'being in the world' (Shinebourne, 2011). This understanding of language influences every stage of IPA, from accessing participant experiences to interpreting their meaning, engaging in dialogue, and situating these experiences within specific contexts.

The third theoretical underpinning, *idiography*, is concerned with individuality and prioritises small sample sizes, allowing the researcher to conduct deep, context-specific research. IPA follows a systematic and thorough approach to analysing each case individually before moving on to the next, ensuring that rich and meaningful analysis is produced (Smith et al., 2014). The idiographic nature of IPA also implies that data analysis is inductive, with patterns, themes, and meanings emerging directly from the participants' accounts rather than from pre-existing theories or hypotheses. In doing so, IPA aims to develop insights grounded in participants' lived experiences, fostering an understanding that emerges from the bottom up and provides an informed understanding of the participants' thoughts, feelings, and behaviours (Noon, 2018a).

3.3.1 Strengths of Interpretative Phenomenological Analysis

Several other qualitative methodologies were considered to address the research question; however, IPA was chosen due to its ability to provide an in-depth understanding of mothers' experiences during the perinatal period. IPA's phenomenological approach ensures that the study not only describes the mothers' experiences but also focuses on the meaning that mothers attach to those experiences, a crucial element in understanding how distress is processed, understood, and managed. Unlike approaches that prioritise solely narrative or social construction, IPA enables a more flexible and psychologically grounded exploration of individuals' landscapes. Its emphasis on subjective experience and interpretative depth aligns closely with the study's aims to understand the cognitive and emotional dimension of maternal mental health (Coates et al., 2014; Smith & Osborn, 2015).

3.4 Research Design (Semi-Structured Interviews)

Qualitative research offers a range of data collection methods, including interviews, focus groups, observations and diaries in natural settings (Willig & Stainton-Rogers, 2008). Interviews are a valuable tool for gaining insights into how people think, feel, act, and experience the world (Brinkmann, 2013). This strength enables the researcher to explore the subjective meanings that people attribute to various phenomena through dialogue. In studying mothers' experiences of

perinatal mental distress, interviewing is a particularly natural and valid method for gathering rich, contextualised accounts. The flexibility of interviews is a key advantage, as it can accommodate multifaceted frameworks and allow the exploration of diverse topics (Brinkmann, 2013). By designing the study around specific research questions, interviews serve as an effective approach to achieving research goals, allowing participants to express themselves naturally (Riley & Chamberlain, 2021).

In line with IPA, which is best suited to a data collection process that will "invite participants to offer a rich, detailed, first-person account of their experiences" (Smith et al., 2009, p. 56), semi-structured interviews were chosen for data collection in this study. This method offers greater flexibility compared to structured interviews, allowing me, as the researcher, to guide the conversation while remaining open to emerging topics. This facilitates an exploration of the participants' 'life-world' and supports gathering in-depth descriptions of their experiences. According to Brinkmann et al. (2020), semi-structured interviews align with the core principles of qualitative research. These include fostering purposeful and rich conversations that allow participants to share their experiences in detail; generating detailed descriptions that provide comprehensive insights into those experiences; and supporting interpretative analysis by exploring how participants make sense of their lives and the meaning they attach to their experiences. The ability to revisit answers sensitively, prompt for clarification, or adjust the flow of the conversation enhances the ability to gather nuanced responses (Smith & Osborn, 2015). Semi-structured interviews also support a dialogical approach to knowledge production, encouraging meaningful exchanges between the researcher and participant and facilitating a deeper understanding of the topic. Compared to unstructured interviews, this method provides a clear framework for maintaining focus on the research objectives while allowing participants to express their thoughts and feelings (Brinkman, 2013). This balance of structure and flexibility makes semi-structured interviews particularly effective for obtaining rich, comprehensive, and contextually relevant data that offers deep insights into participants' experiences, emotions and perspectives.

3.5 Participants

3.5.1 Sampling

This study employed a purposive and homogeneous sampling technique, which is standard for IPA. This sampling approach allows for a detailed exploration of a specific group of individuals who have experienced the phenomena under investigation; in this case, the shared experiences of mothers who have faced perinatal mental distress. A key advantage of a purposive sampling approach is its focus on capturing rich, contextual insights, recognising the importance of understanding the nuance of individuals' lived experiences (Larkin, 2019). By considering these personal accounts, the study aims to identify themes and patterns that reflect shared experiences while acknowledging the role of social, cultural and historical understandings.

Smith et al. (2009) suggest that in IPA, there is no set number for the correct sample size; however, smaller samples are commonly employed to allow adherence to the idiographic commitment of the research approach. In line with Clarke (2010), which recommends a default sample size of three for undergraduate or master's research and four to ten for professional doctorate-level research, the present study completed five interviews. While four additional participants expressed interest in the research, they were unable to participate as they did not meet the inclusion criteria.

3.5.2 Inclusion Criteria

The inclusion criteria for this study were individuals over 18 years old who had carried and given birth within the past five years, had experienced anxiety or depression (self-identified or clinically diagnosed) during the perinatal period, and were residing in Aotearoa New Zealand. Crucially, participants needed to consider themselves to have recovered and maintained stable mental health for at least six months. The reference to ‘recovery’ and ‘stable mental health’ is defined, with reference to local literature, as “living well in the community”. In Aotearoa New Zealand, recovery is understood as living well in the community, whereby each person defines what living well means (Mental Health Commission, 2012). Participants who considered

themselves recovered for the specified period and were willing to participate were eligible for the study. In determining their recovery, mothers may have reflected on factors such as their ability to manage stress, cope with challenges, and regulate emotions, all of which contribute to a sense of control over their thoughts and behaviours (Kleinert et al., 2022).

The four participants who did not meet the inclusion criteria were excluded for the following reasons. Three participants had given birth within the last six months and had experienced postnatal mental distress, meaning they had not yet met the required six-month recovery period. One further potential participant was unable to be included due to residing outside the Central Lakes region, which meant they could not participate in the study as they did not meet the rural living criteria necessary for a homogenous sample.

3.5.3 Recruitment Process

Participants were recruited through maternal support networks in Central Lakes, including organisations like Plunket, Central Lakes Family Services, midwives, counsellors, and Precious Beginnings. This recruitment process was employed to engage mothers living in the Central Otago Region, thereby supporting the research aims, which sought to explore the experiences of mothers in a rural area. These networks were invaluable, and the generosity and enthusiasm of the community members highlighted their strong commitment to supporting mothers. In IPA, participants are often recruited through referrals from professionals, other participants, or opportunities that provide access to a representative sample (Smith, Flowers, & Larkin, 2009). By establishing rapport with maternal professionals, the research employed a snowball sampling technique. An Information Sheet (see Appendix 1) was developed to recruit participants. It was distributed to maternal health professionals, community members, and participants following interviews, to be shared with their social networks via word of mouth, email, and digital communications. A participant recruitment poster was also developed and distributed in relevant locations, including community service waiting rooms and online platforms such as Facebook and Instagram (see Appendix 2). Individuals interested in the study were asked to contact the researcher directly rather than through third-party contact information to protect participants' privacy.

Given the rural setting and the sensitive nature of the issue being explored, a high level of participant interest was not anticipated. Participants were invited to join the study on a first-come, first-served basis, provided they met the inclusion criteria. The study aimed to include up to 10 participants, which was deemed appropriate to the scope of the research and the available resources. This number was identified in line with IPA methods and to ensure that I could provide the necessary attention to the data collected and analyse it meaningfully. If participant numbers exceeded this, I planned to communicate with the community contacts to inform them that spaces were filling up. Those who reached out after the study reached capacity would be thanked for their interest and informed that participant spaces in the research were full.

Table 1

Descriptive Details of the Participants in the Study

Participant Name (Pseudonym)	Number of Children	Length of Interview	Described Timing of Symptom Onset	Presenting Symptom (as described by participants)
Bella	*1*	*44 minutes*	*Post-partum*	*Anxiety*
Molly	*2*	*92 minutes*	*Post-partum*	*Anxiety, Depression, Psychosis*
Matilda	*2*	*65 minutes*	*Post-partum*	*PTSD, Anxiety, Depression*
Sophie	*2*	*63 minutes*	*Post-partum*	*Depression, PTSD*
Jamie	*2*	*43 minutes*	*Prenatal*	*Anxiety*

3.6 The Interviews

Participants were given the option to complete the interview in their homes or in a private meeting room at a community centre. All participants chose to do the interview in their homes, which provided a natural and comfortable environment. I brought baked goods from a local store to the interview as a way to thank participants for their time and to help create a relaxed, person-centred atmosphere. Before starting, I built rapport with each participant by beginning with light conversation that helped us get to know each other. The participant consent form (see Appendix 3), which had been previously emailed to participants, was then reviewed, and

participants were asked to sign it. They were reminded that the interview would be audio recorded and were given the opportunity to ask any questions before the interview began.

The interview schedule (see Appendix 4) was developed based on previous qualitative research focusing on similar topics and informed by discussions with maternal mental health professionals in the community. Smith and Osborn (2008) noted that an interview schedule helps IPA researchers consider what topics to explore, identify potential challenges, and ensure the interview stays focused. The interview schedule was submitted to Dr. Elle Brittain (research supervisor) and the Massey University Human Ethics Committee for review and feedback, particularly regarding the sensitivity of questions. As a part of the research development and method review, a pilot interview with two mothers from the community (not included in the research) allowed me to gather feedback on the interview structure, timing, and question clarity.

The interviews began with a broad question, "*Can you tell me about your experience with perinatal mental distress?".* This open-ended question allowed participants to share their experiences in depth and in their own words. I then employed a funnelling technique, starting with broader questions and narrowing to more specific inquiries. This approach enabled participants to gain a holistic understanding of their experiences, which could then be explored in greater detail. The interview guide was intended to assist in navigating the interview rather than restricting conversation. This flexibility allowed participants to guide the flow of discussion, resulting in a more natural and immersive interview process. Throughout the interview, I adapted questions based on participants' responses, allowing for a deeper exploration of their perspectives. This flexibility ensured that participants had ample space to articulate their ideas and reflect on experiences on their own terms. The addition of probing questions, such as *"What was that like for you at the time?* was used as a tool to guide participants as closely as possible to the meaning of an experience, and therefore, to understand what it was like for them at that moment, that is, the embodied experience of 'being in the world'. This supports Packer's (1985) 'modes of engagement' as a way to prioritise the origin of knowledge, whereby participants are pushed to a point before reflective reconstruction, which naturally occurs over time.

After the interview, audio recordings were transcribed verbatim and sent to participants for

review. They were invited to add, remove, or modify any comments before finalising the transcripts for analysis. The interviews ranged in length from 42 to 91 minutes. Additionally, I kept reflective notes to document my observations and personal reflections, which helped me become aware of potential biases or emotional reactions during the interview.

3.7 Data Analysis

Data analysis using the IPA framework required me to fully immerse myself in the experiences that participants had shared with me. As a researcher, my goal was to interpret and learn from the participants' lived experiences, engaging deeply with the transcripts in an interpretative process. Smith et al.'s (2009) framework for analysis was invaluable, particularly as this was my first independent research project. The steps I followed were based on their recommendations, as outlined below:

Step 1: Reading and Re-reading

I began the analysis by engaging with the transcript, reading and re-reading it multiple times. This started with listening to the interview audio, followed by a careful review of the transcript. I made reflective notes as I read, aiming to absorb as much detail as possible. I also kept a reflective journal to document my thoughts, insights, and initial reflections, which helped me identify key focus areas for further analysis (see Appendix 5).

Step 2: Initial Noting

After familiarising myself with the transcript, I examined the participants' language and the content of their responses, beginning by highlighting comments which stood out before making exploratory notes. These notes formed the foundation for exploring emerging ideas and initiated the process of interpretation discussed earlier. An example of this is presented in Appendix 6.

Step 3: Develop Emergent Themes

I worked with my initial notes to identify emerging themes within the data. Rather than focusing on the narrative accounts, I used my notes to identify recurring themes and patterns. These emergent themes, which represented key aspects of the participants’ experiences, became the

building blocks of my analysis. I revisited the data to refine themes, ensuring they were grounded in the participants' words and descriptions, while interpreting meaning beyond what they shared.

Step 4: Searching for Connections Across Emergent Themes

Next, I examined how emergent themes were connected to one another. I used Miro, an online tool, to create a visual board with post-it notes, which helped organise and explore the relationships between themes. This allowed me to visually arrange themes and identify superordinate themes, which are broader categories that capture overarching ideas. This process strengthened my understanding of how individual experiences were connected through shared patterns and how each theme contributed to the research topic. An example of this can be seen in Appendix 7.

Step 5: Moving to the Next Case

Once the analysis of one participant's transcript was complete, I repeated the process for the next participant's transcript. Following IPA's idiographic approach, I made a conscious effort to set aside the prior themes and interpretations, allowing themes from each participant to emerge. In this step, I endeavoured to maintain the integrity of each participant's unique experience and attempted to refrain from imposing preconceived themes on the new data.

Step 6: Looking for Patterns Across Cases

Finally, I looked for patterns across all the participant interviews. I used a table to compare the superordinate themes from each case, identifying convergences and divergences in the data. This process also revealed new overarching themes. The final result was a master table of superordinate and subordinate themes for the entire group, highlighting broader trends and connections across the cases. An example of this can be seen in Appendix 8.

3.8 Ensuring Reliability and Validity

The evaluation of qualitative research quality has been a topic of considerable debate, with some scholars arguing for the recognition of the uniqueness of each individual study, while others

contend that general guidelines are necessary for evaluating quality. Yardley (2000) offers four broad principles for assessing qualitative research, which are referred to by Smith et al. (2009): *sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance*. These principles can serve as foundational guidelines for ensuring that qualitative research meets specific standards of quality and integrity.

3.8.1 Sensitivity to Context

Yardley (2000) highlights the importance of understanding and engaging with various contexts that shape qualitative research. The researcher must demonstrate sensitivity to these contexts throughout the research project to ensure a deep, nuanced, and ethically sound approach. In this study, the following contexts have been carefully considered:

Theoretical Context

Throughout the study, I actively engaged with relevant literature, aiming to demonstrate a sound understanding of previous studies that used similar methods and topics. This is shown through the use of a comprehensive literature review, which frames the research within an existing body of knowledge, thereby ensuring theoretical validity. I aimed to critically review the literature to justify the need for this particular project, situating it in a broader theoretical context. Sensitivity towards context is also demonstrated in allowing previous IPA research on maternal mental health to guide the development of the interview schedule.

Philosophical Context

The philosophical underpinnings of phenomenology, hermeneutics, and idiography were carefully reflected on, and I hope to have articulated and justified their methodology while addressing the assumptions and worldviews that guide the analysis. This section highlights a commitment to a clear philosophical rationale, ensuring that the chosen approach aligns with the research goals and facilitates the interpretation of meaningful data.

Data Context

Sensitivity to the context of the data is reflected in a commitment to collecting and actively exploring the data. I used probing questions during interviews and employed a rigorous analytical approach to draw out findings, ensuring that all data were thoroughly and meaningfully examined. Here, I sought to illuminate the depth of participant experiences rather than simply note their descriptions.

Socio-Cultural Context

I have demonstrated sensitivity to the socio-cultural context by recognising how language, social dynamics, and cultural factors shape the findings. The research methodology was designed to respect and account for these factors, ensuring that the research findings were not biased or reductive but instead nuanced and culturally sensitive.

Social Context of the Researcher and Participants

I was particularly mindful of relational dynamics with participants, fostering empathy, respect, and openness in all interactions. This is reflected in the commitment to ethical practices, which included creating an environment where participants felt comfortable sharing their experiences, with careful attention to language and the nature of the dialogue.

Participant Sensitivity

I aimed to demonstrate sensitivity towards participants' perspectives at all stages, including design, analysis, and reporting, ensuring that their anonymity, confidentiality, and respect for their views were maintained. This was further supported by approval from Massey University Human Ethics Committee, confirming the study’s commitment to participant wellbeing.

3.8.2 Commitment and Rigour

Yardley (2000) emphasises the importance of dedication and thoroughness throughout the research process, utilising the concepts of *commitment* and *rigour*. My commitment to the research process is demonstrated through consistent engagement with the topic, as evidenced by continuous self-reflection and interpretation in the methodology section. I used reflective notes, which were integral to maintaining a deep and sustained engagement with the project, ensuring the research was thoughtful and intentional throughout.

Rigour is demonstrated in this study through careful and detailed analysis of the data, guided by previous IPA projects. I maintained a high level of analytical rigour by focusing on an in-depth exploration of individual cases before moving to the next. Additionally, I have demonstrated an empathetic understanding of the participants' views, ensuring that their lived experiences informed the study.

3.8.3 Transparency and Coherence

Yardley (2000) suggests that research should be clearly articulated, logically connected and methodologically sound. The criteria of transparency and coherence refer to the clarity and persuasiveness of the descriptions and the arguments. I have carefully articulated every aspect of the research process, from participant interviews to analysis. This includes detailed descriptions of the theme coding procedures, ensuring that the research methods are clear and can be reproduced. The use of excerpts from participant interviews to support themes illustrates how the interviews were interpreted and meaningfully linked to the research questions.

I have demonstrated the alignment of the research question, philosophical perspective, and methodology through a well-structured approach to the analysis and the overall presentation of the findings. Transparency is further enhanced by the following reflexivity section, which highlights my personal experiences and motivations that have shaped the research project. This moves beyond providing context for understanding my researcher positionality, and also describes how individual and external factors have influenced the research process.

3.8.4 Impact and Importance

Yardley (2000) discusses the significance of the study's contribution to knowledge, highlighting that its findings should have meaningful implications for theory, practice, or future research and be relevant and valuable to the field. The value of research can take many forms. It can only truly be assessed in relation to the study's objectives, its intended applications, and the community for whom the findings are most relevant. Many qualitative researchers also focus on the socio-cultural impact of their work, going beyond theoretical and practical implications. In this sense, research can become inherently political, as all discourse and actions arise from a specific social context, serve a social purpose, and have special effects. Given that discourse, ideas, and beliefs are integral to our experiences of health and illness, research can influence and change the way we think or talk about these experiences.

It is my hope, as the researcher, that the present study has demonstrated the importance of understanding mothers' lived experiences of perinatal mental distress through a comprehensive literature review in the previous section. This research is anticipated to contribute to the broader literature in Aotearoa New Zealand, fostering deeper insights into this critical area.

3.9 Ethical Considerations

Ethical considerations were carefully examined through a peer review process between myself and Dr. Elle Brittain, the research supervisor. The Massey University Human Ethics Committee granted approval before participant recruitment. These considerations are discussed below:

Informed Consent: Participants received an information sheet outlining the study, ethical considerations, and potential risks. They were given one week to review the material and ask questions before scheduling an interview. Written and verbal consent was obtained, and verbal confirmation was provided immediately before the interview began.

Right to withdraw: Participants were informed of their right to withdraw at any time up until they approved the final transcript. They were also advised that they could skip any questions or end the interview at any point without an explanation.

Confidentiality and Anonymity: Potential participants contacted the researcher directly to ensure their privacy was protected. Pseudonyms were used during transcription, and identifiable details were adjusted or omitted to ensure anonymity.

Risk to Participants: Participants in this research may have an increased vulnerability; therefore, the inclusion criteria were modified to require participants to have considered themselves 'recovered' for at least six months, as part of the recruitment process. Given the sensitive nature of the topic, interviews were conducted with the utmost care. The researcher monitored for signs of distress and paused or ended interviews when appropriate.

Risk to Researcher: I engaged in continuous reflexivity and discussed the emotional content of the interview with my supervisor, Dr. Elle Brittain. To confirm researcher safety, I communicated with my supervisor before and after each interview.

Debriefing and Support: Participants were provided with contact details for support services in case any distress arose after the interview. Participants were also given the research findings and were provided an opportunity to discuss them with me, the researcher.

Data Protection: Digital data was stored on Massey's secure SharePoint server. Identifiable information was used solely for scheduling and participant communication and kept separate from research data. Hard copies were stored in a locked filing cabinet, and pseudonyms were used in all transcripts and research outputs.

3.10 Reflexivity Statement

As the researcher of this thesis, I bring both personal and academic perspectives which influence this project. My interest in perinatal mental distress is shaped by my own personal experiences

growing up in a family affected by mental health challenges, as well as seeing friends who have faced similar challenges during their motherhood journey. I identify as a Pākeha woman living in Central Otago, and as such, I acknowledge that my cultural positioning and life experiences impact how I have approached the research questions, interactions with participants, and the interpretations of their stories they so kindly shared. I hold both an insider and outsider perspective on this topic; an insider through personal lived experience, yet an outsider, as I am not a mother myself. This balance enabled me to approach the research in an empathetic manner while easing the process of building rapport with the mothers. In an effort to minimise the risk of shaping interpretations through my own lens, I engaged in ongoing reflective practice, including journaling and supervision. This process has supported a greater awareness of my assumptions and helped to keep the voices of mothers at the centre of the research findings.

3.11 Chapter Summary

In this chapter, I have outlined my qualitative research approach, grounded in Interpretative Phenomenological Analysis (IPA). Chosen for its focus on exploring lived experiences, IPA offered a unique framework for capturing the rich, subjective realities of mothers who have experienced perinatal mental distress in rural Aotearoa New Zealand. Drawing on phenomenology, hermeneutics, and idiography, IPA provides space to honour individuals' meaning-making while bringing forward voices that are often underrepresented in research. I used semi-structured interviews to gather in-depth, personal narratives, allowing participants to express themselves freely and openly. A purposive and homogeneous sample strategy guided the recruitment of five mothers through trusted networks in Central Otago. All interviews took place in the comfort of participants' homes, providing a natural setting that supported trust and reflection during these deeply personal conversations. The data were analysed using Smith et al.'s (2009) six-step IPA framework, allowing me to interpret shared patterns while remaining attuned to the uniqueness of each participant's story. To demonstrate rigour and trustworthiness, I applied Yardley's (2000) principles of quality in qualitative research. Finally, I outlined the ethical considerations of the study and the way these were upheld throughout the study.

CHAPTER 4: FINDINGS AND ANALYSIS

4.1 Chapter Overview

This chapter shares the voices and stories of the mothers I interviewed. Through the lens of IPA, I explored their experiences to understand how they made sense of perinatal mental distress. What emerged were three superordinate themes that reflect different layers of their journeys: Identity: The Fragmented and Reformed Self, Psychological: The Storm Inside, and Sociocultural: The Weight of Expectation and Strength in Numbers. These themes are not neat or separate; they overlap and weave together. Within these themes are smaller threads which speak to a movement from struggle to strength, confusion to clarity, and isolation to connection. While I have organised the findings in a way that offers some structure, the relationships they represent are much more nuanced and shaped by emotion, memory, relationships, and place. I discuss the findings below, organised under each superordinate theme. Within these, I explore the subordinate themes in more detail, sharing the mothers' stories in their own words, alongside my interpretation of what their experiences may reveal and mean.

