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A Māori Mother's Journey: Is Cultural Connectedness a Protective Factor Against Postnatal Depression?

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Abstract

There are a significant number of mothers affected by postnatal depression (PND) in Aotearoa, with Māori mothers being disproportionately impacted. Mainstream maternal mental health services continue to operate within Western frameworks, despite the growing evidence for culturally responsive care. The protective factors of whānau relationships, cultural identity, and wairuatanga are often overlooked within these frameworks. This thesis explores whether cultural connectedness is a protective factor against PND for Māori mothers. This qualitative research is guided by a kaupapa Māori methodology and situated within a constructivist paradigm and magnifies the voices of eight Māori mothers who have experienced symptoms of PND. Semi-structured interviews enabled an in-depth exploration of participants' experiences with symptoms of PND, cultural depression, support systems, and pathways to wellbeing. Thematic analysis was guided by the cultural connectedness scale (CCS), which centre's identity, tradition, and spirituality as key dimensions of wellbeing.

Findings reveal that cultural disconnection, structural racism, and inaccessible services exacerbate the psychological and emotional distress felt by Māori mothers. In contrast, reconnection with te ao Māori through tikanga, te reo Māori, peer support, and wānanga were experienced as mana-enhancing, healing, and transformative. These culturally grounded interventions cultivated a sense of belonging and agency that participants recognised as critical to their healing journeys. Moreover, the study draws attention to systemic failures, such as the inadequacy of standardised screening tools and structural barriers that undermine the long-term viability of Māori-led initiatives. This research aligns with the expanding body of advocacy for models that centre mātauranga Māori and uphold tino rangatiratanga. The findings affirm that cultural connectedness functions not only as a protective factor against PND, but as a vital

cornerstone of Māori maternal wellbeing. Structural reform is imperative for adequately supporting Māori mothers. This requires long-term investment in Indigenous initiatives that drive systemic change and can be achieved through culturally aligned practices and Māori-led governance.

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Amene

Be with this māmā as she journeys forward.

Surround her with wisdom, strength, and love each day.

May she be supported to nourish, nurture, and uplift her baby and family.

Amen

To begin, I offer this karakia for all māmā – past, present, and future – who carry the weight of generations and the hope of those yet to come.

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He aha te mea nui o te ao?

He tāngata, he tāngata, he tāngata

What is the most important thing in the world?

It is the people, it is the people, it is the people.

Table of Contents

Abstract ii
Acknowledgements iv
Table of Contents vii
Glossary xi
1. Introduction 1
1.1 Overview 1
1.2 Historical Context 2
1.3 Te Tiriti o Waitangi 5
1.4 Motherhood 7
1.5 Postnatal Depression (PND) 8
1.6 Cultural Connectedness 11
1.7 Barriers to Accessing Mental and Physical Health Care 13
1.8 Objectives of this Thesis 15
2. Literature Review 18
2.1 Introduction 18
2.2 Theoretical Frameworks 19
2.2.1 Relevant Theories 20
2.2.2 Conceptual Models 21
2.3 Prevalence and Risk Factors of PND Among Māori Mothers 23
2.3.1 PND amongst Māori mothers 23
2.3.2 Risk Factors of PND for Māori Mothers 27
2.4 Cultural Connectedness 29
2.5 Impact of Cultural Connectedness on PND 30
2.6 Interventions and Support Mechanisms for PND 33
2.7 Current Healthcare Practices and Effectiveness 34
2.7.1 Screening and detection 34
2.8 International Comparisons 36
2.9 Barriers to Culturally Appropriate Care 39

2.9.1 Socio-economic Challenges 39
2.9.2 Systemic Barriers 40
2.9.3 Cultural Insensitivity 41
2.10 Gaps in Literature 43
2.11 Policy Implications and Recommendations 45
2.11.1 Embedding Kaupapa Māori approaches and Māori-Led Models of Care 45
2.11.2 Improving Detection and Strengthening the Māori mental health workforce 47
2.11.3 Commitment to Long Term, Community Driven Research 48
2.12 Conclusion 49
3. Methodology 50
3.1 Introduction 50
3.2 Research Paradigm 51
3.3 Theoretical Framework 52
3.3.1 Kaupapa Māori 52
3.3.2 Mātauranga Māori 54
3.3.3 Integration of Theoretical Frameworks 55
3.4 Researcher positionality and reflexivity 56
3.5 Data Collection 58
3.6 Participants 59
3.6.1 Recruitment Rationale 60
3.6.2 Procedure 61
3.6.3 Interviews 63
3.6.4 Cultural Connectedness 64
3.6.5 Recording and Transcription 67
3.7 Ethical Considerations 68
3.7.2 Kaupapa Māori Principles 69
Ako Māori (Culturally preferred pedagogy) 69
Tino rangatiratanga (Self Determination) 70
Taonga tuku iho (Cultural aspiration) 70
Kaupapa (Collective philosophy) 71

Kaitiakitanga (Guardianship) 71
Whānau (Extended family structure) 71
3.8 Data Analysis 72
3.8.1 Data Familiarisation 73
3.8.2 Transcription and Writing Support 73
3.8.3 Generating Initial Codes 74
3.8.4 Searching for Themes 74
3.8.5 Reviewing Themes 75
3.8.6 Defining and Naming Themes 75
3.8.7 Producing the Report 76
3.9 Conclusion 76
4. Findings 78
4.1 Introduction 78
4.2 Cultural Connectedness as a Source of Strength 78
4.3 Cultural Disconnection and Whakamā 81
4.4 Reconnection as a Healing Journey 85
4.5 Isolation and Internalised Pressure 90
4.6 Structural Barriers to Care 93
4.7 Symptom Burden and Emotional Distress 97
4.8 Conclusion 102
5. Discussion 104
5.1 Introduction 104
5.1.1 Matariki as an Analytical Framework for Cultural Connectedness 105
5.2 Cultural Connectedness as a Protective Factor Against PND 108
5.3 Cultural Disconnection and Whakamā 113
5.4 Reconnection as a Healing Journey 116
5.5 Isolation and Internalised Pressure 119
5.6 Structural Barriers to Care 122
5.7 Symptom Burden and Emotional Distress 126
5.8 Innovative Responses and Opportunities for Change 129

5.9 Implications for Practice and Policy 133
5.10 Strengths and Limitations 136
6. Conclusion 139
References 142
Appendices 169
Appendix A: Participant Information Sheet 170
Appendix B: Participant Consent Form 173
Appendix C: Interview Questions 176
Appendix D: Ethics Approval Letter 180
Appendix E: Thematic Development Table 181

List of Figures

Figure 1: Research Process 61

Glossary

Aotearoa – New Zealand

Aroha – Love

Awhi – Support, embrace

Haerenga – Journey

Hinatore – A spark of light, a guiding light

Hiwaiterangi – The wishing star (Matariki cluster)

Iwi – Tribe, extended family

Kai – Food

Kaitiakitanga – Guardianship, stewardship

Kanohi ki te kanohi – Face to face

Kaumātua – Elder (male or female)