4.2 Summary of Group Themes

The key findings from the analysis indicate that all participating mothers shared common experiences during periods of perinatal mental distress.

Table 2

Summary of Group Themes

Superordinate Theme	**Subordinate Theme**	**Participant Extracts**
Identity: The Fragmented and Reformed Self		
	Identity as a Mum	*"I think that, entering motherhood as a first-time mum, you are just so lost. You're just like, and because your brain changes, like it's so*

		wild, and you're just like, who am I again? And then you go out and you meet new people in the 'new self' that you are, and make all these different connections."
	The Intersect: Multiplicity of Self	*"...initially, in my early days, I really grieved my past life. I was like, what the hell have we done? Like, this is crazy. I want to go back to just sleeping in and, like, leaving the house without, you know, anything but your wallet and phone."*
	Tension within the Self	*"It was just, I would have just classed myself as insane. I just didn't recognise myself at all."*
	Healing: Reframing and Reformation	*"It's just because cognitively, I have so much more on, my mental load is huge, and I'm doing it by myself because I'm unsupported in the relationship. And that was a big realisation, and I think that was the start of it for me, being on a better journey with it all."*
Psychological: The Storm and Calm Inside		
	Distress Recognition	*"...so it was very easy to just brush it to the side as a normal process. But when I look back on it, I'm like, it wasn't. It wasn't a normal process. It was way harder than what I would now consider as a normal process."*
	Emotional Landscape: The Darkness	*"...it was like there was always a shadow looming, and I didn't know where or what that darkness was, and I didn't know how to deal with that.*
	Loss and Gain of Coping Mechanisms	*"So I look back on it, and I say, all of my coping mechanisms that I had put in place...all of those coping mechanisms like independence and avoidance and perfectionism, like all that kind of stuff. I just couldn't do those when I had Albert, so that world fell down."*
	Healing: Self-Compassion	*"And in that I've learned like I couldn't even tell I mean, having an ADHD diagnosis, seeing how strong I am, recognising myself awareness and capability, recognising where I'm taking too much personal responsibility and where I haven't had the right boundaries, and it's all, it's all just life."*

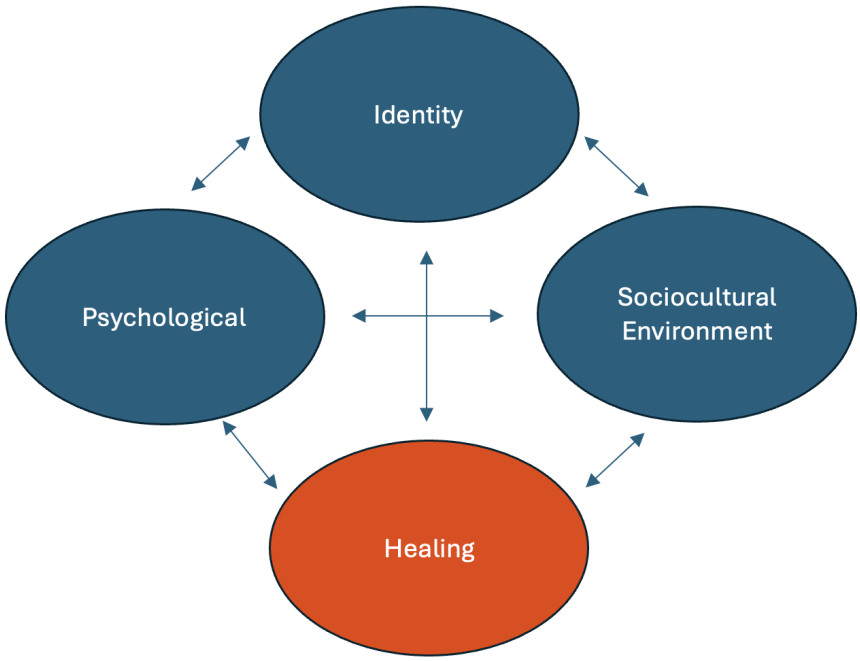
Sociocultural: The Weight of Expectation and Strength in Numbers		
	The Silent Script of the ‘Good Mother’	*“But I would say the pressure is external in that I'm receiving so many messages from so many places, and like all of the stupid society stuff, where you even just walk in the supermarket and you see a magazine of like, Mumma and Bubba, and they're all there being happy, like something that's not even directed at you, but you just see it and take it in, and then there'll be all the stuff that I didn't even notice, that I saw, that just showed me what a mum is meant to be.”*
	Stigma	*“So much self-stigma and so much prejudice. And I didn't want Albert to be taken away from me, because again, like that doesn't fit in with him having skin on skin and being breastfed and cluster feeding and having all this stuff.”*
	Interaction Between Stress and Isolation	*“Yeah, but it was also really hard we realised how isolated Wanaka is, yeah, that that was terrifying, actually realising how isolated we were, and then also having to accept that that's the future of having children, raising children here is that if anything goes wrong, you are incredibly isolated too.”*
	Healing: Through Connection and Belonging	*“Like…when you're at the park with the other mums, you, you know, there are a few mums that I talked to on a really human level, and my barriers totally down, and they’re my people.”*

The first superordinate theme, ‘Identity: The Fragmented and Reformed Self,’ reflects a significant shift in the participants' sense of self. Despite the initial fragmentation, this theme ultimately traces a path of personal growth and renewal. The subordinate themes include ‘Identity as a Mum,’ ‘The Intersect: Multiplicity of Self, ’ ‘Tension within the Self, and Healing: Reframing and Reformation. The second superordinate theme, ‘Psychological: The Storm and Calm Inside,’ centres on the mother’s internal emotional experiences. This theme highlights a journey from recognition of distress to the emergence of healing through self-compassion. This is shown through the subordinate themes ‘Distress Recognition’, ‘Emotional Landscape: The Darkness’, ‘Loss and Gain of Coping Mechanisms’, and ‘Healing: Self-Compassion’. Finally,

the third superordinate theme, 'Sociocultural: The Weight of Expectation and Strength in Numbers', explores how external societal pressures and cultural narratives shaped the participants' understanding of their experiences. The subordinate themes 'The Silent Script of the 'Good Mother', 'Stigma', 'Interaction Between Stress and Isolation', and 'Healing: Through Connection and Belonging', map a transition from shame and isolation towards connection, validation, and belonging. Together, these three superordinate themes illustrate the deeply human struggle to reconcile internal experiences with external expectations, while ultimately seeking authenticity, meaning, and connection in the journey of motherhood.

Figure 1

A Visual Representation of the Group Themes and Their Interaction



4.3 Identity: The Fragmented Self

A common theme across the interviews is identity and the strong shift in a sense of self which participants experienced as they navigated motherhood. Participants described feeling disoriented as they grappled with their identity in this new phase of life. Rather than simply

adding the role of ‘mother’ to their identity, participants shared a more fragmented and conflicted experience, characterised by contradictions and a temporary loss of self-recognition. These struggles weren’t just about adding a new role; they spoke to an identity dilemma. Participants appeared stuck between the person they used to be and the person they were becoming. Through time, connection, and reflection, participants explained a reformation of identity, an integration of a new self. The emotional challenges they faced became part of a process of personal growth, where the evolving maternal identity brought with it not only struggle but also strength and renewal. This journey is discussed below in relation to the subordinate themes: ‘Identity as a Mum’, ‘The Intersect: Multiplicity of Self’, ‘Tension within the Self’, and ‘Healing: Reframing and Reformation’.

4.3.1 Identity as a Mum

Participants described the idea of a new maternal identity, initially expressing shock at how heavy the shift felt. They experienced a fundamental change in their perception of themselves within their world, which brought early disorientation and disempowerment. The mothers described a lack of self-recognition, loss of confidence, and feelings of overwhelm in the unfamiliar world they found themselves in.

Sophie describes noticing a disconnect between past and present versions of herself , where her pre-motherhood identity feels worlds apart from the demands of motherhood.

> *“I think that, entering motherhood as a first-time mum, you are just so lost. You're just like, and because your brain changes, like it's so wild, and you're just like, who am I again? And then you go out and you meet new people in the ‘new self’ that you are, and make all these different connections.”*

For Sophie, the transition into motherhood brought a sense of disconnection from her former self. She describes a profound internal change, suggesting the shift is embodied rather than situational. Her question, “Who am I again?” shows how deeply her identity has shifted. At the same time, Sophie begins to rebuild her identity through new relationships and social

connections, which help her form a “new self” as a mother. Her experience highlights both the unsettling and rebuilding aspects of changes in identity.

For Matilda, the transition to motherhood is felt as a shift from an autonomous self to a self defined in relation to another.

> *“…it was the emotional drain that I never experienced before because I wasn't responsible like I was, but I wasn't fully responsible for another human being. You know, like, being fully responsible for someone else was a new experience, and something I didn't, you know, expect.”*

Matilda describes an unexpected emotional intensity in taking full responsibility for her twins, expressing how deeply this experience changed her perception of herself. This moment signifies the emergence of a new way of being, where her identity became intertwined with the needs of her children.

Molly recounts a similar experience where she is “blindsided” after the birth of her first child, Albert.

> *“With the hindsight that I've gathered. So, speaking from Molly today, and to sort of tell the story when I first had Albert, even the first hour of having him in my arms, I had no idea then, but I was absolutely blindsided. I had no idea what to do.”*

Molly's description of being “blindsided” highlights how underprepared and overwhelmed she felt in becoming a mother. Her experience suggests a loss of confidence in who she was, as her previous sense of self struggled to manage the reality of motherhood. Molly’s statement, “I had no idea what to do,” challenges the prevailing idea that maternal instincts simply kick in.

4.3.2 The Intersect: Multiplicity of Self

'The Intersect: Multiplicity of Self' was a common experience across the interviews. This theme highlights a sense of self that is not a single, but rather a complex and multifaceted identity composed of different parts. These different aspects of self were described as manifesting in various contexts and influencing how participants thought, felt, and behaved. This demonstrates that identity during motherhood can feel both fractured and intertwined, as participants attempted to make sense of who they were while working through shifting roles.

Molly's story reflects a split between two versions of herself, publicly confident and privately overwhelmed.

> *"…and I get to the end of the day, and I would still be in my pyjamas at home and just feeling utterly incapable. And I did the whole of work, I don't know, like total masking and code switching. I just went to work and showed up there, and then at home, was a completely different person. Lots of crying, like memories of lying on the floor and Albert coming up to me and like, patting me."*

Molly's words reflect a sense of helplessness and emotional exhaustion. She describes "masking and codeswitching" to get through the workday. This contrast between her public and private selves, where she maintains composure at work but breaks down at home, points to a form of identity compartmentalisation where different aspects of the self are acted out in various contexts. Her experience suggests a self that was not unified, replaced by situational personas: one that had to hide true emotions, and the other that was utterly exhausted. Her memory of crying on the floor while her child comforted her paints a powerful picture of how her distress affected her daily life and sense of identity.

Sophie nods to a multiplicity of self through her account of internal conflict between her former self and her new, emerging maternal self.

> *"…initially, in my early days, I really grieved my past life. I was like, what the hell have we done? Like, this is crazy. I want to go back to just sleeping in and, like, leaving the house without, you know, anything but your wallet and phone."*

For Sophie, the idea of having more than one version of herself becomes clear in how she describes the contrast between her pre-motherhood self and her current self. Her statement, *"*What have we done?"*,* suggests an appreciation of more than one self and foregrounds a sense of shock, as if she were pushed into a new version of herself that she did not fully choose. Here, Sophie is seen as caught between two versions of her self; one that valued freedom and independence and another now centred on responsibility. These different aspects of her added tension and confusion as she attempted to make sense of her identity.

Another example of the multiplicity of self is evident when Jamie discusses an anticipatory grief for her professional identity, which she describes as lost during her transition to motherhood.

> *"I found that a source of my anxiety was that I used to do rope access work, so quite physical work. I was away from home a lot, and I had quite a lot of anxiety during my pregnancy about what I was going to do after the baby came. Like a loss of my professional identity… And just an understanding through pregnancy that I'd have to reinvent myself afterwards."*

For Jamie, the idea of experiencing multiple versions of selves comes through in how she discusses who she used to be, who she is becoming, and the uncertainty of who she will be in the future. There is a clear contrast between her confident work identity and the new, yet to be defined role of being a mother. Jamie shows an awareness that her identity is changing, and while this involves a sense of loss, it also holds the possibility for growth. Her description shines a light on the inner struggle of navigating between different parts of her self and rebuilding a new understanding of her identity.

4.3.3 Tension within the Self

This subordinate theme reflects the internal conflict many participants experienced between how they believed they ‘should’ be and how they actually were. Their stories reveal a complex mix of emotions, often tied to a sense of losing who they were. This tension created confusion and discomfort as participants tried to make sense of their experiences and understand who they were within the new role of motherhood, highlighting the difficulty in matching internal identities with the external expectation of a maternal identity.

Bella describes increasing distress due to the disconnect between her ‘perfect life’ and her lived reality.

> *“And I think that was probably when I felt I was losing my mind. I was going, and I'm so happy. I've got the perfect life that I've always wanted. I've got a baby. But why am I feeling this way?”*

For Bella, a clear gap emerged between her expectations of motherhood and the reality of her experiences. This contradiction led to her questioning her own mental state, as though something was wrong with her. She illustrates an inner tension where her emotional experiences were mismatched with the perception of the life she had imagined for herself, contributing to self-doubt. This dissonance is central to her shifting maternal identity, underscoring that becoming a mother involves more than adapting to a new role. It involves working through conflicting expectations and actively reconstructing a sense of self, something that Bella identified as part of her healing journey.

The raw intensity of Jamie’s words echoes an intense distress as she describes no longer recognising herself.

> *“It was just, I would have just classed myself as insane. I just didn't recognise myself at all.”*

Jamie's account captures a tension within, expressed through a loss of self-recognition. Her reflections, along with earlier references to shifts in her identity, suggest a fractured sense of self, leaving her feeling lost and disconnected from who she once was. Her use of the word 'insane' reflects the extent to which she perceived herself as different from her former state of stability and self-trust. This identity struggle appears to leave her in a liminal space, not her old self nor yet settled into a new self, resulting in confusion and a sense of unfamiliarity.

Amidst clashing emotions, Sophie recounts a sense of overwhelm during her journey with her daughter, Lola.

> *"Yeah, I think it's just, the wildest thing is experiencing like every emotion all at once. I think it's such a wild thing to experience. Like you can be happy that Lola's here but sad about what happened."*

For Sophie, the coexistence of happiness and sadness adds to a feeling of maternal ambivalence. Experiencing these conflicting emotions simultaneously created an inner tension that left her uncertain about her own honest emotions. Her statement, "the wildest thing," reflects a feeling of being overwhelmed, where it was hard for Sophie to articulate her internal state. This suggests a form of disorientation, where Sophie struggled to make sense of who she is amid the emotional complexity of early motherhood.

Molly also demonstrates the tension within through frustration towards the advice that 'never matched', leading to invalidation and emotional isolation.

> *"It was external sources of people trying to be kind or reaching out for information or receiving advice, but then it never, it never matched up with what was happening on the inside. That was it. It never matched. Yeah, nothing that was ever given to me actually matched until I found fucking Janet Lansbury and unruffled.***"**

Molly's description illustrates the tension she felt between her internal reality and the external advice she received. Instead of feeling supported, the advice often left her feeling more

distressed and isolated, heightening her disconnection from herself and those around her. Her experience reflects how emotional isolation eroded her confidence as a mother. Her discovery of Janet Landsbury's work appears to provide a moment of validation for her reality, highlighting a sense of relief when her inner world was reflected externally. This marks a turning point, where Molly feels more settled in herself.

4.3.4 Healing: Reframing and Reformation

All participants shared the final subordinate theme centred on identity, marking a significant turning point in their journey. This stage of their story involved making sense of their experiences, reframing their challenges, and moving toward growth and healing after grappling with shock, inner conflict, and a fragmented sense of self. It represents a shift from survival mode in the early demands of motherhood to actively integrating those experiences into a more settled identity. From this perspective, their healing was not about returning to their former self, but instead forming a new self characterised by strength, connection and acceptance.

Sophie reflects on her motherhood journey, expressing strength and gratitude for where she is now and who she has become.

> *"I think, as much as it was horrific, going through it like, I am a new person now. I probably get emotional, but like, it has changed me, possibly for the better, you know, like it was so much, but I'm just so grateful now. I'm just so grateful for Lola and my family, my friends and yeah. Going to like the deepest, darkest place, and coming out of it, I think, makes you treasure everything so much more."*

Throughout Sophie's interview, she described periods when it felt almost impossible to imagine herself surviving the hardest parts of her journey. This extract beautifully articulates a transitional moment from what she calls 'the deepest, darkest place.' Her reflection signals the development of a reformed identity: one that has changed, even been strengthened by the intensity of her experiences. Her gratitude for Lola, her family, and her support networks becomes a foundation for making sense of her lived experience. In this way, Sophie's account

highlights a narrative of growth, where gratitude, perspective, and refined selfhood allow her to reframe her suffering as part of a larger process of becoming.

Bella describes a moment of self-awareness and acceptance that supported her path towards healing.

> *"It's just because cognitively, I have so much more on, my mental load is huge, and I'm doing it by myself because I'm unsupported in the relationship. And that was a big realisation, and I think that was the start of it for me, being on a better journey with it all."*

Bella's account is supported by a moment in her transcript where she reflected on discovering the term matrescence. For Bella, this word offered a framework to understand her experiences as part of the transformative journey into motherhood, rather than attributing them to personal fault. Her description conveys a growing acceptance of a strained emotional bandwidth and a sense of moving forward with it. This recognition appears to facilitate an active reintegration of the self, enabling Bella to reconnect with her identity and continue with renewed self-awareness and compassion.

Matilda also illustrates a reframing of her narrative through the realisation that she is not alone, alongside the emergence of a redefined self shaped by the courage to embrace authenticity.

> *"I think the biggest health benefit for new mums is just realising you're not alone and going through that. Yeah, and it sucks for everyone. Yeah. And if anyone says it doesn't, then they're lying, yeah, be real."*

Within Matilda's description lies a call to recognise and integrate the difficult aspects of motherhood alongside its joys. Matilda's sense of isolation was intensified by the unique demands of having twins, which she found particularly challenging to manage. A turning point emerges through her interactions with other mothers, where she was shown that others have experienced similar feelings, both in person and on social media. When Matilda uses the phrase

‘be real’, it symbolises a shift towards embracing a more authentic version of herself with more self-assurance. Her experience suggests that feeling seen and validated by others plays an important role in shaping her identity as a mother.

4.4 Psychological: The Storm and Calm Inside

Participants spoke of psychological struggles that fluctuated between chaos and calm. The title of the theme, ‘Psychological: The Storm and Calm Inside’, was chosen to reflect the descriptions of the participants' emotional distress shared through their interviews. Metaphors such as ‘darkness’ and ‘shadow looming’ show the raw intensity and heaviness of their experiences. The first subordinate theme, *‘*Distress Recognition’*,* highlights how participants came to recognise their distress, often through external sources such as friends, professionals, or educational resources. The other subordinate themes, ‘Emotional Landscape: The Darkness’, ‘Loss and Gain of Coping Mechanisms’*,* and ‘Healing: Self-Compassion’, help to trace the psychological journey the mothers undertook, from being caught in the depths of the storm to finding inner calm.

4.4.1 Distress Recognition

‘Distress Recognition’ captures how participants came to recognise their distress, including the catalysts that prompted them to seek help or initiate change. Looking back from a more stable state of mind, participants described how they struggled to recognise their symptoms in the moment, often interpreting their experiences as a normal part of motherhood. This theme shines light on the temporal nature of distress recognition, where participants recall a gradual progression from internalising their distress, to encountering a catalyst for reflection, and eventually towards a new understanding of their experience. The unfolding process reveals how, over time, participants came to acknowledge that they had been in a ‘tough place’. A realisation that was not always possible in the moment, transpiring through distance, perspective, and reflection.

Molly looks back on where she was, with awareness gathered over time, and demonstrates the realisation that her distress was more than part of the ‘normal process’ of motherhood.

"...so it was very easy to just brush it to the side as a normal process. But when I look back on it, I'm like, it wasn't. It wasn't a normal process. It was way harder than what I would now consider as a normal process."

For Molly, reflection brought a new awareness of the depth and seriousness of her earlier distress, something that was not accessible to her at the time. Her account reveals how she initially normalised her suffering, minimising it as part of a regular postpartum experience. Molly, looking back from her current state, allows for a reinterpretation that signals a shift in understanding and a reclaiming of self. Throughout this process, she begins to rebuild her confidence and recognise the strength it took to endure those challenges.

Bella recalls her experiences, suggesting that symptoms may have begun earlier than she initially realised. She also pinpoints a lack of accessible resources that could have helped her make sense of what she was going through.

"I'm guessing it kind of started from quite early, when I was postpartum, perhaps not recognising it, but then also didn't really have any resources, yeah, to access anything else, to show me."

"And it wasn't until I literally saw, I think, a checklist on Facebook of anxiety symptoms, and I went, 'oh, tick, tick, tick,' and I could tick all of them. And that, for me, was when I went, 'oh, it probably was anxiety.'"

Throughout the interview, Bella describes the way she struggled to recognise her symptoms in the moment, often attributing her experiences to the breakdown of her relationship. The Facebook checklist served as an external source of recognition, acting as a catalyst that allowed her to reinterpret her experience through a new lens. Her response, 'oh, tick, tick, tick' captures the immediacy and clarity of that realisation, marking a moment where hard-to-name emotions suddenly made sense. This highlights a form of retrospective insight, where Bella could look

back and recognise that her anxiety had likely begun earlier than she had previously been aware of.

Jamie describes how her friends supported her in seeking professional help after they noticed a change in her over a period of two to three weeks.

> *"And I'm also lucky in that I have two good friends in town. One of them is a HIP [Health Improvement Practitioner] consultant. The other is one of the HIP at the medical centre. And, you know, they saw their friend go from the sort of normal person, I like to think of myself as kind of normal, to a bit of a shell of a human, within about two or three weeks. And they got me to get help quite quickly"*

Similar to the checklist on Facebook, Jamie's friends act as an external source and catalyst for awareness about her distress. Jamie's statement, 'shell of a human, ' acts as a potent metaphor to describe the way she felt emotionally hollow, as though she was internally absent in some way. Jamie considers herself lucky that her friends supported her, as things may have continued or worsened otherwise. This again illustrates a common experience amongst participants, that distress was hard to identify or articulate when they were in the thick of it.