Karakia – Prayer, incantation

Kaupapa – Purpose, guiding principle, agenda

Kaupapa Māori principles – Māori guiding principles

Kōhanga – Māori-language immersion preschool

Kōrero – Talk, speak, narrative

Kuia – Elderly woman

Kura Kaupapa – Māori-language immersion primary/secondary school Māra kai – Maara kai - Food Garden

Māmae – Pain, hurt

Mahi – Work

Mana – Authority, prestige, spiritual power

Mana motuhake – Autonomy, self-determination

Manaakitanga – Kindness

Māmā – Mother

Marae – Māori meeting grounds

Matariki – Māori New Year (star cluster)

Māoritanga – Māori culture, identity

Pōhutakawa – Matariki star symbolizing those passed on

Pōwhiri – Welcoming ceremony

Pūrākau – Narratives, stories

Rāngahau – Research

Rangatiratanga – Leadership

Rohe – Region, district

Tangihana – Funeral rites

Tamaiti – Child (singular)

Tamaki Makaurau - Auckland

Tamariki – Children (plural)

Taonga tuku iho – Treasures handed down, cultural heritage

Te Aka – Māori dictionary

Te Aka Whai Ora – Māori health authority

Te Tiriti o Waitangi – The Treaty of Waitangi

Te ao Māori – The Māori world view

Te Whatu Ora – Health New Zealand

Tikanga – Customs, protocols

Tino rangatiratanga – Self-determination, sovereignty

Tūpuna – Ancestors

Tupuānuku – Matariki star connected to food grown in the ground

Tupuārangi – Matariki star connected to food from the sky

Ururangi – Matariki star connected to the winds

Waipun-ā-rangi – Matariki star connected to rain

Wairua – Spirit, soul

Wairuatanga – Spirituality

Wāhine – Women

Wānanga – Learning forum, deep discussion

Waitā – Matariki star connected to the ocean

Waitī – Matariki star connected to freshwater

Whakapapa – Genealogy, lineage

Whakamā – Shame, embarrassment

Whānau – Family

Whanaungatanga – Relationships, kinship ties

Whenua – Land, placent

1. Introduction

1.1 Overview

The leading cause of maternal death in Aotearoa[1] New Zealand is suicide, with over half these cases tragically comprised of Māori women (Best Practice Advocacy Centre New Zealand, 2019). This alarming statistic underscores the critical need to address maternal mental health. The focus of this research is on postnatal depression (PND) - a global health issue that profoundly impacts both mother and child. PND affects approximately 10-15% of mothers worldwide, with prevalence influenced by socioeconomic, individual, and cultural factors (O'Hara & Mc Cabe, 2013). PND can be described as persistent feelings of fatigue, sadness, and anxiety, significantly impairing a mother's ability to care for both her and her child (Stewart & Vigod, 2019). Further, PND extends beyond the immediate mother-child dyad and impacts child development, family dynamics, and community health (Field, 2010).

In Aotearoa, there is growing concern around the prevalence of PND among Māori mothers. Factors such as colonisation, systemic racism, and socioeconomic disadvantage contribute to the significant disparities in health and higher rates of mental health issues that Māori have historically experienced and continue to experience (P. Reid et al., 2017). Cultural connectedness can include the sense of belonging, support, and identity one gets from community ties and cultural practices; this is a crucial factor in mental health (M. Durie, 2001). Research has shown that maintaining cultural connectedness can foster a strong sense of identity and community support, potentially serving as a protective factor against PND (Williams, 2018). However, due to the disruption of many traditional support systems - as a result of the colonisation process - many Māori mothers struggle to preserve their cultural connectedness. This disruption exacerbates mental health

[1] I will refer to Aotearoa New Zealand as Aotearoa for the rest of the thesis

challenges and hinders the development of effective culturally appropriate health interventions (Reid et al., 2017; Pihama et al., 2017).

Additionally, beyond the effects on individuals and the nuclear whānau, the profound societal implications of PND among Māori mothers cannot be overlooked. To address these challenges there must be a comprehensive examination into the relationship between PND and cultural connectedness, as well as the integration of traditional Māori health models that focus on the holistic wellbeing of an individual. Models such as Te Whare Tapa Whā, developed by Sir Mason Durie, highlight the need for balance across the four dimensions of health – physical, spiritual, mental, and whānau health – to align more closely with the needs and values of Māori mothers (M. Durie, 2004).

This rangahau aims to explore the relationship between PND and cultural connectedness among Māori mothers. This research is significant as it has the potential to inform interventions that are culturally appropriate and policies that support the mental health of Māori mothers. By understanding the relationship between PND and cultural connectedness, policymakers and healthcare providers can develop and establish strategies that promote cultural resilience while improving maternal mental health outcomes. Additionally, exploring this relationship may offer insights into broader issues of mental health services (Gone & Kirmayer, 2020). This research seeks to contribute to the body of knowledge that highlights the importance of cultural context in mental health care and advocates for holistic approaches that honour the cultural identities and traditions of Māori mothers.

1.2 Historical Context

To begin, it is crucial to explore the impact colonisation has had on Māori maternal mental health. The effects of colonisation are profound. This is reflected in the lack of culturally

appropriate services accessible to Māori mothers, underscored by the systematic devaluation and replacement of Māori health frameworks with Western health models, which often fail to understand the unique values and needs of Māori whānau (Came, 2014; Durie, 1998). A crucial component of empowerment and healing for Māori whānau is the opportunity to reconnect to Māori models of health and wellbeing – drawing on centuries of Indigenous knowledge and practices through a holistic approach that encompasses tinana, wairua, hinengaro, and whānau (M. Durie, 2004; Pere, 1997). This connection is essential for the preservation of Māori culture, identity, and for the improvement of mental health outcomes for mothers.

Colonisation caused many significant transformations within Aotearoa such as the shift from an exclusively Māori inhabited and governed country to a non-Māori dominant one. This profoundly affected Māori society (Ministry for Culture and Heritage, 2023). It impacted language, land ownership, and social structures among Māori communities. The implications of land confiscations included the substantial loss of identity and culture, while the assimilation policies prohibited the use of te reo Māori, further exacerbating the loss of cultural identity and increased vulnerability felt by Māori (Faulkner & Moir, 2023). The erosion of sophisticated systems of traditional knowledge and way of life undermined health autonomy and Indigenous health perspectives. The colonisation process forced Māori to question their worldviews while Western frameworks were simultaneously introduced.

An impactful understanding of Māori health disparities requires an awareness of the historical context in which they have emerged. To highlight this, Huriwai et al., (2022) report that poor mental health is one of the greatest risks to Māori due to Māori adults being significantly more likely to experience mental illness than non-Māori. Such reports provide undeniable evidence for the need to incorporate Māori frameworks into modern health practices (Deverick & Guiney, 2016;

Kingi, 2005). The intersection of cultural connectedness and mental health is a critical area of study, particularly for Indigenous populations. For Māori mothers, cultural connectedness can serve as a protective factor against postnatal depression by fostering a sense of belonging, identity, and support. Research has shown that strong cultural ties and participation in cultural practices can enhance mental wellbeing and resilience among Indigenous people (M. Durie, 2001; Te & Kingi, 2005). One way to strengthen individual identity is through engaging with one's cultural heritage and practices, this also reinforces community support structures, both of which are vital for mental health (Gone & Kirmayer, 2020).

The impact of colonisation on the mental health of Māori mothers is further compounded by enduring economic and social challenges such as systemic discrimination and poverty. This is exacerbated the current healthcare system's inability to meaningfully recognise or prioritise cultural nuances that could be vital to effective mental health care of Māori women. To address these factors, a comprehensive understanding of the historical and ongoing impacts of colonisation is crucial, along with a commitment to integrating Māori practices and perspectives into healthcare services and policies (P. Reid et al., 2017). It is essential for contemporary healthcare practices to incorporate Māori health frameworks as they emphasise a holistic view of health and offer a culturally resonant approach to wellbeing (M. Durie, 2004). These models advocate for an inclusive and culturally sensitive approach by challenging the often compartmentalised and fragmented perspectives of Western healthcare systems (Pihama et al., 2017).

It is important to recognise and validate the role of cultural connectedness in mental health as it not only improves mental health outcomes for Māori mothers, but it fosters empowerment and resilience within Māori communities. A more equitable and effective approach to mental health care

that honours the cultural heritage and identity of Māori mothers can be achieved by integrating traditional Māori values and health practices into modern healthcare systems (Came, 2014).

1.3 Te Tiriti o Waitangi

The colonisation of Aotearoa began in the early 19th century, the impact of this for Māori is multifaceted and has led to profound cultural, political, and socio-economic disruption. Colonisation brought about the erosion of te reo Māori, the displacement of cultural traditions, and land dispossession – alongside the imposition of foreign social and legal systems – which collectively undermined Māori ways of life and disrupted traditional social structures (Walker, 1990). Te Tiriti o Waitangi is a founding document in Aotearoa's history; it intended to establish a relationship between Māori chiefs and the British Crown. The purpose of te Tiriti o Waitangi was to address the grievances felt by Māori by protecting their rights, properties, and autonomy, while facilitating settlement of Europeans in a peaceful manner (Orange, 2011). The two versions (Māori and English) provide different interpretations and understandings of te Tiriti o Waitangi which has caused significant disputes over the years. One such misunderstanding includes the rights to sovereignty. The English version emphasised that Māori would cede sovereignty to the Crown, while the Māori version emphasised partnership between Māori and the Crown, ultimately ensuring the protection of Māori autonomy and authority over lands and taonga (Manatū Taonga - Ministry for Culture and Heritage, 2017; Orange, 2023).

The widespread confiscation of Māori land is one of the devastating impacts of colonisation. In the 1860's the New Zealand wars, known as the Land Wars, erupted between the Crown and Māori over land sovereignty and ownership. From these wars, the New Zealand Settlements Act 1963 was brought into legislation, this allowed for large pieces of Māori land to be confiscated as punishment for "rebellion" (Belich, 1986). Along with confiscating land, the Crown enacted policies

aimed at assimilating Māori into European society. One such policy was The Native Schools Act 1867 which was a system of schools that was aimed at promoting English language and European customs. For the first two years of the Act, Māori were required to provide the land for the schools and contribute towards the teachers' salaries and building costs. Although te reo was accepted when the schools were first established, from the outset, the purpose of the schools was to teach English, and phase te reo and all Māori cultural practices out. As time went on, Māori students were punished for speaking their first language (Calman, 2012; Simon & Smith, 2001). The effects of colonisation on Māori social structures and language are still evident today. A significant consequence being the decline of the once dominant language, te reo Māori.

Despite ongoing challenges in passing te reo Māori between generations, the language has been revived through movements such as kōhanga and kura kaupapa. This has played a critical role in the preservation and revitalisation of the language (King, 2001). Historical losses of language, land, and resources, combined with deliberately discriminatory policies, have contributed to the persistent economic disadvantage experienced by Māori in the present day. The socioeconomic disparities Māori have continued to face throughout generations started when Māori were forced to move to urban areas for employment. This led to traditional support networks and social structures breaking down (R. Walker, 1990). These disparities have contributed to poorer outcomes in education, employment, and health for Māori compared with non-Māori.

All this disruption to governance systems and social structures has persistently negatively affected Māori communities throughout the years. The Western political and legal systems imposed on Māori have consistently undermined Māori decision-making processes and leadership. The Waitangi Tribunal, established in 1975 (Waitangi Tribunal, 2014) was designed as a mechanism to address historical grievances, this process of reconciliation is ongoing. The Treaty facilitated

colonisation process altered the landscape of healthcare for Māori profoundly. The imposed Western health frameworks often failed to, and still do today, recognise the importance of holistic health such as wairua, hinengaro, tinana, and whānau, which are embedded in Māori health frameworks (M. Durie, 2004). This has led to Māori health practices becoming further marginalised and culturally appropriate healthcare hard to access. Further, this disconnection from cultural health practices has exacerbated Māori mental health issues, including postnatal depression (Deverick & Guiney, 2016).

The Māori Health Strategy (2022) highlights the importance of integrating the principles of te Tiriti o Waitangi into health practice, to address these health disparities. If the principles of partnership, protection, and participation are honoured, healthcare providers can work towards integrating contemporary Western health practices with traditional Māori health models. Such measures are essential to providing culturally appropriate care for Māori mothers, preserving Māori identity, and ultimately contributing to improved mental health equity for Māori. These steps are essential in empowering and healing Māori communities (Ministry of Health, 2014).

1.4 Motherhood

Motherhood is shaped by the societal expectations and cultural values of a given context. The dominant ideals around motherhood within Western societies are centred on intensive, individualised mothering, with the expectation that mothers simultaneously fulfil caregiving responsibilities within the home while also contributing to the economic stability of the household through paid employment (Budds, 2021). Parenting within this paradigm places extreme burden on mothers to constantly perform emotionally, intellectually, and economically, frequently resulting in burnout, stress, and isolation (Kim & Kerr, 2024). In contrast to this, mothering in Indigenous cultures emphasises community connection and relational values through collective responsibility.

In pre-colonial times, mothering in Indigenous societies was intertwined with kinship, spiritual practices, and ancestral knowledge (Herewini, 2018). This approach to mothering prioritises whānau support, ceremonial practices, storytelling, and a shared role of parenting rather than individualised maternal labour.

The different paradigms within which people experience motherhood have a profound impact on their mothering experience. Understanding these contrasting models in a post-colonial society is essential. Western ideals of motherhood can often undermine Indigenous parenting by imposing unrealistic societal expectations on them and dismantling communal caregiving responsibilities (Angeli-Gordon, 2025). A positive of this, however, is that it has provided Indigenous mothers with a platform to showcase their cultural resilience in a Westernised society through connection, resistance, cultural reclamation, and relational, inclusive, and grounded practices.