4.4.2 Emotional Landscape: The Darkness

The following subordinate theme addresses the heaviness of emotional states experienced by participants. Participants discussed symptoms related to anxiety, depression, obsessive-compulsive disorder (OCD), panic attacks, and psychosis. This theme delves deeply into the embodiment of these symptoms, underscoring how they impacted both their thoughts and functioning. A key marker of this theme is how internal conflict revealed itself, from metaphors to visual experiences, and intrusive thoughts to insomnia and panic attacks. The striking language and descriptions used by participants offer meaningful insights into their experiences during times of distress.

Bella employs powerful metaphors to convey the weight of her experiences.

> *"...it was like there was always a shadow looming, and I didn't know where or what that darkness was, and I didn't know how to deal with that."*

This raw description from Bella illustrates that the anxiety she experienced was a darkness that was always there, waiting to encroach upon her. The darkness felt like an entity that followed her relentlessly, an unfamiliar and frightening presence. The shadow appears as something separate from Bella, perhaps highlighting repressed emotions which emerge with the increased stress of motherhood.

Molly's first quote describes the way her constant fear and lack of control led to her having hallucinations of a poltergeist in the room. Her second quote highlights the extent of her pain, as she recounts having visions of wanting to throw her child away during feeding.

> *"So it's all done in the dark. And then all of a sudden, I'd be like half asleep, but I would think, 'Oh my God, there's a poltergeist above me.' And I would see myself sitting in the chair, and a poltergeist here."*

> *"...because I was now dreading every single feed. I didn't want to be around Albert. I had visions of like, throwing him away from me, and I never acted on that. I knew that I was never going to act on that, but I had this impulse in me that was like, 'oh, go away', because it hurts so much."*

Throughout Molly's interview, she discussed the challenges she had breastfeeding her son, Albert, referencing trouble latching on and recurring mastitis. This became a source of distress for her, and she questioned her ability amidst the conflicting professional advice mentioned earlier. The first quote by Molly highlights hallucinatory experiences, and this haunting image seems symbolic of the inner turmoil and overwhelm she experienced. The second quote portrays distressing visions of discarding her son, despite her unwillingness to do so. This sensitive description from Molly is incredibly potent, showcasing the depth of her internal conflict.

Sophie shares how insomnia gave way to intrusive, spiralling thoughts that felt increasingly out of her control.

> *"It was, are they called intrusive thoughts? But it was just like, my brain would only think about, am I going to sleep? It was so like, I would be chatting to people, but in my head, it was just like, wondering how they're sleeping. Like, they look like they sleep well. And then I was like, am I going sleep tonight? It was just like, constant chat about that. And then it was just circulating on like, if I don't sleep, I'm going to turn into a crazy woman, and I'm probably going to, you know. You get into horrible thoughts, like, 'I'm probably going to murder my child because I haven't slept', and then, yeah."*

Sophie outlines difficulties with sleep as a primary trigger for the anxiety she experienced. She articulates the way her thoughts began to spiral beyond her control; she became increasingly fixated on her need to sleep, further fueling her distress. This cycle reflects a profound sense of disconnection and loss of agency over her own mind, heightening her anxiety. The way she expresses concern about 'turning into a crazy woman' and potentially killing her child reveals the intensity of the distressing thoughts and emotions she was experiencing.

Jamie shares her experiences with insomnia, describing how prolonged sleep deprivation intensified feelings of claustrophobia and triggered panic attacks.

> *"So, when the insomnia was really bad, it was always around claustrophobia. Okay, so even it got to the point where driving into town, I was in the car, and I was in a traffic jam, you know, behind one of the roundabouts, and I got really claustrophobic and had a panic attack in the car. So claustrophobic in the traffic jam."*

Throughout the interview, Jamie foregrounds her experiences with insomnia.. However, co-occurring experiences of claustrophobia and panic were interconnected, illustrating a complex response to her internal distress. There is a sense of loss of control in Jamie's account where she described being unable to will her body to sleep, and the inability to escape her state triggered panic attacks, contributing towards a loss of sovereignty over both her body and mind.

4.4.3 Loss and Gain of Coping Mechanisms

Participants frequently spoke of times when the adaptive coping strategies they once relied on no longer served them, highlighting a process of loss, adjustment, and the emergence of new ways of coping. The first two extracts are from Molly and Matilda, illustrating how the demands of motherhood limited their ability to draw on previous coping mechanisms. The second two extracts in this section represent a shift towards newly gained coping strategies. Throughout their journeys, mothers described integrating new forms of self-care into their day-to-day lives, ultimately supporting them in regaining agency and providing a sense of calm amidst the storm.

Molly reflects on her coping mechanisms before becoming a mother and articulates a need to let these go after giving birth to her son.

> *"So I look back on it, and I say, all of my coping mechanisms that I had put in place…all of those coping mechanisms like independence and avoidance and perfectionism, like all that kind of stuff. I just couldn't do those when I had Albert, so that world fell down."*

Molly's description illustrates how the transition to motherhood led to her previous coping strategies becoming unhelpful. She exhibits an awareness of her previous reliance on independence and perfectionism, elucidating a sense of control and protection that these used to provide her. Amidst the many changes that came with motherhood, these adaptive coping mechanisms became either inaccessible or ineffective, marking a breakdown in her usual means of stress management.

Matilda discusses the benefits of a more balanced life before having her twins, emphasising the importance of exercise, hobbies, and her social life.

> *"And I also had a probably more balanced life. I had exercise to help, which was a massive help, and I haven't had the same time for that, hobbies and social life, which I*

realised helped me, kept me balanced. And not having that at the moment has exacerbated it for sure."

Matilda's reflections suggest an awareness of how previously established coping strategies supported her emotional wellbeing. She identifies exercise, hobbies, and social connection as essential tools that once helped her maintain balance and manage everyday stressors. Her account implies that these activities were more than just routines; they functioned as protective factors against the emotional strain of everyday life. For Matilda, motherhood appears to have disrupted this balance, limiting her opportunities to utilise the strategies that once grounded her.

Molly reflects on how negative self-talk became a warning sign, an internal cue prompting her to prioritise self-care. This marks a shift in her approach to wellbeing, particularly in contrast to earlier periods where unhelpful strategies, such as perfectionism and independence, heightened her distress.

"And I can't even look after myself right now. So the next time that I had that thought of like, 'oh my god, what have I done?' I was like, 'No, this is your warning signal that you're not looking after yourself right now.' So yeah, I prioritise my self-care so that I can enjoy my children."

Molly's account reflects an increased self-awareness and a move towards new adaptive coping. Rather than reacting passively to distress, she reframed these moments as opportunities to care for herself, reclaiming agency. Linking back to earlier discussions around the loss of previous mechanisms, this represents a shift towards new strategies that support her wellbeing. It suggests not only recovery but growth, as Molly learned to tune into her internal cues and respond with compassionate self-care.

Sophie describes the way breathing strategies and journaling supported her in feeling calmer at night, ultimately helping her combat her insomnia.

"And that was actually a huge change for me in feeling calmer at night, because she gave me these lovely breathing strategies to just sit and do. And I would do that every night, and just like calm my breath. And that's when I started journaling. I would write out on my thoughts. Some of them were so dark, and I was like, get them out before bed. Yeah, very gradually, just and I managed to get off my medication with that."

Sophie's account of learning new coping strategies reveals a sense of regained agency. Her first reference to breathwork is seen as a new tool that helped her regulate her physical state, using the breath to slow her heart rate and signal safety to her body. Her description of writing down her thoughts at night, especially her acknowledgement that 'they were so dark', suggests that the act of writing offered more than reflection and moved into a form of release. The phrase 'get them out at night' symbolises an emotional offloading, where externalising her thoughts allowed her to create distance from them. By putting them on paper, Sophie was able to harness an internal calm and reduce the power these thoughts held over her, supporting her own self-regulation.

4.4.4 Healing: Self-Compassion

Self-compassion emerged as a powerful narrative in the participants' healing journeys, promoting increased understanding and offering a new lens through which to view their experiences. Instead of internalising distress or reinforcing self-criticism, the development of compassion allowed participants to respond to their struggles with empathy and care. This shift in perspective enabled the mothers to reframe their experiences in ways that provided inner calm, supported emotional integration, and allowed them to move forward with acceptance and understanding.

Molly demonstrates a reinterpretation of her experiences with perinatal mental distress, shining light on a newfound gentleness towards herself.

"And in that I've learned like I couldn't even tell, I mean, having an ADHD diagnosis, seeing how strong I am, recognising my self-awareness and capability, recognising where I'm taking too much personal responsibility and where I haven't had the right boundaries, and it's all, it's all just life."

Molly's reinterpretation of her perinatal mental distress reveals an increased capacity for self-compassion and a softer, more accepting view of her past struggles. Her reference to receiving an ADHD diagnosis, formalised after her experiences with perinatal mental distress, provided therapeutic reframing that allowed her to reinterpret her struggles through a fresh perspective. Upon re-evaluation, Molly can cultivate kindness towards herself, whereas her previous response was to believe she needed to do or be more.

Bella places emphasis on feeling proud of herself, something that comes up repeatedly in her reflections.

> *"I think feeling because I'm quite self-aware, lots of self-reflection, and I'm really proud of my journey. I'm proud of coming out of the other end, and I'm proud that I was able to keep going and still have beautiful relationships with my children, and still have a lovely relationship with their dad and things as well, which was something that was important."*

Bella's account also demonstrates a shift in perception, one grounded in compassion rather than guilt. Her commitment to maintaining healthy relationships appears to serve as both a source of strength and a marker of success in her eyes. There is a sense of resilience in Bella's description, where surviving hardship is not minimised but instead celebrated as a sign of growth and integrity.

Matilda expresses a sense of strength in reclaiming her voice after feeling lost, highlighting the importance of recognising that every family's experience of motherhood is unique.

> *"So yeah, dealing with that is hard, but so finding your own voice, yes, finding the balance and what works for you and your family, and recognising that, like all situations, are different as well."*

This extract from Matilda's interview illustrates the emergence of self-compassion as she began to tune into her own needs. By letting go of external comparisons and embracing individuality,

she is seen as unburdening herself from unnecessary pressures. This shift marks a moment of empowerment, where Matilda reclaims a sense of personal authority and rebuilds trust in her own judgment.

4.5 Sociocultural: The Weight of Expectation and Strength in Numbers

The third and final superordinate theme represents the sociocultural environment and its influence over how mothers interpreted and made sense of their experiences with perinatal mental distress. The weight of motherhood ideals was heavily felt, driven by pervasive social narratives that shaped unrealistic expectations and gave rise to guilt and shame when lived realities did not align. In contrast, connection and belonging were seen as crucial antidotes to this isolation. Through authentic relationships and shared understanding, participants found validation, relief, and space to reframe their narratives. This overarching journey is explored through the following subordinate themes: 'The Silent Script of the Good Mother', 'Stigma', 'Interaction between Stress and Isolation', and finally 'Healing: Through Connection and Belonging'.

4.5.1 The Silent Script of the 'Good Mother'

Idealised motherhood emerged as an influential factor in shaping how participants made sense of their experiences. This theme captures the control of societal expectations in defining what motherhood 'should' look like. Collectively, participant accounts show how the silent script of the 'good mother' imposed pressure and set unrealistic standards for success. When their realities fell short of these expectations, they often experienced disappointment, self-doubt, and a sense of falling short. Participants reflected that their experiences felt measured against dominant portrayals of motherhood, or their own internalised beliefs about the 'perfect life'.

Bella reflects on the breakdown of her relationship as a distressing experience, one that stood in stark contrast to the life she had imagined for herself.

> *"I think I was brought up thinking that the normal way of life was to get married and have children, and so I think it was always kind of drilled into me….So I always put pressure on myself and strive to make that happen. And I think that was something that I found really difficult when my relationship was breaking down, was the fact that I was in a situation which I had never planned for, because it was always my expectation and dream to have the standard - the house, the car, the job, the two kids, the husband sort of thing."*

Bella's account illustrates the powerful influence of societal pressures. Her quote demonstrates how deeply embedded social norms and ideals shaped her expectations of herself. She describes having a particular way of life 'drilled into her', symbolising an imprint of societal scripts about how she was 'meant' to be. When her relationship broke down, Bella's distress extended beyond the emotional impact and challenges of loss and becoming a single mother. Instead, her pain also appeared to be rooted in the disconnect between the life she was taught to strive for and the reality she faced.

Influenced by societal messaging, Molly reflects on the external pressures she felt and the sense that she had been taught what a mum is meant to be.

> *"But I would say the pressure is external in that I'm receiving so many messages from so many places, and like all of the stupid society stuff, where you even just walk in the supermarket and you see a magazine of like, Mumma and Bubba, and they're all there being happy, like something that's not even directed at you, but you just see it and take it in, and then there'll be all the stuff that I didn't even notice, that I saw, that just showed me what a mum is meant to be."*

Molly's words illustrate the pervasive nature of societal messaging around motherhood, sometimes explicit and other times more subtle. These messages became a source of comparison that contributed to her distress, with curated images in magazines reinforcing the notion that joy and fulfilment are the expected experiences. For Molly, this idealised narrative created a

disconnect from her lived reality and heightened feelings of isolation. She described the influx of messages as overwhelming, portraying them as unrelenting and difficult to escape.

Sophie discusses her experiences with friends who appeared to be having positive experiences with their newborns.

> *"And actually, when I did hear my friends having babies, and they went perfectly, I would feel a bit sad about that, and they were just like, it's all going well, sleeping and like, newborn bubble. And I would just like, ah, feel a bit stink that I didn't get that. Yeah, that's the little things that kind of, that's kind of stuck with me."*

For Sophie, interactions with her friends, who appeared to be thriving, contributed to her negative self-perception. The contrast between what Sophie experienced and what she sees in her friends brought a feeling of missing out, something that she notes continues to affect her. One aspect of Sophie's account that is unclear is whether her friends were genuinely coping well. It is possible that they, too, were struggling with similar pressures but concealing their distress beneath 'expected' portrayals of motherhood. Regardless, the dominant narrative of joy and ease in the newborn phase left Sophie feeling excluded, adding to her experience of isolation.

Reflecting on her early experiences, Matilda highlights the impact of social media, describing it as a source of comparison that initially added to her struggle.

> *"And yeah, that was hard, so still hard, but yeah, especially my god, like social media and all that awful comparison. Yeah, now I like to follow people who are brutally honest and laugh about their shitty situations much more than I do people who exude perfection."*

Matilda shares the difficulty that came with comparison on social media, where exposure to idealised motherhood fueled unrealistic expectations. When her lived experience did not align with these images, feelings of inadequacy arose, further exacerbating a sense of isolation. Matilda also recognised a positive side of social media, where she found a sense of comfort and

connection with people who show authenticity. These messy, unfiltered experiences of motherhood helped to normalise a broader range of realities, offering Matlida a sense of validation and reassurance that she was not alone.

4.5.2 Stigma

The subordinate theme of stigma relates to the shame that mothers experienced in response to their struggles. Closely tied to the previous subordinate theme, 'The Silent Script of the 'Good Mother', stigma was often grounded in societal standards and unrealistic expectations that left participants feeling isolated in their distress. As a result, mothers were seen to withhold their pain, fearing judgment, shame, or potential consequences of sharing their truth. The stigma referenced contributed to more than emotional suppression; it also hindered help-seeking behaviours, where participants expressed reluctance to reach out for support. The following excerpts speak to the suppressive nature of stigma, how it fuels shame and prevents access to support in times of need.

Bella articulates a fear of being judged if people were to see the other side of motherhood, which she kept hidden from view.

> *"...perhaps when I was going through those things as well, perhaps I was still worried about the stigma, and I just didn't understand it. I didn't want to be judged, and I didn't want people to know that there was another side which I wasn't enjoying and things..."*

Bella's description sheds light on a deeply rooted fear that arose as a consequence of the dominant narrative of motherhood. She internalised the belief that her struggles were somehow abnormal, reinforcing a need to retreat inwards and hide her experiences. Her reference to seeing 'another side' symbolises a moral divide, as though emotions outside of joy and fulfilment are incompatible with motherhood. This internal conflict underscores the pressure to uphold a singular, idealised version of motherhood, one that ignores the complexity and ambivalence of lived experiences.

Through her account, Molly reflects on how self-stigma made it difficult for her to seek support, driven by a fear of negative consequences.

> *"So much self-stigma and so much prejudice. And I didn't want Albert to be taken away from me, because again, like that doesn't fit in with him having skin-on-skin and being breastfed and cluster feeding and having all this stuff."*

This section of Molly's interviews captures a sense of shame that stemmed from cultural stereotypes surrounding motherhood. Molly's account reflects a negative self-perception, where she came to see herself as somehow different or as a failure. A particularly vulnerable moment is shared where she describes her fears that her child might be taken away from her, illustrating how powerfully stigma can impact help-seeking behaviours. This fear brings to light broader societal misunderstandings about maternal mental health, where distress is too often met with judgment rather than care. As a result, the stigma Molly felt not only heightened her isolation but also actively silenced her in a time of need.

Sophie reflects on suicidal thoughts that emerged at the height of her perinatal distress, linking this to the broader tendency within Western culture to avoid confronting complex and uncomfortable topics.

> *"I think because of my suicidal thoughts that were so scary, talking about it, not that I was, they were only ever thoughts, I was never actually suicidal, but talking about people, about death, because there's such a stigma around death, I don't know, it was just very like, yeah, we live and we die. And like, I don't know, normalising chatting about death because it's such a big taboo."*

Sophie reflects on how attending a 'death cafe', a community space for open conversations about death, offered a rare opportunity to voice thoughts she had previously kept hidden. Although Sophie had not experienced a personal loss, the environment gave her permission to express vulnerability without fear of judgment, particularly regarding her experience of suicidal ideation. Sophie links this silence to broader Western cultural norms that stigmatise conversion around

death and emotional pain. Engaging in this space appeared to ease some of the shame she felt, illustrating how stigma can suppress open dialogue and how validating environments can support healing.

4.5.3 Interaction Between Stress and Isolation

A recurring theme across participants' accounts was the compounding effect of isolation and stress during early motherhood. Participants spoke of isolation in various forms: geographic isolation, particularly in the rural setting of Central Otago; social isolation, characterised by distance from extended family or support networks; and cultural isolation, related to the individualistic nature of Aotearoa New Zealand society. These layers of disconnection added to the everyday challenges of motherhood, where the absence of a support system or a 'village' left mothers feeling alone, overwhelmed, and emotionally drained. This interplay between stress and isolation was seen to intensify participants' emotional load and reduce opportunities for rest, care, and wellbeing.

Matilda shares the fear stemming from her realisation of how isolated Wānaka is, particularly with respect to specialist medical care.

> *"Yeah, but it was also really hard. We realised how isolated Wānaka is. Yeah, that was terrifying, actually realising how isolated we were, and then also having to accept that that's the future of having children, raising children here is that if anything goes wrong, you are incredibly isolated too."*

Throughout Matilda's interview, she shared details of the traumatic lead-up to the birth of her twins, which involved travelling between Dunedin, Christchurch, and Auckland to access specialist care. The complexity of her birth experiences was compounded by the stress of being a considerable distance from specialist medical support. This distance is experienced as a vulnerability for Matilda, as access to care was not smooth and involved urgent travel on multiple occasions. For Matilda, the geographic and systemic barriers associated with rural living had a lasting impact, shown through ongoing anxiety about her children's health in the future.

Jamie discusses feeling distanced from her and her partner's family, who are both in the United Kingdom (UK).

> *"I guess the only thing that was recurring was like, as we're both from the UK, travelling back to the UK with one child, yeah, it's actually quite doable. Travelling back with two, maybe less doable. I think that was the only legitimate thing, and I still feel a little bit anxious about it now."*

Jamie shared a growing feeling of anxiety connected to the physical distance from her family. It appears this feeling was heightened following the birth of their second child, as travelling to the UK became increasingly difficult. This separation from her core support network was more than a logistical challenge; it showed up as an embodied distress, with episodes of claustrophobia and panic (as highlighted in earlier excerpts). Jamie's account suggests that the geographical distance between Wānaka and the UK symbolised a more profound emotional isolation and contributed to a mounting sense of vulnerability and entrapment during an already overwhelming time.

Sophie considers her preference for the connectedness that exists in other cultures, comparing them to Aotearoa New Zealand's more individualistic approach.

> *"I really like how other cultures do it. Like New Zealanders, we're just so on our own, really"*

This idea is prominent throughout Sophie's interview as she discussed various cultural practices that played a meaningful role in her healing journey. These experiences offered more than individual support; they fostered connection, openness, and shared understanding with others. Sophie expressed an appreciation for cultural practices that prioritise community and collective care, contrasting them with the individualistic values she perceives as dominant in Aotearoa New Zealand. Within this contrast, she articulates a sense of isolation and loneliness, particularly in the context of motherhood, where the lack of communal support left her feeling unseen and unsupported.

4.5.4 Healing: Through Connection and Belonging

This final subordinate theme centres on connection and belonging as antidotes to the shame and isolation brought about through sociocultural factors. For many, engaging with community groups and forming bonds with other mothers offered a sense of validation and mutual understanding. These relationships created spaces where authenticity was welcomed and where mothers felt safe to speak openly without fear of judgment. In doing so, many mothers described a release of some of the emotional burden and shame that had previously weighed heavily on them.

In reflecting on her journey with perinatal mental distress, Molly highlights the significance of community groups and peer support in making sense of her experiences.

> *"I believe in community groups. Now, I believe in peer support, because they've been the most powerful moments for me in understanding my journey."*

Connection with community groups marked a pivotal moment in Molly's healing journey. She recalled how her peers actively reached out, encouraging her to socialise and even insisting on babysitting her children, offering practical and emotional support that she had previously been missing. This intervention came to Molly at a time of need, gently pulling her out of isolation and into a space of connection. As her support network strengthened, the fear of judgment that once held her back began to ease, allowing her to rebuild confidence in herself and her capabilities as a mother. These social connections became a source of recovery and self-assurance in Molly's journey toward healing.

Matilda discusses the importance of having other people to empathise with in motherhood.

> *"..but I think that is, by far, the biggest thing is having other people to commiserate with. Yeah, and just to, like, be real with."*

For Matilda, connecting with other mothers and sharing stories of hardship became a source of validation and support. Through these interactions, empathy arose as a cure to the internalised pressures she had been carrying. The simple act of being heard and understood appeared to loosen the grip of the idealised motherhood narrative that had kept her feeling unseen. The call to 'be real' was repeated throughout Matilda's account, symbolising her ongoing shift towards authenticity.

Jamie shares her connection with other mothers and the safe space they provide for open connection.

> *"Like… when you're at the park with the other mums, you know, there are a few mums that I talked to on a really human level, and my barriers totally down, and they're my people."*

Jamie's account provides another example of how genuine connections with others who share similar lived experiences can be transformative. She describes being able to engage on a 'human level', subtly contrasting this with the performative expectations of motherhood she encountered in other contexts. In these interactions, Jamie felt safe enough to lower her defences, and this sense of safety provided a space for Jamie to show up authentically, free from judgment. This space of mutual understanding allowed her to begin processing and releasing some of the shame she had been holding on to.

4.6 Chapter Summary

In presenting the key findings of this research, I have begun with the theme 'Identity: The Fragmented and Reformed Self,' which addresses the dramatic shift in how mothers perceive their sense of self. Mothers spoke of disorientation in the early days of motherhood, illustrating themes of fragmentation, disempowerment, and confusion around who they were. Alongside this loss sat an expression of resistance, where participants challenged the source of their expectations and, over time, began to trust their instincts. Mothers were seen as moving towards a more integrated and empowered version of themselves. The theme 'Psychological: The Calm

and Storm Inside' reflects the raw emotional landscape that mothers faced. Their inner worlds were marked by fear, anxiety, and emotional pain; however, they also revealed strength. Through the power of self-reflection and new coping strategies, the mothers were able to cultivate a more compassionate perspective of themselves. This highlights more than survival; it speaks to reclaiming agency where they were able to reshape their internal narrative in the face of struggle.

The subordinate theme' Distress Recognition' revealed a vital turning point. What struck me was how participants often did not recognise their distress until it was mirrored back to them, usually by a friend, social media, or simply through time. It was only then that mothers could reframe their experience as something external to themselves. The process of this reframing enabled healing and often advocacy for themselves and others. The final superordinate theme, 'Sociocultural: The Weight of Expectations and Strength in Numbers,' speaks to the external pressure that others felt from idealised portrayals of motherhood and the stigma that imposed silence. Many described the interaction between stress and isolation, referencing geographic barriers, limited access to services in a rural community, and the pervasive influence of Western Individualism. Again, there was a clear sense of resistance where mothers sought out connection, rejecting silence, and redefining what it means to be 'a good mother'.

Throughout the findings and analysis, it became clear to me that these mothers were not passive in their experiences. Instead, they questioned and reshaped their stories. Their narratives highlight a cultural tension between dominant motherhood ideals and more communal, compassionate models of care. These findings demonstrate the role of place, identity, and belonging in shaping perinatal mental health. When I began this research, I did not expect to uncover such a powerful and hopeful story of recovery. The mother's willingness to share their experiences with a stranger was a gift for which I am grateful. I am honoured to carry these stories forward in the hope that they will inform and soften the space that surrounds mothers today.

CHAPTER 5: DISCUSSION

5.1 Chapter Overview

In this chapter, I take a deeper look at the research findings in relation to the broader literature on perinatal mental distress. I begin with a brief summary of the findings, and the chapter is structured around the three superordinate themes outlined in the analysis, with each section opening into a more detailed exploration of subordinate themes. These are woven into relevant literature to highlight points of convergence and divergence. This process supports IPA's idiographic commitment by foregrounding participant experiences before building them out into broader theoretical and empirical contexts. I then proceed to a discussion of implications for practice, strengths and limitations, and recommendations for future research. Finally, I present my reflections as a researcher to strengthen transparency in the interpretative process and offer insight into how this project has been shaped through my involvement.

5.2 Summary of Findings

The purpose of this study was to explore how mothers living in rural Aotearoa, New Zealand, experience perinatal mental distress. I consider myself privileged to have had the opportunity to interview five mothers who kindly shared personal accounts of their lived experiences. Their stories are the heart of this thesis, providing a voice for an often underrepresented group. Critical to my approach was to move beyond fixed categories and instead explore the interplay of internal and external mechanisms shaping a mother's experiences, with an emphasis on privileging their language and meaning-making. The outcome of this is a layered and dynamic perspective that presents the complexity, transformation, and strength of their experiences.

During the process of IPA analysis, I identified three superordinate themes: 'Identity: The Fragmented and Reformed Self', 'Psychological: The Storm and Calm Inside', and 'Sociocultural: The Weight of Expectation and Strength in Numbers'

‘Identity: The Fragmented and Reformed Self’ is representative of the dramatic identity shifts that mothers experienced. It speaks to a journey of disorientation and disconnection from themselves, and a sense of fragmentation where they no longer recognised who they were. Within this theme, I observed the emergence of resistance as mothers began to reclaim themselves and move forward with greater trust in their instincts. The outcome was the formation of an integrated self that held space for contradiction and strength. ‘Psychological: The Storm and Calm Inside’ highlights the raw descriptions of the emotions experienced by the mothers. Parts of their journey were described as dark and overwhelming, with mothers illuminating the depth of distress and emotional pain. While the storm brought chaos, it also brought clarity and calm, where self-compassion ultimately helped reshape narratives and harness internal strength. ‘Sociocultural: The Weight of Expectation and Strength in Numbers’ illustrates the influence of societal pressures. Idealised portrayals of motherhood promoted images of the perfect, selfless, and always coping ‘good mother’. Mothers described the paradox of these images, which often led to silence that was driven by stigma when their realities did not align with these ideals. The remedy for this was achieved through connection, which enabled participants to resist silence and begin to define motherhood in their own terms.

While each superordinate theme stands on its own, they can also be seen as greatly intertwined. They influence and inform one another in both explicit and subtle ways. They reflect a transformative journey. While unique to each mother, there are similarities in the way they described moving from fragmentation and tension towards strength and self-understanding. Their resilience and courage shine a light on truths that are often hidden, highlighting a narrative in the project that I did not expect, but feel proud to present.

5.3 Discussion of the Findings and Analysis

The following section offers an overview of the findings, situating them within the broader context of existing literature. In IPA, knowledge is co-constructed through the relationship between the researcher and the participant. This approach enables first-person accounts to be explored before building out into broader understandings of the perinatal mental distress (Shinebourne, 2011). By prioritising participant accounts in the early stages of analysis, I was

then able to take an inductive approach by identifying convergences and divergences across experiences. These patterns of meaning highlight the unique ways mothers made sense of their lives, while also revealing shared elements that deepen understandings of the lived experiences of perinatal mental distress. The findings offer rich insights into participants' meaning-making, while the discussion highlights commonalities that recognise a shared humanity.

5.3.1 Identity: The Fragmented and Reformed Self

The theme of identity, as represented in this research, highlights the shift that mothers experienced as they navigated the transition to motherhood. A key marker is the disorientation that mothers described as they struggled to reconcile the role of ‘mum’ with their existing or previous self. Such discrepancies often led to confusion and a temporary loss of self-recognition. The mothers discussed juggling multiple aspects of themselves: the confident professional, the overwhelmed mother, and various other versions of themselves. A sense of grief was evident in participants letting go of past identities or in dreams they held onto, adding further complexity to their self-perception. A tension within was represented in how they felt internally and how they thought they were supposed to feel, causing a mismatch that left some feeling disconnected or even insane. Within this discomfort, resistance became apparent when mothers adopted a new perspective on their challenges and moved towards healing.

Time and self-reflection allowed mothers to reframe their struggles in a new light. They described growing into a more integrated version of themselves, stronger and more accepting. In embracing authenticity, mothers shifted their perspective from being failing mothers to evolving mothers, navigating a transformative stage in their lives. This is represented by the subordinate themes: Identity as a Mum, The Intersect: Multiplicity of Self, Tension within the Self, and Healing: Reframing and Reformation.

The broader literature surrounding the perinatal period reveals similar patterns related to identity transformation in motherhood. Arnold-Baker (2020) offers an engaging perspective on the existential crisis that mothers may experience. She describes the reconfiguration of a mother's existence, referencing change to her relationships with both her physical self and core sense of

being. This aligns with the identity shifts experienced in the present study, illuminating not only a change in roles but also a disruption to a mother's core sense of self. Arnold-Baker (2020) argues that motherhood demands a reevaluation of purpose and being, and motherhood is framed as a question of 'who am I now', highlighting existential development. Such themes emerged in these findings as mothers struggled with internal tensions and grappled to integrate past and present parts of themselves. The superordinate theme of reframing and reforming is also relevant, as mothers found meaning through struggle and began to rebuild a more authentic sense of self. In this way, the identity struggle shifts away from personal struggle and is reframed as a natural human response and an evolving aspect of the self.

Likewise, in earlier work, Gruen (1990) explored postpartum depression in mothers, positioning the transition to motherhood as a period of profound change. This inevitable process of change involves reworking existing roles, day-to-day routines, and interpersonal relationships. Gruen (1990) argues that mothers often experience a diminished sense of self-esteem and identity as a result of a loss of freedom and physical autonomy. This reflects the experiences of mothers in the current research, who often spoke about the emotional experiences that came with adjusting to a new identity. Mothers described grief as they let go of past versions of themselves, particularly professional or personal selves that had once provided a sense of purpose and meaning. The concept of a shifting identity highlights how the disorientation that many mothers experience is tied to an attempt to redefine themselves within a new role. Rather than pathologising identity tension as a failure to cope, it is essential to recognise these shifts as a meaningful part of the maternal experience, as a step in offering better support for mothers.

Kuappi et al. (2012) further illustrate the idea of shifting identities in the context of motherhood, locating changes to identity in relation to the disconnect between idealised concepts of motherhood and the lived reality that many mothers experience. Their findings support themes of discomfort and emotional exhaustion resulting from a loss of autonomy and feelings of isolation. Kuappi et al. (2012) challenge the idea of a fixed identity, instead arguing that maternal identity is negotiated in response to both internal and external influences. This notion is reflected in the present study, where the mothers discussed their attempts to reconcile inner worlds with societal pressures surrounding idealised motherhood and their own beliefs about who they are.

Laney et al. (2015) offer additional insight through their study exploring the influence of motherhood on identity and personal development. Their findings revealed three themes: a temporary loss of self as mothers incorporated children into their identity, the expansion of self-boundaries as the mother-child relationship developed, and an intensification of personality traits such as empathy and emotional depth. The first theme aligns with the current research findings on identity fragmentation and disorientation, as mothers had to temporarily 'fracture' to let go of certain aspects of themselves. While the second theme of self-expansion is not explicitly reflected in this research, it offers an important perspective on the intrapsychic change related to maternal identity. The third theme of intensified personality resonates with the meaning-making and growth inherent in mothers' experiences in the present research. When mothers began to reframe their experiences, they described emerging as stronger and more self-aware. Maternal identity can evolve beyond fragmentation into more empowering and affirming ways of being.

It is also possible to understand the identity struggles described by the mothers in terms of self-discrepancy theory (Higgins, 1987) and maternal identity theory (Mercer, 1985). While these theories were first posited some 40 years ago, they offer important insights into the role of maternal identity. Self-discrepancy theory posits that emotional discomfort arises when there is a mismatch between the 'actual self' (lived reality) and the 'ideal self' (hopes and aspirations) or 'ought self' (beliefs about who they should be). The mothers in the current study recalled discomfort when their lived realities clashed with internalised ideals. These tensions often resulted in feelings of guilt, shame, or a sense of personal failure. Alongside this perspective, maternal identity theory provides a comprehensive framework for understanding how the self is negotiated and sometimes disrupted through both psychological and social experiences of motherhood. This concept is evident in the mothers' accounts of fragmentation and a loss of self, as well as in their journey towards reintegrating their identities through reflection and resistance. Discussed together, these theories support the role of internal and external tensions related to perinatal mental distress while reaffirming the idea that identity is challenged and redefined during the transition to motherhood.

5.3.2 Psychological: The Storm and Calm Inside

Represented here is the complex emotional landscape that participants described as they navigated periods of chaos and calm. The journey through the storm and towards calm is supported by the subordinate themes: ‘Distress Recognition’, ‘Emotional Landscape: The Darkness’, ‘Loss and Gain of Coping Mechanisms’ and ‘Healing: Self-Compassion’. Metaphors such as darkness, spiralling, and a shadow looming were used to convey the raw intensity of their distress and reflected an embodiment of their symptoms. Time, reflection, or external sources supported mothers in recognising the true extent of their experiences and represented a turning point as they began to move towards a place of healing. Mothers reflected on the loss and transformation of coping mechanisms, sharing how previous strategies no longer served them amidst the demands of motherhood. This led mothers to let go and adjust before developing new means of care; independence evolved into connection, and perfectionism gave way to self-compassion. The process of healing was seen in the development of a growing sense of compassion. Welcoming a kinder approach towards themselves allowed participants to reinterpret their experiences as a response to complex circumstances, rather than as personal failure. The mothers exhibited strength in reclaiming their voices, growth in reframing their narratives, and a softness through less self-judgment.

Mothers often found it challenging to identify the extent of their emotions in the moment, with distress eventually recognised through external sources or retrospectively through time. An important finding lay in one of the subordinate themes, Distress Recognition, which represented the delayed identification of their struggles as more than the normal challenges of motherhood. The theme is also evident in a study by Sorsa et al. (2021), who sought to explore the lived experiences of distress during the perinatal period by focusing on the internal processes of help-seeking. Their meta-ethnographic synthesis illustrates that many mothers struggled with recognising and naming their distress, often delaying help-seeking until reaching a point of emotional overwhelm. Similarly, a review by Howard and Khalifeh (2020) sheds light on a structural and experiential delay in distress recognition, pointing out how stigma and low mental health literacy contribute towards disproportionate rates of help-seeking behaviour. Their

findings suggest that women struggle with identifying or disclosing their distress until it becomes oppressive. While this study was not positioned to explore in depth the reasons behind the delayed recognition of stress, the findings likely reflect the broader themes of stigma, awareness, and the difficulty of judging distress levels during the perinatal period. Clapham et al. (2024) suggest that challenges for mothers are often under-recognised due to several factors, including inadequate screening methods, limited data, insufficient mental health services, and inadequate education. Additionally, in Aotearoa New Zealand, a study by Holden et al. (2019) found that lead maternity carers saw mothers as often unreceptive to screening, whereas mothers in their study expressed a strong desire to discuss their mental health concerns in safe spaces. The study concluded that gaps in maternal mental health services exist and that improvements are needed at the patient, provider, and system levels. Given the compounding nature of stress, evidence of underreporting, and the thoroughly documented impact of stigma on help-seeking behaviours, there is a critical need to better understand this area.

Maladaptive cognitions are consistently linked to poorer outcomes in maternal mental health. Specific cognitive distortions, such as self-blame, guilt and denial, have been shown to influence emotional regulation and heighten stress levels negatively. For example, George et al. (2013) assessed coping strategies among mothers with varying anxiety levels, utilising a questionnaire that categorises coping reactions into adaptive problem-solving strategies, such as acceptance or positive reframing, and non-adaptive' techniques, including denial or self-blame. The results found that anxious mothers were more likely to use non-adaptive approaches like self-blame and denial, which are shown to result in negative emotional responses. Their study points out a correlation between anxiety and maladaptive cognitions. Similarly, Coates et al. (2014) conducted a qualitative study to explore mothers' experiences of postnatal distress and identified recurring psychological processes such as guilt, avoidance, and difficulties adjusting to motherhood. These findings further support the relationship between specific cognitive processes and poor mental health outcomes in the perinatal period. This pattern is also represented in the current study, as many of the mothers described feelings of overwhelm and guilt as central to their experiences. For example, some mothers discussed losing agency over their thoughts, which escalated to frightening visions or suicidal ideation. Their accounts not only demonstrate

the emotional intensity of perinatal mental distress but also underscore the influence and impact of cognitions in distress.

Mothers in this study also described a loss of their former coping or stress management strategies, which resulted in dysregulation and feelings of being out of control. Tools they once relied on, such as independence or perfectionism, were rendered ineffective amid the unpredictable demands of motherhood. One mother, for example, reflected on how her past drive for independence eventually turned to overwhelm and burnout. Another similarly discussed the gradual loss of social connection and exercise, which had once supported her in living a more balanced life. Several studies have highlighted how strategies can be lost, adapted, or taken up throughout motherhood. Walker and Murray (2022) sought to understand maternal stressors and coping strategies during the extended postpartum period, encompassing what is termed the fourth trimester and beyond. They identified seven postpartum-specific coping strategies, including taking time alone or with others, managing workload, and managing emotions and thoughts. These strategies were significantly associated with contextual stressors such as isolation and exhaustion, suggesting that when strategies are compromised or unavailable, mothers may experience increased stress. Mothers in the present study discussed loss of former ways of coping; however, they also spoke of a gradual development of new methods of managing distress. For example, the use of breathing techniques and journaling as tools to help regain a sense of internal calm. Mróz et al. (2024) highlight the importance of this adaptive shift in coping strategies among women in later motherhood (aged 35 years and older). Their study found a stronger preference for positive, problem-focused coping strategies, such as planning, reframing, acceptance, and seeking support; these approaches are echoed in the constructive strategies adopted by mothers in the current study.

Crucially, self-compassion was highlighted in this research as an antidote to the chaos of the storm, enabling mothers to harness an inner sense of calm. Mothers described how developing a perspective of kindness towards themselves and acceptance became a turning point in their journey towards healing. A similar finding is presented by Hunter and Dickson (2024), who examined the role of self-compassion in the transition to motherhood. They showcased practices such as kindness towards oneself, mindfulness, and recognising shared experiences, as linked to

a reduction in symptoms of anxiety and self-criticism. These practices were found to promote both psychological wellbeing for mothers and to strengthen the mother-infant bond. Hunter and Dickson (2024) emphasise the significance of self-compassion in improving perinatal care practices and recommend training in this area for healthcare professionals. The present study similarly found that mothers recounted these strategies as supportive in regulating their distress, and they enabled them to reframe challenges with increased understanding. Furthermore, the potential for self-compassion to positively impact mothers is particularly important for those who feel emotionally unsupported or disconnected from wider family.

Mitchell et al. (2018) likewise highlight the importance of self-compassion interventions, which were found to lead to increased positive outlook and a decrease in self-critical thought patterns. These changes align with the internal shifts described by mothers in this study. The online format of their intervention offered flexibility and easy accessibility, suggesting that similar tools could be implemented on a broader scale to support maternal wellbeing. Further reinforcing the positive relationship between self-compassion and mental health, Sawyer Cohen's (2010) study showed that higher levels of prenatal mindfulness and self-compassion were associated with lower levels of anxiety, stress, and depressive symptoms, and predicted stronger prenatal attachment. The voices of mothers, as represented in this research, align with findings in the broader literature. Presented together, they underscore the importance of self-compassion as an internal asset that supports emotional regulation, reliance, and healing.

5.3.3 Sociocultural: The Weight of Expectation and Strength in Numbers

The third and final superordinate theme represents the influence of the sociocultural environment over the mothers' experiences with perinatal mental distress. Ideals of the 'good mother' were internalised from social media, idealised images, and dominant narratives. These portrayals of motherhood shaped how mothers made sense of their roles, adding pressure to meet unrealistic expectations and leading to feelings of guilt, shame, and self-doubt. Mothers described a disconnect from the life they believed they were meant to have, highlighting deeply embedded social and cultural narratives. The stigma around maternal mental health was prevalent throughout mothers' stories and compounded the struggles which mothers experienced. Mothers

often hid the painful parts of their experiences through fear of judgment, further fueling feelings of seclusion. A strong sense of isolation was apparent due to geographic, social, and cultural factors, which further added to distress. For example, in the rural setting of Central Otago, one mother highlighted her difficulty in accessing specialist healthcare and the way this left a lasting emotional imprint. Distance from family and a culture of individualism were strong themes that added to feelings of stress and isolation. Amidst these challenges, healing emerged through connection and belonging, which was a beautiful remedy for the isolation that was prevalent throughout the mothers' accounts. Community groups, authentic relationships, and shared experiences helped mothers rebuild their confidence, embrace who they were, and liberate themselves from the performative pressures associated with motherhood. The negative influence of the sociocultural landscape is apparent in the mothers' accounts; however, sociocultural developments were also helpful, and the connection offered a powerful pathway towards healing. These findings are represented by the subordinate themes: ‘The Silent Script of the ‘Good Mother’, ‘Stigma’, ‘Interaction Between Stress and Isolation’, and ‘Healing: Through Connection and Belonging’.

The sociocultural pressures experienced by mothers are represented in the broader literature of perinatal mental health, with the internalisation of motherhood ideals and the impact of social isolation being particularly prominent themes throughout research. Findings by Kauppi et al. (2012) show that mothers described feelings of shame and negative self-perception as a result of a mismatch between their lived realities and idealised expectations. Sonnerburg and Miller (2021) explored how mothers internalise ‘good mother’ ideology. Their findings show that portrayals of self-sacrifice, joy, and competence become internalised standards, forcing mothers to evaluate their worth against rigid expectations. They found a strong correlation between these assimilated beliefs and symptoms of depression, suggesting that these beliefs act as psychological stressors. Sutherland (2010) conducted a sociological exploration of the relationship between mothering, guilt, and shame, and she argues that societal ideals of ‘good mothering’ are constructed through dominant discourse that portrays mothering as instinctive, selfless, and joyful. Mothers who diverge from these expectations, for example, with feelings of anger or needing time alone, often blamed themselves, resulting in guilt, shame and feelings of

failure. Evidently, perinatal mental distress is more than an individual issue; it is socioculturally embedded and burdens mothers with expectations that act as internal stressors.

The influx of particular messages through social media and magazines emerged throughout mothers' reflections. While Instagram was described as occasionally providing validation and reassurance when mothers engaged with real and honest portrayals of motherhood, the media was generally described as delivering unrealistic comparisons. Kirkpatrick and Lee (2022) showed that the abundance of idealised images of motherhood on Instagram adds additional pressure on new mothers and can negatively impact their mental health. Their research provides evidence of the harmful effects that can occur through repeated exposure to these images, including increased levels of envy and anxiety. Tate (2023) supports this pattern, pointing out that social media platforms often portray highly romanticised and unattainable standards of motherhood, heightening social comparison and potentially increasing feelings of inadequacy. Here, the pervasive nature of idealised media images is seen to contribute to a digital environment that undermines wellbeing more than supports it. In contrast to this view, Price et al. (2017) demonstrated that first-time mothers highly valued the use of social media as both a means of connection and a tool for developing real-world connections. In this way, social media platforms can also provide a real and purpose-driven sense of engagement that allows mothers to filter the type of support or ideas they seek. This point echoes one mother's story in this study, who discussed empowerment through connecting with 'real' motherhood content on Instagram, which gave a sense of validation and alleviated feelings of isolation.

Many of the mothers described how social scripts shaped their understanding of what motherhood should look like, resulting in dissonance when their lived realities did not align with these expectations. These accounts reflect the cognitive dissonance framework proposed initially by Festinger (1957). This framework suggests that individuals who experience misalignment between their internal beliefs and values and their external realities feel psychological discomfort, forcing them to either adjust their beliefs and behaviours or internalise a sense of failure (Harman-Jones & Mills, 2019). Within the context of this research, mothers often responded to this incongruence by engaging in self-blame and feeling a sense of falling short. Henderson et al. (2016) emphasise that feelings of guilt that arise from not meeting maternal

expectations create lower self-efficacy and elevated stress, patterns of which are directly linked to poor mental health outcomes. They highlight the need to move beyond theories and approaches that focus on individual coping strategies and instead shift responsibility toward deconstructing societal narratives.