1.5 Postnatal Depression (PND)

Staggeringly, up to half of all mothers in Aotearoa may experience varying degrees of postnatal distress. Māori, Pacific, and Asian mothers have a greater risk of experiencing this distress than their New Zealand European counterparts. PND, used interchangeably with postpartum distress, often arises within the first year postpartum and remains a prominent health concern in Aotearoa (Anna-Maria Federico, 2024). PND is characterised by its persistent and severe symptoms that often require interventions from professionals. This is unlike the “baby blues” whose symptoms generally subside within two weeks and is experienced by so many new mothers that it is considered ‘normal’ (Better Health Channel, 2023; National Health Service, 2023). Postnatal psychosis is at the extreme end of postnatal depression and involves symptoms of psychosis (being out of touch with reality) and mood changes and usually begins in the first two weeks after the child

is born. The symptoms of PND include persistent fatigue, sadness, feelings of hopelessness, and changes in appetite and sleep (Stewart & Vigod, 2019). These can have significant consequences on a mother's ability to care for her child and herself (Mayo Clinic, 2023). Further, PND can have devastating consequences not only for the mother's mental health, but also for the child's development and the wellbeing of the entire whānau (O'Hara & Mc Cabe, 2013).

PND is typically screened for using depression and psychological distress scales such as the Edinburgh Postnatal Depression Scale (1987), or Patient Health Questionnaire (PHQ-3 or PHQ-9), the Generalised Anxiety Disorder Questionnaire (GAD-7), and the Anxiety and Depression checklist (K10) (Park & Kim, 2023). In Aotearoa, PND can be identified by midwives, Whānau Āwhina Plunket or Well Child Tamariki Ora nurses or other health providers such as General Practitioners. Typically, treatment involves therapy and medication (Mental Health Foundation, 2022). More information on screening and the validity and reliability of these tools for Māori mothers is covered in section 2.7.1.

The early bonding process plays a critical role in a child's cognitive and emotional development. PND can significantly impair this process, underscoring the far-reaching influence of maternal mental health on child wellbeing (Field, 2010). Early identification and intervention are vital. Children whose mothers experience PND are at a higher risk of developmental delays, behavioural problems, and emotional difficulties, than children whose mothers do not experience PND (Stein et al., 2014). PND can increase conflict and stress within a household, putting strain on relationships and whānau dynamics, thus exacerbating the mother's mental distress (Letourneau et al., 2012).

A culturally sensitive approach that can acknowledge the unique challenges faced by Indigenous mothers is imperative when addressing PND among Māori mothers. Māori health

models such as Te Whare Tapa Whā provide a holistic approach to mainstream healthcare as it encompasses taha wairua, taha tīnana, taha whānau, and taha hinengaro (M. Durie, 2004). Community based initiatives that emphasise cultural connectedness and involve whānau can have a positive impact on supporting and improving the mental health of Māori mothers (Pere, 1997). Examples of this include Māori cultural frameworks that support language and community institutions, which may support the wellbeing of whānau, including mothers (Walker, 1990). Additionally, providing healthcare workers with training to recognise the specific needs of Māori mothers and address them appropriately can aid in reducing the barriers to accessing culturally appropriate care, interventions, and support (D. Wilson & Baker, 2012). Ensuring the cultural competence of healthcare providers will aid in improving the quality of care provided to Māori mothers. Furthermore, this allows space to nurture cooperation and trust between Māori mothers and healthcare professionals, which is a vital component in the early identification and effective intervention of PND.

Recognising and addressing the challenges Māori mothers face will aid policymakers and healthcare providers in developing strategies and supports that enhance wellbeing of both mothers and children and promote cultural resilience. This includes the implementation of policies that address the social determinants of health, such as education, poverty, and housing, as well as creating inclusive, safe, and supportive environments that foster cultural identity (Ministry of Health, 2014). Policies that prioritise Māori voices in decision-making processes and support Māori-led initiatives are crucial for these efforts to be a success.

Ultimately, an approach that is comprehensive and culturally supportive can lead to improved mental health outcomes for Māori mothers, improved developmental outcomes for children, and improved whānau dynamics for Māori whānau. A healthcare system that embraces

traditional Māori models of health equally with contemporary healthcare practices can lead to a system that is effective in honouring the cultural identity and needs of Māori mothers. This approach ensures that immediate health concerns are addressed, and it lays the foundation for sustained wellbeing and resilience among Māori communities.

1.6 Cultural Connectedness

A critical factor in mental health for Indigenous populations is cultural connectedness. This includes a sense of identity, belonging, and support derived from community ties and cultural practices (Durie, 2001). Cultural connectedness may provide a protective factor against PND for Māori mothers by fostering community support and sense of identity. The loss of language, land, and traditional knowledge through colonisation has had a well-documented impact on Māori identity and wellbeing (Walker, 1990) The displacement of Māori from ancestral lands and the suppression of te reo Māori are two examples that have deeply affected the social fabric and identity of Māori communities, contributing to their higher mental health issues. Colonisation also brought about the disruption of traditional support systems, presenting many Māori mothers with challenges in maintaining their cultural connectedness, which can exacerbate symptoms of poor mental health (Pere, 1997).

Research has shown the positive impact participation in cultural practices can have on mental wellbeing and resilience for Indigenous people. For Māori mothers this can include community-based initiatives rooted in tikanga, kapa haka, and marae participation – these forms of cultural connection have been identified as key dimensions in Indigenous perinatal mental health frameworks (C. Meredith et al., 2023). These practices foster a sense of belonging and support that Durie describes as crucial for mental health (Chandler & Lalonde, 1998; M. Durie, 2001). One important factor in mitigating the effects of PND is engaging in cultural practices as they reinforce

identity and cultivate an environment of support. Whānau is another important aspect of cultural connectedness, it extends beyond the nuclear family to extended family and community members. Whānau support is an integral part of Māori wellbeing and health as it can provide mothers with practical, emotional, and social support (Pere, 1997). This collective approach to health and wellbeing is often overlooked in individualistic Western healthcare models. This emphasises the importance of having care available that is culturally appropriate and aligns with the values and practices of Māori (M. Durie, 2004). However, the marginalisation and lack of integration of Māori health frameworks continues to erode cultural practices and create unnecessary barriers to maintaining cultural connectedness.

To appropriately address and care for the mental health needs of Māori mothers, healthcare approaches must be holistic and integrate cultural connectedness. This includes ensuring culturally sensitive healthcare that is responsive to Māori mothers' needs, providing opportunities of cultural engagement, and recognising the importance of one's cultural identity (Ministry of Health, 2014). Addressing the holistic needs of Māori whānau is essential to providing comprehensive support. At the same time, community-based initiatives that centre cultural connectedness have shown promise in enhancing the mental health of Māori mothers. (Reweti, 2023). Initiatives that aid in rebuilding traditional support systems, such as cultural workshops, marae-based services, and programmes that involve whānau and community, provide safe environments for Māori mothers to come together, share, feel understood, support one another, and build their own village. On a larger scale, these initiatives imitate and rebuild the traditional support systems that were lost throughout the colonisation process, leading to significant positive impacts on mental health outcomes (Pere, 1997).

Recognising and addressing the challenges Māori mothers are faced with provides context for policymakers and healthcare providers when developing supports and strategies to improve mental health outcomes, wellbeing, and cultural resilience for mothers and children. This includes addressing social determinants of health alongside creating spaces that are inclusive, supportive, and safe environments that strengthen cultural identity (Health, 2014). Ultimately, approaches that are comprehensive and culturally supportive can aid in improved developmental outcomes for tamariki, better mental health outcomes for Māori mothers, and stronger overall dynamics within the whānau.