The role of stigma was described throughout mothers' stories, leading to internalised shame and acting as a barrier to seeking support. Stigma surrounding maternal mental health can negatively impact help-seeking behaviour. Byatt et al. (2015) highlight that low treatment uptake reflected internalised stigma or guilt related to motherhood experiences, and suggest that mothers may avoid mental health care because it clashes with cultural ideals of being self-reliant and emotionally resilient during pregnancy. Kuappi et al. (2012) similarly support this, identifying a central theme of stigma for mothers who perceived that they were labelled as 'crazy' when discussing mental health issues. In the current study, two mothers described fearing what would happen to their child if they were to seek mental health support. In a study to understand the referral decisions made by midwives for perinatal mental health care, Johnson et al. (2023) found that many women avoid disclosing mental health concerns based on the belief that their child could be taken away. Furthermore, healthcare professionals perceived this as a significant barrier to necessary treatment, meaning that mothers miss out on receiving essential treatment and care. Collectively, these findings underscore the impact of stigma surrounding maternal mental health, demonstrating its silencing effect for mothers and how it prevents them from accessing the support they need.

The thread of isolation was consistently present throughout mothers' accounts, including references to geographic distance, cultural disconnection, and a lack of support networks. The interaction between stress and isolation was seen to interact and compound the experience of emotional overwhelm. These experiences align with Biaggi et al.'s (2016) findings, which show that both emotional and practical isolation heighten feelings of helplessness. On the other hand, mothers also described their process of healing as tied to relational turning points, such as support from peers and validation received through community connection. Kay et al. (2024) emphasise the importance of emotional and practical support in mitigating stress during the perinatal period. Their findings showed that higher levels of perceived support were linked to

lower levels of depressive symptoms, affirming the role of social support in buffering psychological distress. Mothers in the current study described how connection with others allowed them to feel seen and less alone in their experiences. Additionally, mothers discussed relationships with their partners as either positive or negative influences on their mental state. The importance of this relational dynamic is further supported by Antoniou et al. (2021), who illustrate that interpersonal relationships, specifically perceived support from partners, are a crucial factor in the occurrence of perinatal mental health issues. Social connections are vital protective factors for mothers, offering necessary emotional and practical support and fighting feelings of isolation. When mothers in the current study encountered environments that promoted authenticity and vulnerability, there was a substantial shift in their self-perception and overall well-being, highlighting the importance of belonging in moving towards a space of healing.

5.4 Implications for Practice

Perinatal mental health is an essential foundation for strong whānau, communities, and broader society. Maternal mental health carries implications that extend well beyond the immediate mother–infant dyad. Yet, research exploring the lived experience of perinatal mental distress in the Aotearoa, New Zealand context remains limited. This qualitative study offers a unique contribution by deepening the understanding of how identity, psychological processes, and sociocultural dynamics shape mothers' experiences of distress during the perinatal period. The findings underscore the importance of adopting a broader, more inclusive approach to recognising perinatal mental distress, one that accounts for the full emotional spectrum mothers may experience.

The findings of this research highlight several important implications for health care that actively support mothers. Perinatal mental health care needs are highly individualised, with the current study presenting a case for more expansive and compassionate care that reflects the complexity of mothers' lived experiences. These findings support a broader approach to perinatal mental health assessment, one that extends beyond diagnosis and includes the full spectrum of emotional experiences. Many mothers in this study did not initially identify their experiences as anxiety or depression, yet still faced considerable psychological distress. Healthcare professionals should

therefore be able to recognise more subtle or emerging signs of emotional struggle. Language around perinatal wellbeing should move away from deficit-based models and instead adopt a more inclusive, strengths-based framework that normalises a wide range of emotional responses, especially in early motherhood.

Routine mental health screening remains essential, but it must be delivered in a way that is non-judgmental, culturally safe, and emotionally attuned. Healthcare professionals should allow time for open conversations that recognise stigma and fear of judgement as potential barriers to disclosure (Hore et al., 2019; McCarthy et al., 2021). These conversations should look to challenge unrealistic societal expectations of motherhood and acknowledge the legitimacy of maternal ambivalence. Clear and consistent information about what is normal during the perinatal period, including emotional challenges, should be standard within antenatal education and clinical care.

Providing education around maternal identity development is a vital area for practice. Identity transformation emerged as a central theme in this study, yet the conversation around this topic is limited in the day-to-day interactions of mothers. Supporting individuals to understand that identity disruption is a common and evolving part of the transition to motherhood may reduce shame and confusion. Clinicians, particularly midwives, GPs, and health nurses, can incorporate psychoeducation about identity development to support self-reflection and reduce internal conflict.

The findings also point to the value of teaching adaptive coping strategies that incorporate self-compassion, self-care, and emotional literacy. Many mothers in this study described the loss or breakdown of former coping mechanisms and the need to develop new ones. Professional development for those working with mothers could include skill-based approaches supporting emotional regulation, distress tolerance, and connection to self. Mindfulness, self-compassion and acceptance-based strategies can help mothers in reframing unhelpful internal narratives and distancing more challenging emotions from feelings of failure. Such tools should be offered and integrated into general perinatal care as preventative resources, rather than as a response to acute distress.

Given the compounding effect of isolation, particularly in rural settings, healthcare professionals should actively encourage participation in peer support groups and mother–infant initiatives. Importantly, community-based connections were shown to be a powerful antidote to the loneliness experienced by mothers, supporting a much-needed sense of belonging and validation, which helped to reduce the adverse impact of stigma. Mother and infant groups provide a valuable template for sharing support and resources with mothers within the community. They can be supported simultaneously through relational care to promote positive maternal wellbeing. Professionals should be informed about local resources and refer mothers to these networks early in the perinatal journey.

Finally, educational resources used by healthcare professionals, specifically midwives, nurses, and GPs, should stress the importance of normalising emotional challenges to combat unhelpful portrayals of consistent joy and ease during the perinatal period. Resources, including online support, hand-outs, and antenatal classes, could incorporate the voices of mothers with lived experience, such as those presented in this study, to offer honest and relatable narratives that reduce stigma and challenge narrow representations of maternal success. Incorporating the psychological realities of motherhood, such as anxiety, overwhelm, and identity loss, into maternal education can support a more empathetic and responsive model of care.

5.5 Strengths and Limitations of the Research

Qualitative research, by nature, offers rich, in-depth explorations of lived experiences, which enable a nuanced perspective of the way individuals make sense of their realities. The prioritisation of first-person accounts, honouring individual voices and personal meaning-making are each strengths. However, this idiographic approach, while rich in context, has limitations, namely the generalisability of findings. That said, the present study engaged with the specific and subjective nature of the research questions and sought to shed light on mothers' experiences and the way they perceive perinatal mental distress, rather than drawing conclusions for all mothers in similar circumstances.

A key strength of the study lies in the use of a homogeneous sampling approach to research, as required by IPA's commitment to exploring shared experiences within a specific context. This technique called for the selection of a group of individuals who had navigated the experience of perinatal mental distress while living in a rural region. While the mothers shared essential experiences, such as rural living and self-defined recovery, their differences, such as socioeconomic status, partner support, or previous mental health history, were not necessarily fully captured in their stories. Additionally, although the study welcomed participants from diverse backgrounds, all participants identified as European/Pākehā or of White European descent. The cultural homogeneity limits the study's ability to speak to the role of broader cultural worldviews, including Indigenous perspectives on maternal mental health.

Another strength of the research was its rural setting, focusing on the Central Otago Region of the South Island, Aotearoa, New Zealand. This brought forward the unique sociocultural, geographical, and systemic realities of motherhood experienced in a highly localised way. Limited access to specialist mental health care, distance from extended family, and heightened social isolation were shown to elevate levels of distress. In turn, this highlighted the critical role of the local community and support in fostering maternal wellbeing in rural communities, an area of understanding which is currently lacking in the literature.

Another methodological strength of the research is the expanded definition of the perinatal period, beginning at conception through to the first 12 months postpartum. The term perinatal mental distress was also used, as opposed to perinatal anxiety or depression, to speak to the full range of emotional responses for mothers in this timeframe. This approach broadened the lens of the focus and allowed mothers to share emotional experiences in their own terms, while reflecting the evolving nature of distress. This also allowed space for the inclusion of factors often excluded from medicalised models of mental health. A recent report in Aotearoa New Zealand called for the development of an inclusive screening approach that moves beyond narrow diagnostic labels, such as perinatal depression or perinatal anxiety, and instead recognises the full spectrum of perinatal mental distress (Wilkinson, 2022). The current research aims to inform practice by providing insight into this area.

Ethically, the study required recruiting mothers who considered themselves recovered, implemented as a safeguard to protect the vulnerable nature of potential participants discussing sensitive topics. While this is a strength in terms of protecting participant wellbeing, it may have skewed findings towards narratives of healing. This was not the goal of the research; however, it was an emergent characteristic of the findings.

Finally, it is essential to acknowledge that interviewing has limitations, particularly in terms of the interviewer-interviewee relationship, which can raise concerns about power dynamics and potential biases (Kvale, 2002). These challenges were mitigated through a sensitive and empathetic approach, alongside the inclusion of reflexivity, which highlights the researcher's positionality and assumptions (Leavy, 2020). Ensuring anonymity and confidentiality, creating a trusting environment, using neutral language, and prompting further self-reflection can all support quality data collection, all of which were key ethical considerations in the current research.

5.6 Recommendations for Future Research

This study has used an IPA approach to research to explore mothers' lived experiences of perinatal mental distress in the context of rural Aotearoa New Zealand. This research adds to the limited scope of research in this area, and as a qualitative study, it offers rich and meaningful findings which can inform both practice and policy. However, these findings are unique within their setting, and there are straightforward suggestions for future research in the realm of perinatal mental health in the country.

Given the context of Aotearoa New Zealand, Māori-centred research approaches should be considered. Kaupapa Māori research is grounded in Māori philosophy and emphasises the importance of self-determination, cultural integrity, and Māori communities maintaining control over the research process. This approach challenges neocolonial dominance by empowering Māori and ensuring that research benefits not only the participants but also their whānau and communities (Bishop, 1999). Māori-centred research, and in particular Kaupapa Māori research, focuses on addressing poor outcomes linked to social determinants of health for Māori. Future

research would benefit from incorporating Kaupapa Māori principles to ensure that Māori experiences and worldviews are meaningfully represented in maternal mental health in Aotearoa New Zealand.

As part of ethical requirements, the present study included mothers who identified as recovered from their distress. As previously stated, this may have introduced a bias towards stories of healing, which, while meaningful in the field of maternal mental health, also limits the scope of findings. Future research would benefit from exploring the experiences of mothers who are in the process of navigating perinatal mental distress, clearly with the need for strict ethical safeguards in place. This type of approach would enable essential insights into real-time processes of struggles, coping, and meaning-making, enabling a comprehensive understanding to inform early intervention strategies.

Furthermore, research focusing on emotional literacy within the perinatal period would be beneficial, given that several mothers described struggling to name or understand the emotional intensity of their experiences while they were in the midst of it. This has very real implications for help-seeking behaviours, delaying support which could mitigate the compounding effects of stress and stigma. This can lead to mothers minimising their struggles through fear of how they would be perceived or the consequences of their disclosures. Future research could explore how emotional literacy is shaped or inhibited by societal narratives and the consequential influence of stigma on a mother's ability to identify and express distress. Research in this area would deepen understanding of the barriers that prevent early recognition and support, as well as inform the development of interventions which enhance emotional awareness and reduce shame.

Another important direction for research would be to explore the interconnected role of community and self-compassion in supporting mental health throughout the perinatal period. Exploration of the role of external connection and internal kindness, and their potential for working together to buffer distress, is a critical area to understand in more depth. This focus could allow for a better understanding of how shared experiences, peer validation, and non-judgmental community spaces help mothers to reframe their challenges with enhanced compassion and to interrupt cycles of shame. Such research could potentially inform the

development of more holistic, community-based interventions that focus on relational support as an essential pathway to maternal wellbeing.

5.7 Researcher Reflections

When I think back to the beginning of the research project, I can recall feeling a strong sense of advocacy for mothers who experience perinatal mental distress. I believe that on a personal level, this was influenced through my own upbringing, where I witnessed first-hand the far-reaching impact of maternal mental health. At an academic level, I recall becoming more interested in this topic during my postgraduate degree after taking a Health Psychology paper. This piqued an interest in research on the subject, where I quickly learned that perinatal mental distress impacts a large portion of the population while remaining largely under-researched and under-discussed. Through engaging directly with mothers' stories, I have developed an appreciation for the complexity and courage embedded in these experiences. Listening to mothers share their stories was both moving and confronting. Now, as I near the completion of my thesis, this project has deepened my appreciation for the importance of creating safe spaces where voices can be heard without judgment.

As a researcher engaging in IPA, I became acutely aware of my own positionality and the way it shaped this thesis. Being a woman, but not a mother, living within rural Central Otago yet growing up in urban Christchurch, brought both proximity and distance to the topic. I grappled with feelings of being an outsider, questioning who I was to attempt to understand the motherhood journey, while also sitting with the sadness of possibly not becoming a mother myself. I have not personally experienced perinatal mental distress; however, I have seen family members and friends face these challenges. This, alongside my connections to the community and awareness of local service gaps, influenced my sensitivity to participants' contexts. Throughout the project, I worked to hold these perspectives with reflexivity, acknowledging both the privileges and limitations they carried.

The process of IPA was more than an academic or technical exercise; it required sitting alongside the mothers' stories, returning to them over and over to ensure their meaning was not reduced but

honoured. At times, this felt heavy. I questioned whether the themes truly reflected participants' meanings and whether I had missed essential parts of their stories. Conversations with my supervisor helped to ease these doubts and supported me in moving forward. I was also struck by the tension between representing individual voices while drawing broader patterns —a balance that carried both ethical and interpretive responsibilities.

Writing the final words of this research, I feel a profound respect for the resilience of mothers, as well as a heightened awareness of the structural and cultural factors that can both protect and undermine mental health. I also hold a deeper appreciation for Indigenous models of health, such as Te Whare Tapa Whā, which remind us that wellbeing cannot be separated from whānau, community, and connection to place. Finally, this thesis has been transformative on a personal level. It has taught me patience in the research process, reminding me that meaningful qualitative work often requires more time than expected. It has also taught me humility in the face of others' stories, and the value of holding compassion - for participants, for all mothers, for the communities in which we find ourselves, and for myself as a developing researcher. I am reminded that this type of research is never an endpoint, but part of an ongoing conversation about how we, as a society, can better support one another with dignity, empathy, and care.

5.8 Conclusions

The findings of this thesis highlight the complex and multifaceted nature of perinatal mental distress. They speak to the interplay of personal, social, cultural, and structural factors that shape a mother's journey and emphasise the importance of understanding their experiences through a holistic lens. The mother's stories reveal the challenges of navigating identity shifts, stigma, isolation, and deeply ingrained notions of motherhood, while also shining a light on resilience and strength gained through self-compassion, connection, and a sense of belonging. By situating these experiences within the broader context of rural Aotearoa New Zealand, this research contributes to a growing body of work which calls for culturally responsive support for mothers experiencing perinatal mental distress. Lastly, this study reaffirms the value of centring mothers' voices in shaping future directions for research, services, and support systems.

REFERENCES

Accortt, E. E., Cheadle, A. C. D., & Dunkel Schetter, C. (2015). Prenatal depression and adverse birth outcomes: An updated systematic review. *Maternal and Child Health Journal, 19*, 1306–1337. https://doi.org/10.1007/s10995-014-1637-2

Ahmadpour, P., Faroughi, F., & Mirghafourvand, M. (2023). The relationship of childbirth experience with postpartum depression and anxiety: A cross-sectional study. *BMC Psychology, 11*, Article 58. https://doi.org/10.1186/s40359-023-01105-6

Ainsworth, M. D. (1978). The Bowlby-Ainsworth attachment theory. *Behavioural and Brain Sciences, 1*(3), 436–438. https://doi.org/10.1017/s0140525x00075828

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Strange Situation Procedure (SSP) [Database record]. *APA PsycTests*. https://doi.org/10.1037/t28248-000

Aktar, E., Qu, J., Lawrence, P. J., Tollenaar, M. S., Elzinga, B. M., & Bögels, S. M. (2019). Fetal and infant outcomes in the offspring of parents with perinatal mental disorders: Earliest influences. *Frontiers in Psychiatry, 10*, Article 391. https://doi.org/10.3389/fpsyt.2019.00391

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Angel, R., & Worobey, J. L. (1988). Single motherhood and children's health. *Journal of Health and Social Behavior, 29*(1), 38–52. https://doi.org/10.2307/2137179

Antoniou, E., Stamoulou, P., Tzanoulinou, M.-D., & Orovou, E. (2021). Perinatal mental health; The role and the effect of the partner: A systematic review. *Healthcare, 9*(11), Article 1572. https://doi.org/10.3390/healthcare9111572

Arfaie, K., Nahidi, F., Simbar, M., & Bakhtiari, M. (2017). The role of fear of childbirth in pregnancy-related anxiety in Iranian women: A qualitative research. *Electronic Physician, 9*(2), 3733–3740. https://doi.org/10.19082/3733

Arnold-Baker, C. (Ed.). (2020). *The existential crisis of motherhood*. Springer Nature.

Barker, E. D., Jaffee, S. R., Uher, R., & Maughan, B. (2011). The contribution of prenatal and postnatal maternal anxiety and depression to child maladjustment. *Depression and Anxiety, 28*, 696–702.

Bayrampour, H., McDonald, S., & Tough, S. (2015). Risk factors of transient and persistent anxiety during pregnancy. *Midwifery, 31*(6), 582–589. https://doi.org/10.1016/j.midw.2015.02.009

Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health, 9*(8), 541–545.

Bergunde, L., Garthus-Niegel, S., Alexander, N., & Steudte-Schmiedgen, S. (2022). Perinatal mental health research: Towards an integrative biopsychosocial approach. *Journal of Reproductive and Infant Psychology, 40*(4), 325–328. https://doi.org/10.1080/02646838.2022.2101781

Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders, 191*, 62–77.

Biaggi, A., & Pariante, C. M. (2020). Risk factors for depression and anxiety during the perinatal period. In *Handbook of perinatal clinical psychology* (pp. 239–265). https://doi.org/10.4324/9780429351990-18

Bishop, R. (1999). Kaupapa Māori research: An indigenous approach to creating knowledge. In N. Robertson (Ed.), *Maori and psychology: Research and practice: The proceedings of a symposium sponsored by the Maori and Psychology Research Unit*. Māori and Psychology Research Unit.

Bishop, F., & Yardley, L. (2014). Qualitative assessment. In Y. Benyamini, M. Johnston, & E. C. Karadēmas (Eds.), *Assessment in health psychology* (pp. 290–300). Hogrefe Publishing.

Blom, E., Jansen, P., Verhulst, P., Hofman, A., Raat, H., Jaddoe, V., Coolman, M., Steegers, E., & Tiemeier, H. (2010). Perinatal complications increase the risk of postpartum depression: The Generation R Study. *British Journal of Obstetrics and Gynaecology, 117*(11), 1390–1398. https://doi.org/10.1111/j.1471-0528.2010.02660.x

Bowen, A., Duncan, V., Peacock, S., & Schwartz, L. (2014). Mood and anxiety problems in perinatal Indigenous women in Australia, New Zealand, Canada, and the United States: A critical review of the literature. *Transcultural Psychiatry, 51*(1), 93–111. https://doi.org/10.1177/1363461513501712

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Brinkmann, S., & Kvale, S. (2015). Ethics in qualitative psychological research. In *The Sage handbook of qualitative research in psychology* (2nd ed., pp. 263–279). Sage.

Brinkmann, S. (2013). *Qualitative interviewing*. Oxford University Press.

Brinkmann, S., Jacobsen, M. H., & Kristiansen, S. (2020). Historical overview of qualitative research in the social sciences. In P. Leavy (Ed.), *The Oxford handbook of qualitative research* (2nd ed., pp. 22–58). Oxford University Press. https:doi.org//10.1093/oxfordhb/9780190847388.013.10

Buss, C., Davis, E. P., Hobel, C. J., & Sandman, C. A. (2011). Maternal pregnancy-specific anxiety is associated with child executive function at 6–9 years of age. *Stress, 14*(6), 665–676.

Buultjens, M., Robinson, P., & Milgrom, J. (2012). Online resources for new mothers: Opportunities and challenges for perinatal health professionals. *The Journal of Perinatal Education, 21*(2), 99–111. https://doi.org/10.1891/1058-1243.21.2.99

Byatt, N., Xiao, R. S., Dinh, K. H., & Waring, M. E. (2015). Mental health care use in relation to depressive symptoms among pregnant women in the USA. *Archives of Women's Mental Health, 19*(1), 187–191. https://doi.org/10.1007/s00737-015-0524-1

Cairney, J., & Wade, T. (2002). Single parent mothers and mental health care service use. *Social Psychiatry and Psychiatric Epidemiology, 37*, 236–242. https://doi.org/10.1007/s00127-002-0539-6

Cassidy, J., & Shaver, P. R. (Eds.). (2018). *Handbook of attachment: Theory, research, and clinical applications* (3rd ed.). The Guilford Press.

Chin, K., Wendt, A., Bennett, I. M., & Bhat, A. (2022). Suicide and maternal mortality. *Sex and Gender Issues in Behavioural Health, 24*, 239–275. https://doi.org/10.1007/s11920-022-01334-3

Clapham, B., Breheny, M., Reweti, A., Severinsen, C., & Ware, F. (2024). Missed opportunities for addressing maternal mental health: A thematic analysis of mothers' experiences of using the Well Child Tamariki Ora service in Aotearoa NZ. *Health & Social Care in the Community, 2024*(1). https://doi.org/10.1155/2024/5890641

Clarke, V. (2010). Review of the book *Interpretative phenomenological analysis: Theory, method and research*. *Psychology Learning & Teaching, 9*, 57–56.

Coates, R., Ayers, S., & De Visser, R. (2014). Women's experiences of postnatal distress: A qualitative study. *BMC Pregnancy and Childbirth, 14*, Article 359. https://doi.org/10.1186/1471-2393-14-359

Coleman, P., Nelson, E. S., & Sundre, D. L. (1999). The relationship between prenatal expectations and postnatal attitudes among first-time mothers. *Journal of Reproductive and Infant Psychology, 17*, 27–39.

Coo, S., García, M. I., Mira, A., & Valdés, V. (2020). The role of perinatal anxiety and depression in breastfeeding practices. *Breastfeeding Medicine, 15*, 495–500.