1.7 Barriers to Accessing Mental and Physical Health Care

There are numerous barriers to accessing appropriate mental health care for Māori mothers which can have severe implications on their ability to receive support for PND in a timely manner. Despite the public healthcare system in Aotearoa, one of the primary barriers for Māori mothers is cost. There are financial obstacles individuals face that prevent them from seeking the care they need, including childcare, transportation, and other related costs (Dawson et al., 2019). Location, timing, and scheduling can pose additional challenges especially for individuals living in remote or rural areas where facilities are less accessible anyway (Lee & North, 2013).

There is also a lack of accessible culturally appropriate care in Aotearoa, which is another significant barrier. Many Māori mothers report that they often feel marginalised or misunderstood within the healthcare system (Hayward et al., 2025). The healthcare system in Aotearoa is predominantly shaped by Western biomedical models, which do not align with the cultural practices and values of Māori mothers (Came, 2014). The cultural disconnect experienced by Māori can lead to feelings of mistrust in healthcare professionals and the services they offer. Additionally, Māori mothers may experience bias and discrimination when seeking healthcare due to institutionalised racism (Dawson et al., 2019). The absence of culturally competent staff or Māori health

practitioners exacerbates the difficulties Māori mothers face when seeking the support they need. Another barrier to accessing care is the stigma associated with mental illness. Many communities are reluctant to speak openly about mental health due to fear of being shamed or judged (Elder, 2023). Often deterred by this stigma, Māori mothers may choose not to seek support, resulting in untreated symptoms and worsening mental health outcomes. Compounding this, delayed recognition and intervention within communities lacking awareness of PND can further hinder access to care.

Shepherd (2024) discusses the very real experiences of Māori mothers' encounters with the health system unwelcoming and shaped by racial discrimination and culturally unsafe environments. She argues that while it is a complex and confronting task to address the deeply embedded and normalised racism, Te Tiriti o Waitangi offers an essential basis for challenging these structural injustices. Core Māori values such as tino rangatiratanga, manaakitanga, and whakawhanaungatanga are often absent in mainstream health services, not only highlighting the continuous breaches of te Tiriti o Waitangi and failure to provide equitable care, but it also undermines the quality of care provided. Creating an equitable healthcare system that supports the wellbeing and maternal mental health of Māori mothers and their whānau starts with addressing these systemic barriers to access (Came et al., 2019). A healthcare environment that honours Māori culture and promotes long term resilience can be achieved if systemic barriers can be addressed and Māori health models can be integrated into contemporary healthcare. This requires a multifaceted approach to address barriers to care and include community engagement, integrating Māori health models into mainstream healthcare, and policy changes (Hayward et al., 2025). Healthcare needs to be culturally appropriate, affordable, and accessible to ensure improved maternal mental health outcomes for Māori mothers. This includes promoting support programmes based in the community that

emphasise working with whānau and cultural connectedness, cultural competence training for healthcare providers, and increased representation of Māori health practitioners (Ministry of Health, 2014). Providing a safe space for mothers to feel heard and respected can aid in bridging the gap between healthcare providers and the communities they serve.

Policy changes need to address the social determinants of health including education, poverty, and housing, to begin to create inclusive, supportive environments that foster cultural identity (Paterson, 2018). Another crucial step in implementing change is to provide initiatives that reduce financial barriers and promote economic stability (Jeffreys et al., 2024). Reducing financial barriers and ensuring healthcare services are culturally safe have the potential to significantly improve the overall wellbeing of Māori whānau (Jeffreys et al., 2024). Community based initiatives that emphasise cultural connectedness have a profound positive impact on the mental health of Māori mothers are also needed and should be funded. Research shows that mental health outcomes can be significantly enhanced when programmes incorporate traditional Māori values and practices (Reweti, 2023). Initiatives that offer whānau oriented support groups and culturally safe spaces aid in rebuilding traditional support systems, delivering vital physical, emotional, practical, and social support needed for improved mental health.

1.8 Objectives of this Thesis

The main objective of this thesis is to explore the relationship between cultural connectedness and PND by talking with Māori mothers. By interviewing Māori mothers, this research seeks to explore if cultural connectedness can serve as a protective factor against PND and identify the challenges Māori mothers face when maintaining cultural ties.

A research question that is key to guiding this study is: How does cultural connectedness influence the severity and duration of PND among Māori mothers? This question seeks to uncover

how community ties, cultural practices, and a sense of belonging impact both the persistence and the intensity of PND symptoms. Additionally, this study seeks to understand the barriers faced by Māori mothers in accessing culturally appropriate mental health care and how systemic factors such as institutionalised racism and colonisation have shaped these barriers (Bécares & Atatoa-Carr, 2016).

This study has used Māori health models such as Te Whare Tapa Whā, which encompasses taha tinana, taha wairua, taha hinengaro, and taha whānau, to highlight the value in approaches to maternal mental health care that are culturally relevant (Durie, 2004). This study intends to contribute to the development of culturally appropriate policies and interventions that support the mental wellbeing and health of Māori mothers through exploring the interplay between maternal mental health and cultural connectedness (M. Durie, 2001).

I hope this research provides insights into the relationship between maternal mental health and cultural connectedness that can inform policymakers and healthcare providers about the role of cultural resilience in addressing PND among Māori mothers. This research also aims to advocate for the implementation of culturally sensitive policies and interventions based on research with Māori mothers. The goal is to aid in working towards an equitable healthcare system that respects the cultural practices and values of Māori mothers, leading to improved mental health and overall wellbeing (Ministry of Health, 2014).

To summarise, this thesis seeks to contribute to the growing database of knowledge on cultural connectedness and maternal mental health among Indigenous populations. By addressing the unique challenges Māori mothers face and highlighting the importance of culturally appropriate care, the rangahau aims to enhance wellbeing and promote cultural resilience for Māori mothers and their whānau. The findings from this study could have significant implications for policy

development, healthcare practice, and future research into maternal mental health (Reid et al., 2017).

2. Literature Review

2.1 Introduction

Maternal mental health is a worldwide health concern with PND affecting many mothers across the globe. Its impact, however, extends beyond the individual, influencing fathers, tamariki, and wider whānau (O'Hara & Mc Cabe, 2013). In Aotearoa, Māori mothers are more at-risk of suffering from PND than their non-Māori counterparts (M. Durie, 2001a; Latham, 2020b), therefore the exploration of protective factors to mitigate the risk within this population is necessary. Among Indigenous people, cultural connectedness has been recognised as a significant feature of mental health resilience. Cultural connectedness can be described as "the engagement with and engagement of one's culture" (Snowshoe et al., 2017). Cultural connectedness is the cornerstone for identity, sense of purpose, and social support – vital characteristics in mental wellbeing and resilience (M. Durie, 2001a). Tikanga Māori – the values, customs, and practices that guide Māori ways of being – play a vital role in shaping health outcomes for Māori (CCDHB, 2017). To develop effective, culturally appropriate, and sensitive interventions, there must be an understanding of the role cultural elements play in reducing the risk of PND.

The signing of te Tiriti o Waitangi in 1840 was to ensure the establishment of shared governance between Māori and the Crown through mutual respect. Te Tiriti o Waitangi was established to protect the rights of the Indigenous peoples of the land, while facilitating the peaceful settlement of European settlers (Orange, 2011). However, marginalisation and injustices against Māori were accentuated by the often-unmet promises signed for and agreed upon. Ongoing efforts through Treaty settlements to right the wrongs inflicted upon Māori aim to empower Māori people by restoring rangatiratanga and promoting equitable development (Durie, 1998).

This literature review aims to explore the relationship between PND and cultural connectedness among Māori mothers. Firstly, it will explore theoretical frameworks that underpin the current research on PND, followed by the methodology used to gather and analyse relevant literature. Next, it will examine the prevalence and risk factors of PND. After this, it will dissect the role of cultural practices and identity in mental health focusing on what cultural connectedness is and the impact it has on Māori mothers with PND. Following this, focusing on cultural connectedness, it will explore the role of cultural identity and practices in mental health. It will then discuss the impact of cultural connectedness on PND, followed by interventions and support mechanisms for PND. The relevance of Māori models of health will be discussed throughout the review. Further, this review will explore both contemporary and historical factors, such as te Tiriti o Waitangi, that influence the health of Māori. Lastly, this literature review will identify gaps in the current research and seek to comprehensively understand how cultural connectedness can serve as a protective factor against PND. The practical implications of this research will be reviewed to initiate discussions around the role community-led initiatives play in supporting maternal mental health, the integration of cultural practices into healthcare, and the potentiality of this research influencing policy change to better support Māori mothers. Successful case studies from Indigenous populations will be examined.

2.2 Theoretical Frameworks

To explore PND among Māori mothers there must first be an understanding of various theoretical frameworks. This section will explore Brofenbrenner's Ecological Systems Theory, Cultural Safety Theory and Kaupapa Māori Theory. It will also explore conceptual models such as the Biopsychosocial Model and Te Whare Tapa Whā model. Lastly it will discuss the application of these theories and models to PND among Māori mothers.

2.2.1 Relevant Theories

A relevant theory is one that originated in Aotearoa nursing known as Cultural Safety theory, developed by Irihapeti Ramsden (1996), to address systemic power imbalances and deliver respectful and responsive to different cultures. This concept emphasises the importance of and critical need for cultural awareness, reflexivity, and recognition of institutional bias in healthcare practices and service delivery (P. Reid & Robson, 2006). This theory suggests that it is the duty of healthcare services to recognise and respect patients' cultural identities. Research argues that the dismissal of cultural identity and values, lack of cultural safety, and experiences of racism, within a healthcare setting often results in Māori disengaging from healthcare programmes. This contributes to poorer overall health outcomes for Māori (Curtis et al., 2019; Wild et al., 2021). Improving the mental health outcomes for Māori mothers relies heavily on considering cultural safety when addressing their needs. This is supported by current literature on improving health outcomes for Indigenous populations through culturally safe practice (Australia Institute of Health and Welfare, 2024; Cargo et al., 2019; Vincze et al., 2021; A. M. Wilson et al., 2020). A systematic review conducted by Vincze et al, (2021) found that when health interventions incorporate culturally safe principles, the outcomes and experiences of Indigenous women is likely to improve. The "Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives Final Report" underscores this need for cultural safety and equitability by highlighting the systemic barriers often faced by Māori patients when accessing healthcare (Clarke, 2020). The report identifies discrimination, structural inequities, and the absence of culturally appropriate care as persistent barriers Māori patients face within the healthcare system (Clarke., 2020). The barriers to access Māori women face reflect the deep institutional issues present in healthcare service delivery today. The institutional issues include the marginalisation of Māori knowledge and provider bias, this reflects the need for

organisational structures to provide more than just a training module for cultural safety but to embed it as a structural imperative within the organisation (Clarke, 2020)

Central to this research is Kaupapa Māori theory. This theory highlights the need to conduct research in a mana enhancing way, meaning the research must be respectful, relevant, and beneficial to the Māori communities it is studying. This framework is grounded in Māori cultural practices, values, and beliefs, which offers a critical lens for both understanding and addressing the health disparities experienced by Māori communities (Tuhiwai Smith, 1999). Kaupapa Māori theory champions an approach to research that is driven by Māori perspectives, with the aim of uplifting Māori voices and experiences. The elegance of Kaupapa Māori theory lies in the way it challenges dominant research paradigms to prioritise methodologies that empower Māori communities, to ensure said communities' benefit from the research outcomes. Further, this framework emphasises the interconnectedness of all aspects of life – reflecting the Māori worldview. Health is understood holistically, encompassing physical, mental, social, and spiritual dimensions of wellbeing (Reweti, 2023). Lastly, Kaupapa Māori methodology challenges the Western-centric research paradigms. It centres Māori epistemologies and serves as a catalyst for transformative change within Māori communities. As such, it is a powerful tool for decolonising research (Cram, 2001; Tuhiwai Smith, 1999).

2.2.2 Conceptual Models

A prominent model within PND research is the Biopsychosocial model which offers a holistic approach by integrating biological, psychological, and social factors (Engel, 1977). A model such as this is important when considering the multifaceted nature of PND among Māori mothers. This model examines how genetic predispositions, individual psychological states, and social environments collectively shape mental health outcomes. In a Māori context, the Meihana Model

builds on this framework by incorporating cultural dimensions into clinical assessment and care, underscoring the importance of addressing these factors in maternal mental health care (Pitama et al., 2007a). These models are important to note as they are holistic and consider the medical aspects of PND as well as the mental and cultural elements.

The Indigenist Ecological Systems Model (IESM) prioritises the importance of cultural context, Indigenous knowledge, and the interconnectedness of individuals, their communities, and the environment. Additionally, this model focuses on local languages, practices, and knowledge. Much like the biopsychosocial model, the IESM emphasises the holistic nature of wellbeing among Indigenous populations. The IESM complements the biopsychosocial model enabling healthcare service providers to address mental health needs unique to Indigenous communities through a culturally relevant framework (O'keefe et al., 2022). Recent research supports these models by reinforcing the importance of integrating social, environmental, and cultural dimensions to achieve a holistic perspective on the mental health needs of Indigenous women (Gone & Kirmayer, 2020).

Another model central to service delivery in Aotearoa was developed by Māori health expert, Sir Mason Durie. This is the Te Whare Tapa Whā model, a Māori framework to understand health and wellbeing from an Indigenous perspective (Durie, 1985). This model is made up of four dimensions of health: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health), and taha hinengaro (mental health). Te Whare Tapa Whā emphasises the importance of considering the wider contexts that influence the health and wellbeing of Māori mothers. Further highlighting the need for a holistic approach to addressing PND. This model understands that each pillar of the whare must be in balance to maintain overall wellbeing, if one dimension is out of balance, the wellbeing of a person is adversely affected. This model underscores the need for culturally congruent and holistic healthcare approaches (Durie, 1998). Studies have shown that

implementing this model supports improved health outcomes for Indigenous populations, including Māori. This is linked to increased engagement in health services, an emphasis on holistic approaches to wellbeing, and the integration of cultural relevance in healthcare (Health Quality and Safety Commission, 2023; Rochford, 2004). Further, models grounded in Te Whare Tapa Whā - such as the Meihana model - have shown support for culturally responsive assessment and care planning for Māori patients across multiple health contexts (Pitama et al., 2007).