Côté-Arsenault, D., Donato, K. L., & Earl, S. S. (2006). Watching & worrying: Early pregnancy after loss experiences. *MCN: The American Journal of Maternal Child Nursing, 31*(6), 356–363. https://doi.org/10.1097/00005721-200611000-00005

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. The British Journal of Psychiatry: The Journal of Mental Science, 150, 782–786. https://doi.org/10.1192/bjp.150.6.782

Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health, 30*(2), 230–235. https://doi.org/10.1089/jwh.2020.8882

Crowther, S. (2016). Providing rural and remote rural midwifery care: An "expensive hobby." *New Zealand College of Midwives Journal, 52*, 26–34. https://doi.org/10.12784/nzcomjnl52.2016.4.26-34

Davis, E. P., & Sandman, C. A. (2010). The timing of prenatal exposure to maternal cortisol and psychosocial stress is associated with human infant cognitive development. *Child Development, 81*(1), 131–148.

Dawson, P., Auvray, B., Jaye, C., Gauld, R., & Hay-Smith, J. (2022). Social determinants and inequitable maternal and perinatal outcomes in Aotearoa New Zealand. *Women's Health*. Advance online publication. https://doi.org/10.1177/17455065221075913

Dawson, P., Jaye, C., Gauld, R., & Others. (2019). Barriers to equitable maternal health in Aotearoa New Zealand: An integrative review. *International Journal for Equity in Health, 18*, Article 168. https://doi.org/10.1186/s12939-019-1070-7

Del Ciampo, I. R., & Del Ciampo, L. A. (2018). Breastfeeding and the benefits of lactation for women's health. *Revista Brasileira de Ginecologia e Obstetrícia / RBGO Gynecology and Obstetrics, 40*(06), 354–359. https://doi.org/10.1055/s-0038-1657766

Delgado-Herrera, M., Aceves-Gómez, A. C., & Reyes-Aguilar, A. (2024). Relationship between gender roles, motherhood beliefs and mental health. *PLOS ONE, 19*(3). https://doi.org/10.1371/journal.pone.0298750

Dennis, C. L., Coghlan, M., & Vigod, S. (2013). Can we identify mothers at risk for postpartum anxiety in the immediate postpartum period using the State-Trait Anxiety Inventory? *Journal of Affective Disorders, 150*(3), 1217–1220. https://doi.org/10.1016/j.jad.2013.05.049

Dennis, C. L., Falah-Hassani, K., & Shiri, R. (2017). Prevalence of antenatal and postnatal anxiety: Systematic review and meta-analysis. *The British Journal of Psychiatry, 210*(5), 315–323. https://doi.org/10.1192/bjp.bp.116.187179

DeSouza, R. (2015). Motherhood, migration and methodology: Giving voice to the "other". *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2004.1919

Ding, X.-X., Wu, Y.-L., Xu, S.-J., Zhu, R.-P., Jia, X.-M., Zhang, S.-F., Huang, K., Zhu, P., Hao, J.-H., & Tao, F.-B. (2014). Maternal anxiety during pregnancy and adverse birth outcomes: A systematic review and meta-analysis of prospective cohort studies. *Journal of Affective Disorders, 159*, 103–110.

Doornbos, B., Dijck-Brouwer, D. A., Kema, I. P., Tanke, M. A., van Goor, S. A., Muskiet, F. A., & Korf, J. (2009). The development of peripartum depressive symptoms is associated with gene polymorphisms of MAOA, 5-HTT and COMT. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 33*(7), 1250–1254.

Dowse, E., Chan, S., Ebert, L., Wynne, O., Thomas, S., Jones, D., Fealy, S., Evans, T. J., & Oldmeadow, C. (2020). Impact of perinatal depression and anxiety on birth outcomes: A retrospective data analysis. *Maternal and Child Health Journal, 24*, 718–726.

Drevets, W. C. (2000). Neuroimaging studies of mood disorders. *Biological Psychiatry, 48*(8), 813–829.

Durie, M. H. (1994). Tirohanga Māori: Māori health perspectives. In M. H. Durie, *Whaiora: Māori health development* (pp. 67–81). Oxford University Press.

Ekeroma, A., Ikenasio-Thorpe, B., Weeks, S., Kokaua, J., Puniani, K., Stone, P., ... & Hovell, M. (2012). Validation of the Edinburgh Postnatal Depression Scale (EPDS) as a screening tool for postnatal depression in Samoan and Tongan women living in New Zealand. *New Zealand Medical Journal, 125*(1351), 41–49.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129–136. https://doi.org/10.1126/science.847460

Ennis, L. R. (Ed.). (2014). *Intensive mothering: The cultural contradictions of modern motherhood*. Demeter Press. http://www.jstor.org/stable/j.ctt1rrd8rb

Eriksson, C., Jansson, L., & Hamberg, K. (2006). Women's experiences of intense fear related to childbirth investigated in a Swedish qualitative study. *Midwifery, 22*(3), 240–248. https://doi.org/10.1016/j.midw.2005.10.002

Evans, K., Morrell, C. J., & Spiby, H. (2017). Women's views on anxiety in pregnancy and the use of anxiety instruments: A qualitative study. *Journal of Reproductive and Infant Psychology, 35*(1), 77–90. https://doi.org/10.1080/02646838.2016.1245413

Fairbrother, N., Janssen, P., Antony, M. M., Tucker, E., & Young, A. H. (2016). Perinatal anxiety disorder prevalence and incidence. *Journal of Affective Disorders, 200*, 148–155. https://doi.org/10.1016/j.jad.2015.12.082

Fairbrother, N., Young, A. H., Janssen, P., Antony, M. M., & Tucker, E. (2015). Depression and anxiety during the perinatal period. *BMC Psychiatry, 15*(1), Article 206. https://doi.org/10.1186/s12888-015-0526-6

Faisal-Cury, A., & Rossi Menezes, P. (2007). Prevalence of anxiety and depression during pregnancy in a private setting sample. *Archives of Women's Mental Health, 10*(1), 25–32. https://doi.org/10.1007/s00737-006-0164-6

Falah-Hassani, K., Shiri, R., & Dennis, C. L. (2017). The prevalence of antenatal and postnatal co-morbid anxiety and depression: A meta-analysis. *Psychological Medicine, 47*(12), 2041–2053. https://doi.org/10.1017/S0033291717000617

Fallon, V., Halford, J. C. G., Bennet, K. M., & Harrold, J. A. (2018). Postpartum-specific anxiety as a predictor of infant-feeding outcomes and perceptions of infant-feeding behaviours: New evidence for childbearing-specific measures of mood. *Archives of Women's Mental Health, 21*, 181–191.

Fearon, R. M. P., & Roisman, G. I. (2017). Attachment theory: Progress and future directions. *Current Opinion in Psychology, 15*, 131–136. https://doi.org/10.1016/j.copsyc.2017.03.002

Feeney, J., Alexander, R., Noller, P., & Hohaus, L. (2003). Attachment insecurity, depression, and the transition to parenthood. *Personal Relationships, 10*(4), 475–493. https://doi.org/10.1046/j.1475-6811.2003.00061.x

Festinger, L. (1957). *A theory of cognitive dissonance.* Stanford University Press.

Field, T. (2017). Prenatal anxiety effects: A review. *Infant Behavior and Development, 49*, 120–128. https://doi.org/10.1016/j.infbeh.2017.08.008

Fisher, J., de Mello, M. C., Patel, V., Rahman, A., Tran, T., Holton, S., & Holmes, W. (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: A systematic review. *Bulletin of the World Health Organization, 90*(2), 139–149. https://doi.org/10.2471/BLT.11.091850

Folliard, K. J., Crozier, K., & Wadnerkar Kamble, M. M. (2020). "Crippling and unfamiliar": Analysing the concept of perinatal anxiety; definition, recognition and implications for psychological care provision for women during pregnancy and early motherhood. *Journal of Clinical Nursing, 29*, 4454–4468.

Fraley, R. C. (2002). Attachment stability from infancy to adulthood: Meta-analysis and dynamic modelling of developmental mechanisms. *Personality and Social Psychology Review, 6*(2), 123–151. https://doi.org/10.1207/S15327957PSPR0602_03

Furber, C. M., Garrod, D., Maloney, E., Lovell, K., & McGowan, L. (2009). A qualitative study of mild to moderate psychological distress during pregnancy. *International Journal of Nursing Studies, 46*, 669–677.

Furtado, M., Chow, C. H. T., Owais, S., Frey, B. N., & Van Lieshout, R. J. (2018). Risk factors of new-onset anxiety and anxiety exacerbation in the perinatal period: A systematic review and meta-analysis. *Journal of Affective Disorders, 238*, 626–635.

Galbally, M., Stein, A., Hoegfeldt, C. A., & van IJzendoorn, M. (2020). From attachment to mental health and back. *The Lancet Psychiatry, 7*(10), 832–834. https://doi.org/10.1016/s2215-0366(20)30337-0

Gastaldon, C., Solmi, M., Correll, C. U., Barbui, C., & Schoretsanitis, G. (2022). Risk factors of postpartum depression and depressive symptoms: Umbrella review of current evidence from systematic reviews and meta-analyses of observational studies. *The British Journal of Psychiatry, 221*(4), 591–602. https://doi.org/10.1192/bjp.2021.222

Gavin, N. I., Gaynes, B. N., Lohr, K. N., Meltzer-Brody, S., Gartlehner, G., & Swinson, T. (2005). A systematic review of prevalence and incidence. *Obstetrics and Gynaecology, 106*(5), 1071–1083. https://doi.org/10.1097/01.AOG.0000183597.31630.db

George, A., Luz, R. F., De Tychey, C., Thilly, N., & Spitz, E. (2013). Anxiety symptoms and coping strategies in the perinatal period. *BMC Pregnancy and Childbirth, 13*, Article 233. https://doi.org/10.1186/1471-2393-13-233

Gerhardt, B. C., Serra, J. G., Zimmer, C., & Arteche, A. X. (2024). *Role of self-criticism in postpartum mental health: A network analysis.* Psicologia: Reflexão e Crítica, 37, Article 38. https://doi.org/10.1186/s41155-024-00321-2

Glover, V. (2007). The effects of maternal anxiety or stress during pregnancy on the fetus and the long-term development of the child. *Nutrition and Health, 19*, 61–62.

Gorham, M. (2018). *Exploring women's experiences of anxiety and providing care to their babies during pregnancy and the year after birth: An interpretative phenomenological analysis (IPA)* [Master's thesis, University of Limerick]. https://hdl.handle.net/10344/9701

Goldman, L. S., Nielsen, N. H., Champion, H. C., & for the Council on Scientific Affairs, A. M. A. (1999).Awareness, Diagnosis, and Treatment of Depression. Journal of General Internal Medicine,14(9), 569–580. https://doi.org/10.1046/j.1525-1497.1999.03478.x

Green, J. M., & Kafetsios, K. (1997). Positive experiences of early motherhood: Predictive variables from a longitudinal study. *Journal of Reproductive and Infant Psychology, 15*, 141–157.

Greene, M. M., Rossman, B., Meier, P., & Patar, K. (2018). Elevated maternal anxiety in the NICU predicts worse fine motor outcome in VLBW infants. *Early Human Development, 116*, 33–39.

Grigg, C. P., & Tracy, S. K. (2013). New Zealand's unique maternity system. *Women and Birth, 26*(1), e59–e64. https://doi.org/10.1016/j.wombi.2012.09.006

Grigg, C., Tracy, S., Tracy, M., Schmied, V., & Monk, A. (2015). Transfer from primary maternity unit to tertiary hospital in New Zealand—Timing, frequency, reasons, urgency, and outcomes: Part of the Evaluating Maternity Units study. *Midwifery, 31*(9), 879–887. https://doi.org/10.1016/j.midw.2015.04.018

Grigoriadis, S., Graves, L., Peer, M., Mamisashvili, L., Tomlinson, G., Vigod, S. N., Dennis, C. L., Steiner, M., Brown, C., Cheung, A., Dawson, H., Rector, N. A., Guenette, M., & Richter, M. (2019). A systematic review and meta-analysis of the effects of antenatal anxiety on postpartum outcomes. *Archives of Women's Mental Health, 22*, 543–556.

Gruen, D. S. (1990). Postpartum depression: A debilitating yet often unassessed problem. *Health & Social Work, 15*(4), 261–270. https://doi.org/10.1093/hsw/15.4.261

Guo, L., Zhang, J., Mu, L., & Ye, Z. (2020). Preventing postpartum depression with mindful self‐compassion intervention: A randomized controlled study. *Journal of Nervous and Mental Disease, 208*(2), 101–107. https://doi.org/10.1097/NMD.0000000000001096

Hahn-Holbrook, J., Cornwell-Hinrichs, T., & Anaya, I. (2018). Economic and health predictors of national postpartum depression prevalence: A systematic review, meta-analysis, and

meta-regression of 291 studies from 56 countries. *Frontiers in Psychiatry, 8*, Article 248. https://doi.org/10.3389/fpsyt.2017.00248

Hammar, A., & Ardal, G. (2009). Cognitive functioning in major depression—A summary. *Frontiers in Human Neuroscience, 3*, Article 26. https://doi.org/10.3389/neuro.09.026.2009

Harmon-Jones, E., & Mills, J. (2019). An introduction to cognitive dissonance theory and an overview of current perspectives on the theory. In E. Harmon-Jones (Ed.), *Cognitive dissonance: Reexamining a pivotal theory in psychology* (2nd ed., pp. 3–24). American Psychological Association. https://doi.org/10.1037/0000135-001

Hannerfors, A.-K., Hellgren, C., Schijven, D., Iliadis, S. I., Comasco, E., Skalkidou, A., Olivier, J. D. A., & Sundström-Poromaa, I. (2015). Treatment with serotonin reuptake inhibitors during pregnancy is associated with elevated corticotropin-releasing hormone levels. *Psychoneuroendocrinology, 58*, 104–113. https://doi.org/10.1016/j.psyneuen.2015.04.009

Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology, 43*(1), 1–12. https://doi.org/10.1037/0012-1649.43.1.1

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). Blackwell. (Original work published 1927)

Helen Clark Foundation. (2022). *Ahurutia te rito: It takes a village*. Helen Clark Foundation. https://helenclark.foundation/publications-and-medias/ahurutia-te-rito-it-takes-a-village/

Henderson, A., Harmon, S., & Newman, H. (2016). The price mothers pay, even when they are not buying it: Mental health consequences of idealized motherhood. *Sex Roles, 74*, 512–526. https://doi.org/10.1007/s11199-015-0534-5

Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review, 94*(3), 319–340. https://doi.org/10.1037/0033-295X.94.3.319

Highet, N., Stevenson, A. L., Purtell, C., & Coo, S. (2014). Qualitative insights into women's personal experiences of perinatal depression and anxiety. *Women and Birth, 27*(3), 179–184. https://doi.org/10.1016/j.wombi.2014.05.003

Holden, G., Corter, A. L., Hatters-Friedman, S., & Soosay, I. (2019, September 2). Brief Report: A qualitative study of maternal mental health services in New Zealand: Perspectives of Māori and Pacific mothers and midwives. *Asia-Pacific Psychiatry, 12*, e12369. https://doi.org/10.1111/appy.12369

Holzschneider, K., & Mulert, C. (2011). Neuroimaging in anxiety disorders. *Dialogues in Clinical Neuroscience, 13*(4), 453–461. https://doi.org/10.31887/DCNS.2011.13.4/kholzschneider

Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: a review of progress and challenges. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *19*(3), 313–327. https://doi.org/10.1002/wps.20769

Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgram, J. (2014). Perinatal mental health 1: Non-psychotic mental disorders in the perinatal period. *The Lancet, 384*, 1775–178.

Huggins, B., Jones, C., Adeyinka, O., Ofomata, A., Drake, C., & Kondas, C. (2020). Racial disparities in perinatal mental health. *Psychiatric Annals, 50*(11), 489–493. https://doi.org/10.3928/00485713-20201007-02

Hunter, S., & Dickson, C. (2024). Women's experiences of the transition to motherhood and self‐compassion. *Journal of Family and Child Health*, 1 (1), 28–39. https://doi.org/10.12968/jfch.2024.1.1.28

Iturralde, E., Hsiao, C. A., Nkemere, L., & others. (2021). Engagement in perinatal depression treatment: A qualitative study of barriers across and within racial/ethnic groups. *BMC Pregnancy and Childbirth, 21*, Article 512. https://doi.org/10.1186/s12884-021-03969-1

Jagtap, A., Jagtap, B., Jagtap, R., Lamture, Y., & Gomase, K. (2023). Effects of Prenatal Stress on Behavior, Cognition, and Psychopathology: A Comprehensive Review. *Cureus*, *15*(10), e47044. https://doi.org/10.7759/cureus.47044

Jeong, Y. J., Nho, J. H., Kim, H. Y., & Kim, J. Y. (2021). Factors influencing quality of life in early postpartum women. *International Journal of Environmental Research and Public Health, 18*(6), 2988. https://doi.org/10.3390/ijerph18062988

Job, K. A. (2022). *Exploring labour and birth experience and relationships with maternal sleep and symptoms of postnatal mental distress in Aotearoa/New Zealand: A mixed methods study* (Master's thesis, Massey University).

Johnson, J., Hope, L., Jones, L., & Bradley, E. (2023). *A mixed methods study to understand perinatal mental healthcare referral decisions among midwives and health visitors in the UK*. *Frontiers in Psychiatry, 14*, Article 1056987. https://doi.org/10.3389/fpsyt.2023.1056987

Jones, K., Harrison, V., Moulds, M. L., & others. (2022). A qualitative analysis of feelings and experiences associated with perinatal distress during the COVID-19 pandemic. *BMC Pregnancy and Childbirth, 22*, Article 572. https://doi.org/10.1186/s12884-022-04876-9

Kammerer, M., Taylor, A., & Glover, V. (2006). The HPA axis and perinatal depression: A hypothesis. *Archives of Women's Mental Health, 9*(4), 187–196. https://doi.org/10.1007/s00737-006-0131-2

Kauuppi, S., Sillanpää, M., & Mäki, J. (2012). Postnatal depression: When reality does not match expectations. In *Perinatal depression* (pp. 54–78). https://doi.org/10.5772/33013

Kay, T. L., Moulson, M. C., Vigod, S. N., Schoueri-Mychasiw, N., & Singla, D. R. (2024). The role of social support in perinatal mental health and psychosocial stimulation. *The Yale Journal of Biology and Medicine, 97*(1), 3–16. https://doi.org/10.59249/WMGE9032

Keefe, R. H., Brownstein-Evans, C., & Rouland Polmanteer, R. S. (2016). Having our say: African-American and Latina mothers provide recommendations to health and mental

health providers working with new mothers living with postpartum depression. *Social Work in Mental Health, 14*(5), 497–508. https://doi.org/10.1080/15332985.2016.1140699

Kirkpatrick, C. E., & Lee, S. (2022). Comparisons to picture-perfect motherhood: How Instagram's idealized portrayals of motherhood affect new mothers' well-being. *Computers in Human Behavior, 137*, 107417. https://doi.org/10.1016/j.chb.2022.107417

Kleinert, T., Nash, K., Leota, J., Koenig, T., Heinrichs, M., & Schiller, B. (2022). A self-controlled mind is reflected by stable mental processing. *Psychological Science, 33*(12), 2123–2137. https://doi.org/10.1177/09567976221110136

Kvale, S. (2002). Dialogue as oppression and interview research. Paper presented at the Nordic Educational Research Association Conference, Tallinn, Estonia, March 7–9.

Kyle, M., & Aileone, L. (2013). *Mapping the rural midwifery workforce in New Zealand*. Midwifery and Maternity Providers Organisation & Health Workforce New Zealand.

Laney, E. K., Hall, M. E. L., Anderson, T. L., & Willingham, M. M. (2015). Becoming a mother: The influence of motherhood on women's identity development. *Identity, 15*(2), 126–145. https://doi.org/10.1080/15283488.2015.1023440

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology, 16*(2), 182–198. https://doi.org/10.1080/14780887.2018.1540655

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*(2), 102–120.

Leach, C. W. (2016). The meta-theory of examining emotion in social relationships. *Psychological Inquiry, 27*(2), 113–116. https://doi.org/10.1080/1047840X.2016.1162129

Leavy, P. (2020). Introduction to the Oxford Handbook of Qualitative Research, Second Edition. In *The Oxford handbook of qualitative research* (2nd ed., pp. 1–20). https://doi.org/10.1093/oxfordhb/9780190847388.013.9

Levinson, D. F., & Nichols, W. E. (2017). Genetics of depression. In *Charney & Nestler's Neurobiology of Mental Illness* (4th ed., pp. 301–313). Oxford University Press.

Low, P., Paterson, J., Wouldes, T., Carter, S., Williams, M., & Percival, T. (2005). Factors affecting antenatal care attendance by mothers of Pacific infants living in New Zealand. *New Zealand Medical Journal, 118*(1216), U1489.

Lugg, W. (2022). The biopsychosocial model – History, controversy and Engel. *Australasian Psychiatry, 30*(1), 55–59. https://doi.org/10.1177/10398562211037333

Manuel, J. I., Martinson, M. L., Bledsoe-Mansori, S. E., & Bellamy, J. L. (2012). The influence of stress and social support on depressive symptoms in mothers with young children. *Social Science & Medicine, 75*(11), 2013–2020. https://doi.org/10.1016/j.socscimed.2012.07.034

Maternal Care Action Group NZ. (2022**).** *Maternal mental health report* [Submission no. 086 to the Productivity Commission's *A fair chance for all* inquiry]. New Zealand Treasury. https://www.treasury.govt.nz/sites/default/files/2024-05/pc-inq-fcfa-sub-086-maternal-care-action-group-nz.pdf

Matthey, S. (2008). Using the Edinburgh Postnatal Depression Scale to screen for anxiety disorders. *Depression and Anxiety, 25*(11), 926–931. https://doi.org/10.1002/da.20415

McCarthy, M., Houghton, C., & Matvienko‐Sikar, K. (2021). Women's experiences and perceptions of anxiety and stress during the perinatal period: A systematic review and qualitative evidence synthesis. *BMC Pregnancy and Childbirth, 21*(1), Article 811. https://doi.org/10.1186/s12884-021-04271-w

McCormack, C., Hutchinson, D., Burns, L., Wilson, J., Elliot, E., Allsop, S., Najman, J., Jacobs, S., Rossen, L., Olsson, C., & Mattick, R. (2017). Prenatal alcohol consumption between conception and recognition of pregnancy. *Alcohol: Clinical and Experimental Research, 41*, 369–378. https://doi.org/10.1111/acer.13305

Meghani, D. T., Vozar, T. M., Maki, K., Clarke, U., & Bartolini, E. (2024). Psychological aspects of perinatal mental health. In A. Wenzel (Ed.), *The Routledge International Handbook of*

Perinatal Mental Health Disorders (pp. 26–52). Routledge. https://doi.org/10.4324/9781003206903-4

Meltzer-Brody, S., Howard, L. M., Bergink, V., Vigod, S., Jones, I., Munk-Olsen, T., Honikman, S., & Milgrom, J. (2018). Postpartum psychiatric disorders. *Nature Reviews Disease Primers, 4*, Article 18022. https://doi.org/10.1038/nrdp.2018.22

Meltzer-Brody, S., & Rubinow, D. (2021). An overview of perinatal mood and anxiety disorders: Epidemiology and etiology. In E. Cox (Ed.), *Women's mood disorders* (pp. 19–36). Springer. https://doi.org/10.1007/978-3-030-71497-0_2

Mercer, R. T. (1985). The process of maternal role attainment over the first year. *Nursing Research, 34*(4), 198–204. https://doi.org/10.1097/00006199-198507000-00002

Merritt, M. (2005). *A case study for helping to prevent postnatal depression: Towards a cultural tool for Māori women* (Master's thesis, Massey University).