2.3 Prevalence and Risk Factors of PND Among Māori Mothers

PND is a significant and recognised health issue globally. In Aotearoa, Māori mothers experience higher vulnerability to it due to intersecting social, structural, and cultural risk factors (M. Durie, 2001; Latham, 2020). PND can have a severe impact on a mother's ability to care for both herself and her newborn. Research suggests that among women in Aotearoa, the prevalence of PND is between 11% and 16% (Deverick & Guiney, 2016). While these statistics highlight the need for targeted mental health service, there is limited research into the prevalence of PND among Māori mothers. Effective development of culturally appropriate interventions begins with addressing this gap.

2.3.1 PND amongst Māori mothers

Mothers who are Māori, Pacific, and Asian are more likely to experience perinatal distress (Low et 2021; Mental Health Foundation, 2022; H. Walker, 2022) with rates estimated as high as one in three Māori, Pacific, or Asian women compared to -15% of all women. A 2015 mental health survey of new mothers in Aotearoa found that 14% of participants met the criteria for possible PND, with lower income households experiencing higher rates (Deverick & Guiney, 2016). Considering the intersection between socioeconomic status and mental health, these findings suggest that financial stressors may increase the risk of PND. Additionally, the Growing Up In New Zealand

study found that Māori women experience and report symptoms of PND in the third trimester at a rate of 1.2 times higher than European women (Morton et al., 2015) Such disparities emphasise the need for mental health strategies that specifically address the unique challenges faced by Māori mothers. Merritt (2005) argue that, due to socio-cultural factors, Māori women have a greater vulnerability to anxiety-based and depressive illnesses. Socio-cultural factors could include the pressures of maintaining cultural connections while dealing with societal expectations, systemic inequities, and colonisation. These have the potential to create unique stressors for Māori women. Although this research does not provide prevalence rates specifically for Māori, it did highlight the need to consider socio-demographic factors when understanding PND.

Interconnected systemic and socioeconomic inequities are vital risk factors in the development of PND among Māori mothers. Māori women often experience higher rates of housing instability, poverty, and unemployment, than their non-Māori counterparts, increasing their vulnerability to maternal mental health challenges and positioning socioeconomic status as a significant determinant in developing PND (Dawson et al., 2019). Understanding these socioeconomic factors is essential to understanding the lived experiences of Māori mothers. Further, systemic, institutional, and personal barriers to healthcare exacerbate the risk for Māori women. This includes cultural insensitivity, institutionalised racism, and inaccessibility to healthcare services that are culturally safe (Sheridan et al., 2024; D. Wilson et al., 2021). The lack of culturally safe care can lead to Māori mothers becoming distrustful of healthcare providers, resulting in reluctance to seek help, and contributing to worsening mental health outcomes further.

Compounding these risks is the erosion of tikanga, traditional support systems, and whānau structures, due to colonisation (Mead, 2003; Pool, 2016). The stripping away of these critical social supports through the dismantling of such structures has left Māori mothers disconnected from their

cultural heritage. A multifaceted approach to address these inequities, including restoration of traditional support structures, policy changes, and increased access to culturally competent healthcare, is needed. These challenges are not to be underestimated; an inclusive and holistic implementation strategy is imperative to the positive health and wellbeing outcomes for Māori mothers. The teen birth rate of Māori mothers in Aotearoa is in line with Pacific teen birth rates, and higher than all other ethnicities. This is significant as research by Tembo et al., (2023) underscores the social-cultural influences contributing to PND among adolescent mothers (Allen & Clarke, 2019). Additionally, research conducted by Waqas et al., (2023) emphasised the heterogeneity of perinatal depression, further suggesting the necessity of tailored approaches when addressing the complex and diverse needs of affected individuals. Collectively, these factors foster an environment that leaves Māori mothers vulnerable to experiencing depressive and anxiety-based disorders postnatally. These insights highlight the overwhelming need for comprehensive mental health care that can address the needs of new mothers, both immediate and long term.

Community networks and social support are two critical factors in mitigating the risk of Māori mothers developing PND. Evidence suggests that mothers who receive essential practical and emotional support from their social networks - such as whānau, community organisations, and friends - significantly reduce their risk of developing PND (Gurung et al., 2018). These support networks play a critical role in mitigating the everyday stressors of early parenting, contributing to improved mental wellbeing. Whānau-centred initiatives that prioritise Indigenous knowledge systems and amplify Māori voices have been shown to foster a sense of cultural connectedness and collective self-determination, contributing to improved health outcomes for Māori mothers. Evidence suggests that such initiatives reduce the feelings of isolation and disconnection by restoring traditional support systems that were eroded during colonisation (Reweti, 2023).

Approaches that are culturally grounded reaffirm how significant Māori practices and values are in mainstream healthcare settings. Additionally, culturally tailored adaptations of contemporary interventions have demonstrated positive outcomes. An example of this is the Mellow Parenting programme which, when adapted to align with kaupapa Māori principles, has seen success in reducing barriers to access and improving mental health (Penehira & Doherty, 2013). These initiatives are designed to resonate with Māori mothers' cultural experiences and values to increase their effectiveness.

Integrating Māori values and worldviews into everyday health practices ensures a more effective and supportive environment for these mothers (Reweti, 2023). This integration reinforces cultural identity and pride while promoting mental wellbeing, both of which are essential in overall health. The significance of providing or receiving culturally safe care cannot be overstated. Ensuring Māori mothers receive the appropriate resources, and support is both extremely important and deeply personal. Receiving culturally appropriate care is about respecting and valuing the cultural beliefs and practices of Māori mothers, creating a community within which they can thrive. Scroggins et al., (2024) researched the role community-based interventions play in improving perinatal mental health outcomes. The researchers found that interventions entrenched in the community's cultural context offer a safety net for new mothers, so they are not facing the challenges of parenting alone. Moreover, the availability and accessibility of culturally sensitive services were found to help bridge the gap between contemporary healthcare and traditional support systems, offering a more holistic approach to care.

Overall, access to culturally appropriate resources and a strong social support network are crucial steps in reducing the prevalence of PND among Māori mothers. In order to have these resources in place, there must be a commitment to valuing and understanding the beliefs and

practices of Māori culture. Future research should further explore the effectiveness of interventions that are culturally tailored, this will ensure all Māori mothers receive the support required to thrive.