Micali, N., Simonoff, E., & Treasure, J. (2011). Pregnancy and post-partum depression and anxiety in a longitudinal general population cohort: The effect of eating disorders and past depression. *Journal of Affective Disorders, 131*(1–3), 150–157. https://doi.org/10.1016/j.jad.2010.09.034

Ministry of Health. (2012). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Ministry of Health.

Miranda, R., & Mennin, D. S. (2007). Depression, generalized anxiety disorder, and certainty in pessimistic predictions about the future. *Cognitive Therapy and Research, 31*(1), 71–82. https://doi.org/10.1007/s10608-006-9063-4

Mitchell, A. E., Whittingham, K., Steindl, S., & Kirby, J. N. (2018). Feasibility and acceptability of a brief online self-compassion intervention for mothers of infants. *Archives of Women's Mental Health, 21*(5), 553–561. https://doi.org/10.1007/s00737-018-0829-y

Mughal, M. K., Giallo, R., Arnold, P. D., Benzies, K., Kehler, H., Bright, K., & Kingston, D. (2018). Trajectories of maternal stress and anxiety from pregnancy to three years and

child development at 3 years of age: Findings from the All Our Families (AOF) pregnancy cohort. *Journal of Affective Disorders, 234*, 318–326. https://doi.org/10.1016/j.jad.2018.02.095

Moore, S. E., & Côté-Arsenault, D. (2018). Navigating an uncertain journey of pregnancy after perinatal loss. *Illness, Crisis & Loss, 26*(1), 58–74. https://doi.org/10.1177/1054137317740802

Moses-Kolko, E. L., Perlman, S. B., Wisner, K. L., James, J., Saul, A. T., & Phillips, M. L. (2010). Abnormally reduced dorsomedial prefrontal cortical activity and effective connectivity with amygdala in response to negative emotional faces in postpartum depression. *American Journal of Psychiatry, 167*(11), 1373–1380. https://doi.org/10.1176/appi.ajp.2010.09081235

Mothers Helpers. (2015). *NZ PND survey results* [PDF]. Mothers Helpers. https://www.mothershelpers.co.nz/wp-content/uploads/2015/12/NZ-PND-Survey-Results.pdf

Mróz, M., Stobnicka, D., Marcewicz, A., Szlendak, B., & Iwanowicz-Palus, G. (2024). Stress and Coping Strategies among Women in Late Motherhood. *Journal of Clinical Medicine*, *13*(7), 1995. https://doi.org/10.3390/jcm13071995

Mulder, E. J., De Medina, P. R., Huizink, A. C., Van den Bergh, B. R., Buitelaar, J. K., & Visser, G. H. (2002). Prenatal maternal stress: Effects on pregnancy and the (unborn) child. *Early Human Development, 70*(1), 3–14.

National Collaborating Centre for Mental Health (UK). (2015). *Children's attachment: Attachment in children and young people who are adopted from care, in care, or at high risk of going into care (NICE Guideline No. 26)*. National Institute for Health and Care Excellence. https://www.ncbi.nlm.nih.gov/books/NBK338143/

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing, 18*(2), 34–35.

Noon, E. J. (2018a). Interpretive phenomenological analysis: An appropriate methodology for educational research? *Journal of Perspectives in Applied Academic Practice, 6*(1), 75–83. https://doi.org/10.14297/jpaap.v6i1.304

O'Connor, T. G., Heron, J., Golding, J., Beveridge, M., & Glover, V. (2002). Maternal antenatal anxiety and children's behavioural/emotional problems at 4 years. *The British Journal of Psychiatry, 180*(6), 502–508.

O'Hara, M. W., & McCabe, J. E. (2013). Postpartum Depression: Current Status and Future Directions. Annual Review of Clinical Psychology, 9(1), 379–407. https://doi.org/10.1146/annurev-clinpsy-050212-185612

O'Hara, M. W., & Wisner, K. L. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice & Research Clinical Obstetrics & Gynaecology, 28*(1), 3–12. https://doi.org/10.1016/j.bpobgyn.2013.09.002

O'Mahen, H., Fedock, G., Henshaw, E., Himle, J. A., Forman, J., & Flynn, H. A. (2012). Modifying CBT for perinatal depression: What do women want? *Cognitive and Behavioral Practice, 19*(2), 359–371. https://doi.org/10.1016/j.cbpra.2011.05.005

Onyemaechi, C. I., Aroyewun, B. A., & Ifeagwazi, C. M. (2017). Postpartum depression: The role of self-esteem, social support and age. *IFE PsychologIA, 25*(2).

Parkash, K. R. (2021). *Beyond baby blues: A phenomenological study exploring postpartum depression and screening efficacy* (Publication No. 28546295) [Doctoral dissertation, The Chicago School of Professional Psychology]. *ProQuest Dissertations & Theses Global*.

Patterson, J. A., Foureur, M., & Skinner, J. P. (2011). Patterns of transfer in labour and birth in rural New Zealand. *Rural and Remote Health, 11*(2), Article 1710.

Perinatal and Maternal Mortality Review Committee (PMMRC). (2022). *Fifteenth annual report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2022*. Health Quality & Safety Commission. https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/PMMRC/Publications-resources/15thPMMRC-report-final.pdf

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20*(1), 7–14.

Prenoveau, J. M., Craske, M. G., West, V., Giannakakis, A., Zioga, M., Lehtonen, A., & Cooper, P. (2017). Maternal postnatal depression and anxiety and their association with child emotional negativity and behavior problems at two years. *Developmental Psychology, 53*(1), 50.

Price, S. L., Aston, M., Monaghan, J., Sim, M., Tomblin Murphy, G., Etowa, J., Pickles, M., Hunter, A., & Little, V. (2017). Maternal knowing and social networks: Understanding first-time mothers' search for information and support through online and offline social networks. *Qualitative Health Research, 28*(10), 1552–1563. https://doi.org/10.1177/1049732317748314

Quirin, M., Pruessner, J. C., & Kuhl, J. (2008). HPA system regulation and adult attachment anxiety: Individual differences in reactive and awakening cortisol. *Psychoneuroendocrinology, 33*(5), 581–590. https://doi.org/10.1016/j.psyneuen.2008.01.013

Radesky, J. S., Zuckerman, B., Silverstein, M., Rivara, F. P., Barr, M., Taylor, J. A., … Barr, R. G. (2013). Inconsolable infant crying and maternal postpartum depressive symptoms. *Pediatrics, 131*(6), e1857–e1864. https://doi.org/10.1542/peds.2012-3316

Räisänen, S., Lehto, S. M., Nielsen, H. S., Gissler, M., Kramer, M. R., & Heinonen, S. (2014). Risk factors for and perinatal outcomes of major depression during pregnancy: A population-based analysis during 2002–2010 in Finland. *BMJ Open, 4*(11), e004883. https://doi.org/10.1136/bmjopen-2014-004883

Rallis, S., Skouteris, H., McCabe, M., & Milgrom, J. (2014). The transition to motherhood: Towards a broader understanding of perinatal distress. *Women and Birth, 27*(1), 68–71. https://doi.org/10.1016/j.wombi.2013.12.004

Reck, C., Müller, M., Tietz, A., & Möhler, E. (2013). Infant distress to novelty is associated with maternal anxiety disorder and especially with maternal avoidance behavior. *Journal of Anxiety Disorders, 27*(4), 404–412. https://doi.org/10.1016/j.janxdis.2013.03.009

Reid, J., Anderson, A., Cormack, D., Reid, P., & Harwood, M. (2018). The experience of gestational diabetes for Indigenous Māori women living in rural New Zealand: Qualitative research informing the development of decolonising interventions. *BMC Pregnancy and Childbirth, 18*(1). https://doi.org/10.1186/s12884-018-2103-8

Reupert, A., Maybery, D., Nicholson, J., Göpfert, M., & Seeman, M. V. (2015). *Parental psychiatric disorder: Distressed parents and their families*. Cambridge University Press.

Reweti, A. (2023). Understanding how whānau-centred initiatives can improve Māori health in Aotearoa New Zealand. *Health Promotion International, 38*(4). https://doi.org/10.1093/heapro/daad070

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.

Riley, S., & Chamberlain, K. (2021). Designing qualitative research in psychology. In M. McCullen (Ed.), *SAGE handbook of qualitative research design*. SAGE.

Riley, S., & LaMarre, A. (2003). Developments in qualitative inquiry. In M. McCullen (Ed.), *APA handbook of research methods in psychology*. APA.

Rocca, E., & Anjum, R. L. (2020). Complexity, Reductionism, and the Biomedical Model. In R. L. Anjum, S. Copeland, & E. Rocca (Eds.), *Rethinking causality, complexity and evidence for the unique patient* (pp. 87–104). Springer. https://doi.org/10.1007/978-3-030-41239-5_5

Rocha, N. A. C. F., dos Santos Silva, F. P., dos Santos, M. M., & Dusing, S. C. (2020). Impact of mother–infant interaction on development during the first year of life: A systematic review. *Journal of Child Health Care, 24*(3), 365–385. https://doi.org/10.1177/1367493519864742

Roddy Mitchell, A., Gordon, H., Lindquist, A., Walker, S. P., Homer, C. S. E., Middleton, A., Cluver, C. A., Tong, S., & Hastie, R. (2023). Prevalence of perinatal depression in low- and middle-income countries: A systematic review and meta-analysis. *JAMA Psychiatry, 80*(5), 425–431. https://doi.org/10.1001/jamapsychiatry.2023.0069

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing, 53*(3), 304–310.

Rubertsson, C., Hellström, J., Cross, M., & Sydsjö, G. (2014). Anxiety in early pregnancy: Prevalence and contributing factors. *Archives of Women's Mental Health, 17*(3), 221–228.

Sanjuan, J., Martin-Santos, R., Garcia-Esteve, L., Carot, J. M., Guillamat, R., Gutierrez-Zotes, A., … de Frutos, R. (2008). Mood changes after delivery: Role of the serotonin transporter gene. *The British Journal of Psychiatry, 193*(5), 383–388. https://doi.org/10.1192/bjp.bp.107.045427

Sawyer Cohen, J. (2010). *Mindfulness and self-compassion in the transition to motherhood: A prospective study of postnatal mood and attachment* (Publication No. 3447974) [Doctoral dissertation, Columbia University]. ProQuest Dissertations & Theses Global.

Sbrilli, M. D., Haigler, K., & Laurent, H. K. (2021). The indirect effect of parental intolerance of uncertainty on perinatal mental health via mindfulness during COVID-19. Mindfulness, 12(8), 1999–2008.https://doi.org/10.1007/s12671-021-01657-x

Schetter, C. D., & Tanner, L. (2012). Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice. *Current opinion in psychiatry, 25*(2), 141.

Scott, K. M., Wells, J. E., Angermeyer, M., et al. (2010). Gender and the relationship between marital status and first onset of mood, anxiety and substance use disorders. *Psychological Medicine, 40*(9), 1495–1505. https://doi.org/10.1017/s0033291709991942

Severo, M., Ventriglio, A., Bellomo, A., Iuso, S., & Petito, A. (2023). Maternal perinatal depression and child neurocognitive development: A relationship still to be clarified. *Frontiers in Psychiatry*, *14*, 1151897. https://doi.org/10.3389/fpsyt.2023.1151897

Shenoy, D. P., Lee, C., & Trieu, S. L. (2016). The mental health status of single-parent community college students in California. *Journal of American College Health, 64*(2), 152–156. https://doi.org/10.1080/07448481.2015.1057147

Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis, 22*(1), 16-31.

Signal, T. L., Paine, S. J., Sweeney, B., Muller, D., Priston, M., Lee, K., Gander, P., & Huthwaite, M. (2017). The prevalence of symptoms of depression and anxiety, and the level of life stress and worry in New Zealand Māori and non-Māori women in late pregnancy. *The Australian and New Zealand Journal of Psychiatry, 51*(2), 168–176.

Silver, M., Moore, C. M., Villamarin, V., et al. (2018). White matter integrity in medication-free women with peripartum depression: A tract-based spatial statistics study. *Neuropsychopharmacology, 43*(7), 1573–1580. https://doi.org/10.1038/s41386-018-0023-y

Smith, G. H. (1992b, November). *Tane-nui-a-rangi's legacy: Propping up the sky. Kaupapa Māori as resistance and intervention* (Conference Presentation). New Zealand Association for Research in Education/Australia Association for Research in Education Joint Conference, Deakin University, Australia.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. *Qualitative Research in Psychology, 6*(4), 346–347.

Smith, J. A., & Osborn, M. (2004). Interpretative phenomenological analysis. In G. M. Breakwell (Ed.), *Doing social psychology research* (pp. 229–254). The British Psychological Society and Blackwell Publishing Ltd.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain, 9*(1), 41–42.

Sockol, L. E., Epperson, C. N., & Barber, J. P. (2014). The relationship between maternal attitudes and symptoms of depression and anxiety among pregnant and postpartum first-time mothers. *Archives of Women's Mental Health, 17*(3), 199–212. https://doi.org/10.1007/s00737-014-0424-9

Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research, 34*(5 Pt 2), 1101-1118.

Sonnenburg, C., & Miller, Y. (2021). Postnatal depression: The role of "good mother" ideals and maternal shame in a community sample of mothers in Australia. *Sex Roles, 85*, Article 85. https://doi.org/10.1007/s11199-021-01239-0

Sorsa, M. A., Kylmä, J., & Bondas, T. E. (2021). Contemplating Help-Seeking in Perinatal Psychological Distress-A Meta-Ethnography. *International journal of environmental research and public health*, *18*(10), 5226. https://doi.org/10.3390/ijerph18105226

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development, 7*(4), 349–367. https://doi.org/10.1080/14616730500365928

Staneva, A., Bogossian, F., Pritchard, M., & Wittkowski, A. (2015). The effects of maternal depression, anxiety, and perceived stress during pregnancy on preterm birth: A systematic review. *Women and Birth, 28*(3), 179–193.

Stats New Zealand. (n.d.). *Population*.Retrieved September 01, 2024, from https://www.stats.govt.nz/topics/population

Stats New Zealand. (2024, February 15). *Births and deaths: Year ended June 2024*. https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-june-2024

Stein, A., Craske, M. G., Lehtonen, A., Harvey, A., Savage-McGlynn, E., Davies, B., Goodwin, J., Murray, L., Cortina-Borja, M., & Counsell, N. (2012). Maternal cognitions and mother-infant interaction in postnatal depression and generalized anxiety disorder. *Journal of Abnormal Psychology, 121*(4), 795–809. https://doi.org/10.1037/a0026847

Stein, A., Pearson, R. M., Goodman, S. H., Rapa, E., Rahman, A., McCallum, M., & Pariante, C. M. (2014). Effects of perinatal mental disorders on the fetus and child. *The Lancet, 384*(9956), 1800–1819.

Sutherland, J. A. (2010). Mothering, guilt and shame. *Sociology Compass*, *4*(5), 310–321. https://doi.org/10.1111/j.1751-9020.2010.00283.x

Talge, N. M., Neal, C., & Glover, V. (2007). Antenatal maternal stress and long-term effects on child neurodevelopment: How and why? *Journal of Child Psychology and Psychiatry, 48*(3–4), 245–261.

Tate, M. K. (2023). The impact of social comparison via social media on maternal mental health, within the context of the intensive mothering ideology: A scoping review of the literature. *Issues in Mental Health Nursing, 44*(9), 854–870. https://doi.org/10.1080/01612840.2023.2238813

Te Whatu Ora. (2022). *Te Pae Tata: Interim New Zealand Health Plan 2022*. https://www.tewhatuora.govt.nz/publications/te-pae-tata-interim-new-zealand-health-plan-2022/

The Ministry of Health. (2021, November 26). *Maternal mental health service provision in New Zealand: Stocktake of District Health Board services*. Manatū Hauora / The Ministry of Health.

Travis, L. A., Lyness, J. M., Shields, C. G., King, D. A., & Cox, C. (2004). Social support, depression, and functional disability in older adult primary-care patients. *The American Journal of Geriatric Psychiatry, 12*(3), 265–271. https://doi.org/10.1097/00019442-200405000-00005

Turpin, G., Barley, V., Beail, N., Seaire, J., Slade, P., Smith, J., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested guidelines for trainees and courses. *Clinical Psychology Forum, Division of Clinical Psychology of the British Psychological Society*.

Uher, R., & McGuffin, P. (2010). The moderation by the serotonin transporter gene of environmental adversity in the etiology of depression: 2009 update. *Molecular Psychiatry, 15*(1), 18–22.

Valdez, C. R., Ramirez Stege, A., Martinez, E., D'Costa, S., & Chavez, T. (2017). A community‐responsive adaptation to reach and engage Latino families affected by maternal depression. *Family Process, 57*(2), 539–556. https://doi.org/10.1111/famp.12310

Van den Bergh, B. R., Mennes, M., Oosterlaan, J., Stevens, V., Stiers, P., Marcoen, A., & Lagae, L. (2005). High antenatal maternal anxiety is related to impulsivity during performance on cognitive tasks in 14- and 15-year-olds. *Neuroscience & Biobehavioral Reviews, 29*(2), 259–269.

Verdoux, H., Sutter, A. L., Glatigny-Dallay, E., & Minisini, A. (2002). Obstetrical complications and the development of postpartum depressive symptoms: A prospective survey of the MATQUID cohort. *Acta Psychiatrica Scandinavica, 106*(3), 212–219. https://doi.org/10.1034/j.1600-0447.2002.02398.x

Viktorin, A., Meltzer-Brody, S., Kuja-Halkola, R., Sullivan, P. F., Landén, M., Lichtenstein, P., & Magnusson, P. K. (2016). Heritability of perinatal depression and genetic overlap with nonperinatal depression. *American Journal of Psychiatry, 173*(2), 158–165. https://doi.org/10.1176/appi.ajp.2015.15010085

Vidal, J., Ciudad‐Fernández, V., Navarrete, J., Soler, J., Schmidt, C., Molinari, G., & Cebolla, A. (2024). *From self‐criticism to self‐compassion: Exploring the mediating role of two emotion dysregulation variables in their relationship to depressive symptoms. Current Psychology, 43*, 26,539–26,547. https://doi.org/10.1007/s12144-024-06325-6

Waldie, K. E., Peterson, E. R., D'Souza, S., Underwood, L., Pryor, J. E., Carr, P. A., Grant, C., & Morton, S. M. B. (2015). Depression symptoms during pregnancy: Evidence from Growing up in New Zealand. *Journal of Affective Disorders, 186*, 66–73. https://doi.org/10.1016/j.jad.2015.06.009

Walker, L. O., & Murry, N. (2022). Maternal Stressors and Coping Strategies During the Extended Postpartum Period: A Retrospective Analysis with Contemporary Implications. *Women's Health Reports*, *3*(1), 104. https://doi.org/10.1089/whr.2021.0134

Wardrop, A. A., & Popadiuk, N. E. (2013). Women's experiences with postpartum anxiety: Expectations, relationships, and sociocultural influences. *The Qualitative Report, 18*(40), 1–24. https://doi.org/10.46743/2160-3715/2013.1564

Warfa, N., Harper, M., Nicolais, G., & Bhui, K. (2014). Adult attachment style as a risk factor for maternal postnatal depression: A systematic review. *BMC Psychology, 2*, 56. https://doi.org/10.1186/s40359-014-0056-x

Wenzel, A. (2013). Strategic decision making in cognitive behavioral therapy. American Psychological Association. https://doi.org/10.1037/14188-005

Whitehead, J., Davie, G., de Graaf, B., Crengle, S., Fearnley, D., Smith, M., Lawrenson, R., & Nixon, G. (2022). Defining rural in Aotearoa New Zealand: A novel geographic classification for health purposes. *New Zealand Medical Journal, 135*(1559), 24–40.

Wilkinson, C., Gluckman, P., & Low, F. (2022). *Perinatal mental distress: An under-recognised concern*. The University of Auckland. https://doi.org/10.17608/k6.auckland.21112594.v1

Will, T. R., Proaño, S. B., Thomas, A. M., Kunz, L. M., Thompson, K. C., Ginnari, L. A., Jones, C. H., Lucas, S. C., Reavis, E. M., Dorris, D. M., & Meitzen, J. (2017). Problems and progress regarding sex bias and omission in neuroscience research. *eNeuro, 4*(6), ENEURO.0278-17.2017. https://doi.org/10.1523/ENEURO.0278-17.2017

Willig, C. (2014). Discourses and discourse analysis. In U. Flick (Ed.), *The SAGE handbook of qualitative data analysis* (pp. 341–353). SAGE. https://doi.org/10.4135/9781446282243.n23

Willig, C., & Stainton-Rogers, W. (Eds.). (2008). *The SAGE handbook of qualitative research in psychology*. SAGE. https://doi.org/10.4135/9781848607927

Winnicott, D. W. (1945). Primitive emotional development. *The International Journal of Psycho-Analysis, 26*, 137–143.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena: A study of the first not-me possession. *International Journal of Psychoanalysis, 34*(2), 89–97.

Wisner, K. L., Sit, D. K. Y., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Costantino, M. L., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry, 70*(5), 490–498. https://doi.org/10.1001/jamapsychiatry.2013.87

World Health Organisation. (n.d.). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

World Health Organisation. (2019). F53.0 – Postpartum depression. In *International Classification of Diseases (10th ed.)*. https://icd.who.int/browse10/2019/en#/F53.0

World Health Organisation. (2022). *Guide for Integrating Perinatal Mental Health into Maternal and Child Health Services*. Geneva: World Health Organisation. https://www.who.int/publications/i/item/9789240057142

Yang, K., Wu, J., & Chen, X. (2022). Risk factors of perinatal depression in women: A systematic review and meta-analysis. *BMC Psychiatry, 22*(1), Article 63. https://doi.org/10.1186/s12888-021-03684-3

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Zacher Kjeldsen, M. M., Bricca, A., Liu, X., Frokjaer, V. G., Madsen, K. B., & Munk-Olsen, T. (2022). Family history of psychiatric disorders as a risk factor for maternal postpartum depression: A systematic review and meta-analysis. *JAMA Psychiatry, 79*(10), 1004–1013. https://doi.org/10.1001/jamapsychiatry.2022.2400

APPENDICES

Appendix 1: Participant Information Sheet

Kia ora,

My name is Natalie Thiele, I'm a 33-year-old female living in the beautiful Wānaka, New Zealand. I moved to the region from Christchurch around 10 years ago after falling in love with the scenery and lifestyle that comes with it.

I am doing a Master's Degree in Psychology at Massey University, supervised by Dr Elle Brittain (Ngāti Kahungunu ki Te Wairoa, Ngāti Rakaipaaka). The research prioritises lived experiences and will explore mothers' journeys with perinatal mental distress within the context of Aotearoa / New Zealand. I hope to provide a space where mothers feel comfortable talking about their experiences, ultimately aiming to build awareness and empower individuals, whanau, and the wider community.

If you are interested in participating in this research project, more information is available on the following pages.

Information Sheet

Exploring Mother's Experiences of Perinatal Mental Distress in Aotearoa / New Zealand.

You are invited to take part in a study exploring mother's experiences of perinatal mental distress in Aotearoa / New Zealand. Before you choose whether or not to participate, it's important you understand why the research is being done and what it involves. Please take the time to read the following information carefully and ask me if there is anything that is unclear or if you would like more information. Thank you for reading this.

Terms

Perinatal - The term 'Perinatal' refers to the time period from conception, throughout pregnancy, and up until the first 12 months of the child's life.

Mental Distress - The term 'Mental Distress' is defined here as a state of emotional suffering resulting in anxiety (e.g. recurring restlessness or 'unease', irritability, and/or feelings of impending danger or panic), or depression (e.g. persistent feelings of sad/empty moods, loss of interest in previously enjoyed activites, feelings of hopelessness, and/or low-self-esteem)

What is the purpose of the research?

The purpose of this research is to explore perinatal mental distress (anxiety or depression) from the perspective of mothers who have experienced it. The project aims to add to our understanding of mothers' experiences during the perinatal period, especially about mental distress. A key goal is to hear and prioritise the voices of mothers while exploring the internal and external factors that influence the emergence of anxiety or depression. Ultimately, the hope is to raise awareness, combat stigma, and ensure mothers and their support networks can be empowered to identify patterns and seek help early on.

Am I eligible to take part?

The be included in the study, you must meet the following criteria:

1) Have carried and given birth to a child or children within the last five years
2) Be over the age of 18
3) Have experienced anxiety or depression during your perinatal period, whether self-identified or diagnosed by a health professional, while living in Aotearoa
4) Consider yourself to have been in stable mental health for at least six months, defined here as "living well within the community"

What would my participation in the research involve?

I will conduct the interviews with you in a one-on-one situation. Alternatively, you are welcome to have a friend, family, or another support person present. Interviews will last between 60 to 90 minutes and will be audio recorded and transcribed.

Deciding whether or not to participate
Taking part in this research is entirely voluntary. While deciding whether or not to participate, you may like to discuss the research with friends, family, or healthcare professionals. If you decide to participate, you will be given this information sheet to keep (and be asked to sign a consent form). You can change your mind at any time and withdraw from the study without giving a reason, up until one week after confirming your interview transcript.

If you are interested in taking part in this research, please contact me to discuss the project further. Together we can arrange a time and place to do the interview.

What are my rights as a participant?
Please read the following information carefully as it is important for you to understand it before agreeing to take part in this research:

- All personal information relating to you will be kept confidential. Your identity and interview will be kept confidential, and the transcript will be anonymised so that you cannot be identified in the research in any way. All information that you share will be held securely on Massey University's network, OneDrive, which is a highly secure cloud system.
- You can choose not to answer specific interview questions and will be free to withdraw at any time, up until one week after returning the final copy of your interview transcript. You do not have to explain why you are withdrawing, but please know, that what you share in the interview may influence the research in some way.

Where will the interview take place?
The interview can happen at your home or at a community venue. I am happy to travel to you for the interview. It is important that you feel comfortable, and that the space is quiet so that the interview can be recorded carefully. It may be an option to complete the interview via Zoom if this is preferred, please let me know and we can discuss this option further.

What will happen after the interview?
You will have the opportunity to ask questions should you wish. I will transcribe (write up) the interviews and send you a copy which you will be able to add, remove, or adjust any comments before returning a final version. Once you have confirmed your transcript, you will still have one week to withdraw from the study without needing to provide any reason. Findings from the research will be shared with you either via email, phone, or post (depending on your preference). I am happy to meet with you after this if you would like to discuss the findings further.

What recognition will I receive for my time and involvement?
You will be given a $40 Prezzy card as a thank-you for your participation.

Who should I contact for more information or if I have concerns?
Please know that you are free to email me directly if you have any questions or concerns about the research at any stage of the project. Alternatively, you can contact my supervisor, Dr. Elle Brittain.

Natalie Thiele – Psychology Masters Student

natalierosethiele@gmail.com

Dr. Elle Britian – Clinical Psychologist and Research Supervisor

E.Brittain@massey.ac.nz

If you wish to speak to someone who is not involved with this research project, you can contact an independent health and disability advocate at 0800 555 050 or advocacy@hdc.org.nz

Keeping safe
Because the research is about perinatal mental distress, specifically anxiety or depression, some discussion throughout the interview may bring forward feelings of discomfort. There will be time during the interview to check in on how you're feeling, as well as time at the end when we can talk about how you're feeling. If you become uncomfortable or upset during the interview, we will stop until you feel ok to continue. If you want to talk to someone following the interview, we can assist in accessing a local counsellor or support service.

Counselling and support services in Queenstown and Central Lakes District:

Central Lakes Family Centre: 0508 440255

Primary Mental Health Brief Intervention Service (BIS): 0800 477 1155

SDHB Central Lakes Community Mental Health Service: 0800 467846

People in New Zealand also have the option to text or call 1737 at any time to speak with a trained counsellor.

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 3, Application OM3 24/22. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 3, email humanethics3@massey.ac.nz.

Appendix 2: Recruitment Poster

Seeking Participants for Research on Maternal Mental Health

Are you a mother who has experienced anxiety or depression during pregnancy or within the first 12 months post-partum? We invite you to take part in a local research project exploring mothers' experiences with perinatal mental distress. Your insights could significantly contribute to our understanding and improvement of mental health support for mothers.

Research Details

What will you do?
A one-on-one interview about your experiences with this topic (whānau support welcome)
Privacy and Confidentiality
All responses will be kept anonymous and confidential
Incentive
Participants will be given a $40 prezzy card as a thank you for their time

Eligibility Criteria

- Be over the age of 18
- Have carried and given birth to a child, or children, within the last 5 years
- Have experienced anxiety or depression during your perinatal period while living in Aotearoa (self-identified or diagnosed by a professional)
- Consider yourself as recovered for at least the last 6-months

How to Participate

For more information on this project or to express interest in participating please email **natalierosethiele@gmail.com**

Appendix 3: Consent Form

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

CONSENT FORM

Principle Investigator: Natalie Thiele

Semi-structured interview study exploring mothers' lived experiences with perinatal mental distress in Aotearoa / New Zealand

I have read and understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and that I may withdraw from participating at any time until one week after I have returned my interview transcript. I understand that consent includes agreeing to use my anonymised data in the researchers' project.

	Initial Showing Consent
I confirm that I have read, or had read to me, and understand the Information Sheet for the project in which I have been asked to take part and have had the opportunity to ask questions.	
I have been given sufficient time to consider my participation in this research.	
I understand that my participation is voluntary and that I am free to withdraw at any time up to and during the interview without giving any reason.	
I understand that I am free to withdraw my data without giving any reason up to one week after I have returned my transcript.	
I understand that my participation is confidential and that my responses will be anonymised in the interview transcript and in any reports on this research.	
I understand that the interview will be audio recorded and that the file will be stored securely and only listened to by the Investigator signed below.	
I am clear about who to reach out to if I have any questions about the research.	
I understand my role as a participant in this research project.	
I would like to receive a summary of the findings from the research.	

Participant Declaration:

I, ... (**Participant's** full name) hereby volunteer to participate in the above-named study.

Signed (participant) ..... Date.....

Researcher Declaration:

I, ... (**Investigator's** full name) certify that the details of this procedure have been fully explained and described in writing to the person named above

Signed (participant) ..... Date.....

Appendix 4: Interview Schedule

Planned Interview Questions:

- Can you tell me about what experience you've had with perinatal anxiety or depression?
- What sort of symptoms did you, or those around you, notice?
- Can you describe a particular time during your perinatal period when you felt particularly distressed?
- How did it feel at the time, experiencing anxiety or depression?
- How have you been able to access support? If so, what kind of support?
- Were there any particular strategies or resources you found helpful? If so, what were they?
- What do you feel has stopped you from accessing support? If applicable, why?
- How could your experience of anxiety or depression have been made easier to deal with?
- If you had therapy/external support, how was your experience with it? What was helpful or unhelpful?
- What do you think healthcare professionals could do to better support mothers' experiences of mental distress?
- How have your experiences with anxiety or depression impacted your journey into motherhood?
- How have these experiences impacted your relationships? For example, with your baby (both unborn and newborn), partner, family, and friends.
- How do you feel your experience with anxiety or depression has impacted your bonding and attachment with your baby?
- Do you feel like these experiences have taught you anything about yourself and/or motherhood?
- When reflecting on your journey, how do you make sense of your experience with perinatal mental distress?
- What advice would you give to other mothers experiencing similar feelings of anxiety or depression?
- Is there anything else you would like to add?

Question prompts:

- Can you tell me a little more about that?
- What was that like for you?
- To make sure I understand what you're saying.

Appendix 5: Example of Reflective Journal Extract

Examples of randomly selected extracts from my reflective journal throughout the research process.

29/05/24 - Meeting with Precious Beginnings

Left the meeting feeling excited and supported. Alex has offered her support and welcomed me to come along to the precious beginning as an opportunity to learn more. She has also agreed to help with participant recruitment. Lengthy discussion around the importance of early child development, and looking at how countries do things differently. Potential of the perinatal workshop next month.

03/09/24 - First Interview with Bella

I felt really nervous going into this interview, and I practised the interview questions multiple times in the morning. Bella was so calm, kind, and welcoming. Some tears in the interview, so we slowed down and shifted the conversation until she felt comfortable talking. I was moved by Bella's sense of pride and strength in her journey. She reflected on feeling proud of staying true to her values by prioritising strong family relationships. Strong attributions of distress towards the breakdown of her relationship with her partner. Interested in her comment about a Facebook list being a source of recognition that she was experiencing anxiety. She seemed really grateful for the work I was doing, noting the topic wasn't discussed enough, and offered to help in any way possible.

01/11/24 - Second Interview with Mary

I left feeling a little out of my depth after the interview with Mary, as it was very emotional. She shared distressing psychosis type experiences, and I left questioning who I am to do these interviews. Note to speak to my supervisor about this. I remember feeling grateful for bringing in the baked goods and sipping on tea, which allowed for moments

to pause and slow down the conversation. Strong sense of community support as alleviating distress and feelings of isolation. Note Mary's mention of receiving an ADHD diagnosis, which appeared to offer a reframing of her experiences. Medical disappointment early on seemed to follow Mary throughout her motherhood journey, where she continued to question her decisions.

10/01/25 - Reflections from Analysis of first Transcript

Very overwhelming process. Realising the depth and time that is needed to get through the analysis section. Continuing to review the transcript, I am concerned that I am missing essential information or misinterpreting what Bella is saying. Interested in the concept of identity and having different parts of the 'self' which seem to be in tension with each other. Tension also exists in emotions, feelings, both angry and happy at the same time.

Appendix 6: Example of the Initial Noting of a Participant's Transcript

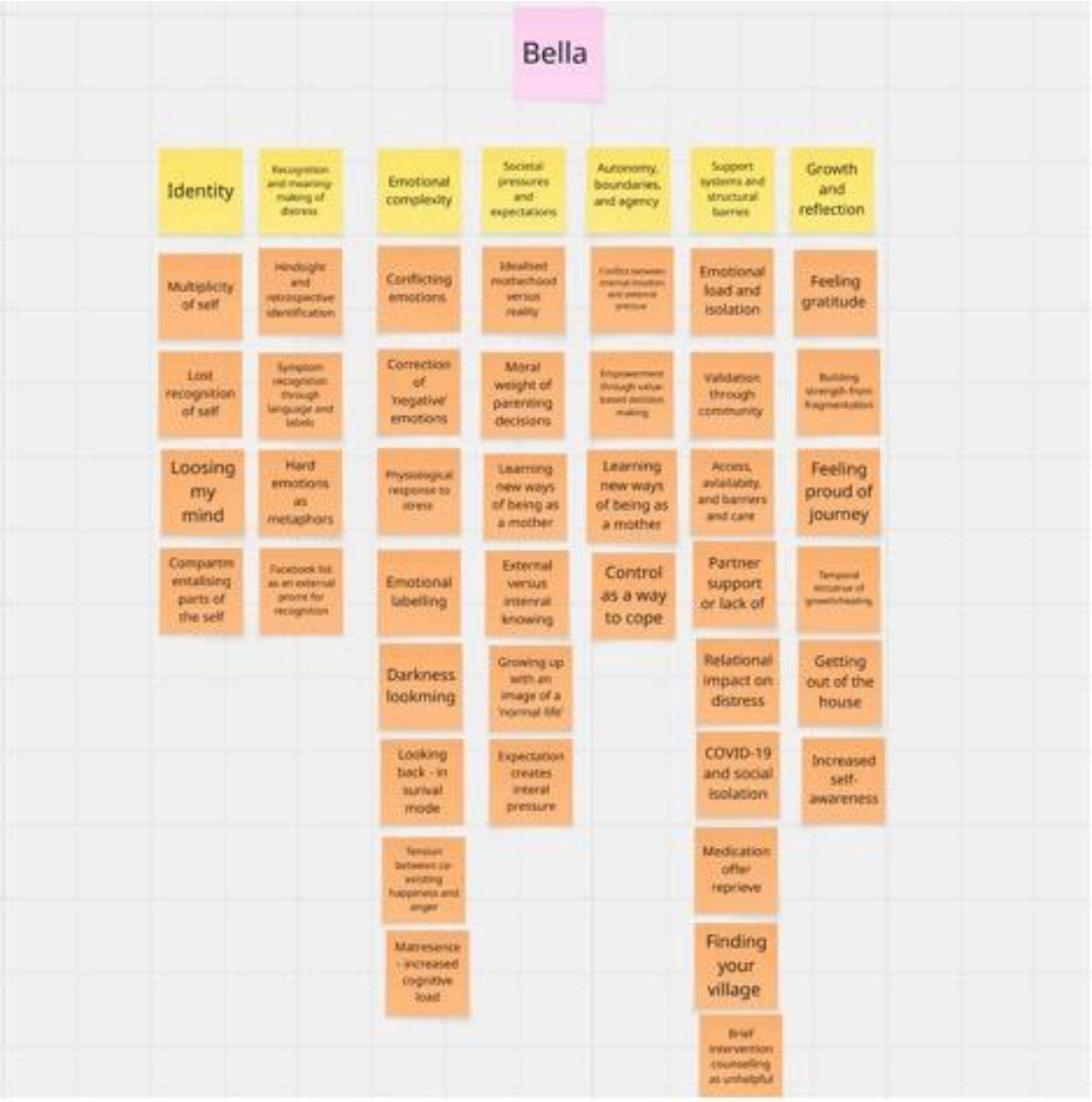
Example of step 2 of the data analysis, initial noting, for the first interview with Bella.

Emergent Themes	Original Transcript		Exploratory Notes
	Interviewer:	Okay, so can you tell me about what experiences you've had with perinatal anxiety or depression?	Symptom recognition – feeling unsure where or what to attribute feelings towards – relationship breakdown
Relational impact on distress	Bella:	Yeah, so for a long time, I didn't realise that I was probably suffering from anxiety after the birth of my first, and I think the reason was I was going through kind of a breakdown in the relationship that I was in, and so I don't think I recognised it as being a perinatal thing as such as a, oh, this is happening because of my relationship breakdown sort of thing. But I think now having my second, it made me realise that I was probably definitely suffering anxiety with my first.	
Delayed recognition of distress			Only when looking back is she able to reflect on the possibility of anxiety during first pregnancy
	Interviewer:	Right. So it's been in hindsight looking back on it?	Hard emotions as part of the human experience in times of increased stress
	Bella:	Yeah.	
	Interviewer:	And so, you said that you almost didn't understand what to relate the anxiety to. And you feel now that you have a lot more clarity around that?	
	Bella:	Yeah, yep. So there were things with my first like, I didn't really want other people holding her, because I wanted the soul connection and things with her, and that was just so important for me to have that time with her. And so a lot of people didn't pressure me to kind of hand her over or anything, but there were the odd people that go, no, she's crying, let me take her and I'm going, no, that's the last thing she needs, from my perspective. And I found it hard, I think, because I learned how to set boundaries that were comfortable for me and my new baby, and that was something I'd never really done before, was set boundaries for people. So I found that hard and that, I think, it	Need for control
Control as a way to cope			Learning how to set boundaries increased anxieties.
External support creates conflict			When does external support become unhelpful
Learning new ways of being as a mother			Navigating a new world.

Temporal structure of growth/healing?		heightened my anxieties to a degree. And yea, the second time around, I was just a lot more relaxed about things, and a lot more willing to kind of be like, yeah, hand her over, it's fine. Yeah like, I'm always going to be her mum. I know that it's fine. It's not going to break my bond with the child, and so, yeah, it's the hindsight of going, oh I was probably a bit 'OTT' with the first.	Experience provides understanding for future situations to responded to in different ways
External versus internal knowing	Interviewer:	Yeah, that's a nice place to be able to get to. Yeah, setting boundaries can be really difficult.	Where is the line with being over the top? Who decides this?
	Bella:	Yeah, yeah.	
	Interviewer:	And so when you were experiencing the anxiety at the time, what sort of symptoms did you, or maybe those around you, notice?	
Emotional labelling	Bella:	I found it hard to regulate. So it would be heightened, and obviously, my baby wasn't at any kind of risk, but sometimes I'd be like, I just don't know what she needs. And it would really kind of get to me, because I'd be like, oh my God, she's, she's crying. I've done this, and I've done this, and I've done all of the things. What is it that I can do? And it would make me feel so tense inside and panicky and kind of nervous and worried. All of the all of those kinds of emotions, really, but it wasn't all the time. I was so incredibly happy in my baby bubble.	Language around symptoms – emotional regulation, overwhelm in knowing how to respond to babies needs.
External versus internal knowing			There is a sense of doubt – question self.
Physiological repones to stress			Feeling tense as a somatic response to uncertainty?
	Interviewer:	Would you be able to describe for me, a particular time that comes to mind in your perinatal period, where you were feeling these symptoms...	Conflicting emotions - correcting 'negative' with 'positive'

Appendix 7: Example of Searching for Connections Across Emergent Themes

Example of step 3 of the data analysis, searching for connections across emergent themes, for the first interview with Bella.



Appendix 8: Looking for Patterns Across Cases

Step 6, looking for patterns across cases. The master table of subordinate and subordinate themes for the group of mothers.

Individual Superordinate Themes	Group Supordinate Themes	Group Subordinate Themes
Bella: **Identity** **Recognition of meaning-making** **Emotional complexity** **Social Pressures and Expectations** **Autonomy, boundaries, and agency** **Support systems and structural barriers** **Growth and reflection**	**Identity: The Fragmented and Reformed Self** **Psychological: The Storm and Calm Inside** **Sociocultural: The Weight of Expectation and Strength in Numbers**	**Tension within the Self** **Healing: Reframing and Reformation** **Distress Recognition** **Emotional Landscape: The Darkness** **Loss and Gain of Coping Mechanisms** **Healing: Self-Compassion** **The Silent Script of the 'Good Mother'** **Stigma** **Interaction Between Stress and Isolation** **Healing: Through Connection and Belonging**
Molly: **Hindsight and the temporal structure of the self** **Symptom labelling** **Transitional moments and real-time processing** **Emotional landscape** **Autonomy, agency, and disempowerment** **Reformation of the self** **Societal norms and pressures** **Support systems** **Growth and sense-making**	**Identity: The Fragmented and Reformed Self** **Psychological: The Storm and Calm Inside** **Sociocultural: The Weight of Expectation and Strength in Numbers**	**Identity as a mum** **The Intersect: Multiplicity of Self** **Tension within the Self** **Healing: Reframing and Reformation** **Distress Recognition** **Emotional Landscape: The Darkness** **Loss and Gain of Coping Mechanisms** **Healing: Self-Compassion** **The Silent Script of the 'Good Mother'** **Stigma** **Healing: Through Connection and Belonging**

Matilda: Navigating isolation and loss Support systems (formal and informal) Emotional and psychological journey Increased need for control Complicated birth Meaning-making and adaptation Healing through acceptance The mother redefined in relation to her children	Identity: The Fragmented and Reformed Self Psychological: The Storm and Calm Inside Sociocultural: The Weight of Expectation and Strength in Numbers ~~Birthing context~~	Identity as a mum The Intersect: Multiplicity of Self Healing: Reframing and Reformation Loss and Gain of Coping Mechanisms Healing: Self-Compassion The Silent Script of the 'Good Mother' Stigma Interaction Between Stress and Isolation Healing: Through Connection and Belonging
Sophie: Symptom recognition Meaning-making Birthing context Conflicting information Identity transformation Isolation and comparison Support systems Learning to cope and active healing Cultural practices and models of care Reflections and advocacy	Identity: The Fragmented and Reformed Self Psychological: The Storm and Calm Inside Sociocultural: The Weight of Expectation and Strength in Numbers ~~Birthing context~~	Identity as a mum The Intersect: Multiplicity of Self Tension within the Self Healing: Reframing and Reformation Emotional Landscape: The Darkness Loss and Gain of Coping Mechanisms The Silent Script of the 'Good Mother' Stigma Interaction Between Stress and Isolation Healing: Through Connection and Belonging
Jamie: Distress in feeling trapped Emotional journey Comparing the self before and after The hat of motherhood Support systems Living away from family Healing and moving forward New stress management techniques	Identity: The Fragmented and Reformed Self Psychological: The Storm and Calm Inside Sociocultural: The Weight of Expectation and Strength in Numbers	Identity as a mum The Intersect: Multiplicity of Self Tension within the Self Healing: Reframing and Reformation Distress Recognition Emotional Landscape: The Darkness Loss and Gain of Coping Mechanisms Interaction Between Stress and Isolation Healing: Through Connection and Belonging