2.3.2 Risk Factors of PND for Māori Mothers

There are several crucial factors that influence the prevalence of PND among Māori mothers. One such factor is cultural disconnection. Colonisation and urbanisation led to the disruption of traditional support systems, which increased the vulnerability to PND for Māori mothers (Chan et al., 2021). Due to this disconnection, mothers often find culturally relevant support difficult to access, which is critical for feeling understood and supported during the perinatal period. Additional factors associated with an increased risk of PND are high rates of gestational diabetes and high-risk pregnancies, which have been linked to increased prenatal and postnatal psychological distress (Brandon et al., 2008; C. A. Wilson et al., 2020). Together, these challenges and barriers to care exacerbate the emotional and psychological strain felt by mothers and further delay access to meaningful mental health care. This results in increased severity and duration of PND. Additionally, research has found there is a significant impact on maternal mental health due to racial discrimination. Experiences of racial discrimination by either the mother or her partner are associated with higher levels of both prenatal and postnatal depression (Bécares & Atatoa-Carr, 2016). This is particularly relevant, as experiences of discrimination can lead to anxiety and chronic stress - both of which are recognised risk factors of PND (Leigh & Milgrom, 2008). To ensure Māori mothers are well supported, services must honour their cultural perspectives and integrate traditional knowledge with contemporary approaches to care. Reducing feelings of disconnection and isolation – key contributors of PND – requires mental health services to also reflect Māori worldviews in practice (Waqas et al., 2023). Providing support that integrates and respects these cultural values plays an essential role in influencing Māori mothers' sense of

inclusion and community cohesion. Ensuring these resources are available and accessible reflects a deep appreciation of Māori cultural beliefs and practices. Regular reflection and evaluation on the effectiveness of these interventions is crucial in ensuring they stay relevant to the evolving needs of Māori mothers.

Adapting specific screening tools is one-way mental health services can ensure Māori mothers are accurately assessed. Chan et al., (2021) discussed the necessity of adapting screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) to be more culturally relevant for Indigenous women. The adaptations must be sensitive to both the coping mechanisms and unique cultural expressions of distress in Māori mothers. Traditional or cultural expressions of distress may not align with the criteria used in mainstream diagnostic tools, increasing the likelihood of misdiagnosis or under-diagnosis of PND (Chan et al., 2021).

Further, it is critical to explore the efficacy of current treatment tools in meeting the needs of Māori women. Often the specific cultural contexts and needs of these women are not considered in mainstream services (Merritt, 2005). This oversight highlights the systemic flaws within mainstream services and sheds light on the urgent need for a paradigm shift. To create health care services that are genuinely supportive and effective, mainstream approaches must stop perpetuating a 'one-size-fits-all' approach. Services should implement strategies that are grounded in the lived experiences and cultural fabric of Māori mothers. Additionally, low resilience and poor-quality sleep have both been linked as risks of PND (Baattaiah et al., 2023). Disrupted sleep is common among new mothers and can have a profound impact on their mental health. For Māori mothers, this impact is often exacerbated by the added stress of navigating a culturally insensitive. Additional layers of stress such as this increase their vulnerability to PND. Implementing comprehensive culturally sensitive support systems is crucial in improving maternal mental health outcomes for Māori

mothers. These support systems should integrate holistic approaches, community support, and traditional practices to provide an environment that fosters empowerment and resilience among mothers. The incorporation of traditional practices in service delivery offers a sense of cultural continuity. Including community networks provides vital emotional and practical support. Acknowledging and incorporating these elements will increase the relevance and potentially the effectiveness of care for Māori mothers. Comprehensive support systems address symptoms of PND and promote long-term resilience and wellbeing. To ensure resources are available and accessible there must be a mutual and ongoing commitment and collaboration between policymakers, Māori communities, and healthcare providers.

2.4 Cultural Connectedness

Cultural connectedness can be referred to as the sense of belonging and identity to one's cultural heritage and community. The concept of cultural connectedness is extremely significant for Indigenous populations, including Māori mothers, this is because it encompasses traditional values, practices, and social support systems. Research suggests that cultural connectedness is a protective factor against various mental health issues including PND. Cultural practices and beliefs are influential in the management of PND and further highlights the importance of cultural connectedness in mitigating the risks of developing PND (Evagorou et al., 2016). A study by Oates et al., (2004) discusses the cross-cultural equivalence of PND, exploring how cultural factors influence the experience and management of PND. Complementing this, research by Elliot et al., (2020) emphasises the importance of cultural connectedness in addressing PND, showing how cultural movements reduce stigma and promote mental health.

Cultural connectedness is more than just traditional values and practices; it includes the broader environmental and social contexts that Māori mothers live in. This is seen in the role of

extended whānau and the crucial part they play in providing the practical and emotional support needed in the postnatal period. Demonstrating this is a study by Durie (2001), who emphasises whānau plays a central role in providing support networks and maintaining cultural identity – both are critical in mitigating the effects of PND. Similarly, Mark and Lyons (2010) discuss the benefits of integrating traditional healing practices with modern healthcare to support Indigenous mothers experiencing PND symptoms. This affirms that cultural connectedness is beneficial for the overall wellbeing of both mother and child. Further, implementing traditional practices such as rongoā – shown to be effective in promoting mental wellbeing - offers a holistic approach that addresses both emotional and physical health (Mark & Lyons, 2010). Importantly, such approaches contribute to ensuring culturally appropriate care is available to Māori mothers.

Community-based programmes play a critical role in promoting cultural connectedness. Programmes that focus on traditional practices, cultural education, and language revitalisation provide safe platforms that allow Māori mothers to reconnect with their cultural heritage. These community programmes are crucial for mental health and aid in fostering a sense of belonging and identity (Pere, 1997a). Finally, the impact of systemic factors and policy on cultural connectedness must be considered. Essential for cultural connectedness are policies that preserve and promote Māori culture, including Māori perspectives in healthcare planning and funding for cultural programmes. Came et al (2017) discusses the role of policy in promoting Māori wellbeing by addressing health disparities and how this contributes to the resilience and overall health of Māori communities

2.5 Impact of Cultural Connectedness on PND

Within the context of PND, cultural connectedness plays a significant role in the mental health of individuals. Research indicates that strong cultural engagement and identity are protective

factors against poor mental health. The broader understandings of findings by Shepherd et al., (2017) - that cultural connectedness enhances wellbeing – has relevance for Māori mothers experiencing PND symptoms. Supporting this is Penehira et al., (2014), who emphasise the importance of engaging with kaupapa Māori practices in fostering belonging, resilience, and emotional strength. Cultural connectedness encompasses more than just traditions and customs, for Indigenous cultures cultural connectedness is a comprehensive understanding of one's identity and community (Masotti et al., 2023). During the postnatal period, this type of connection can provide a sense of belonging and support, essential for new mothers. Research suggests that common risk factors for PND include discrimination and social stressors. While this was examined in the context of Indigenous men and violent offending by Shepherd et al., (2017), their findings shed light on the alleviating effects that cultural connectedness can have on such stressors. Fostering a sense of cultural identity can equip individuals with strengthened capacity to navigate the challenges of parenthood. Further, community support and engagement in cultural practices can offer both emotional and practical assistance, helping to reduce the pressures and difficulties that contribute to PND.

A systematic review and meta-analysis conducted by Owais et al., (2020) concluded that in Canada, non-Indigenous women are significantly less likely to experience mental health issues in the perinatal period - particularly depression and anxiety - than their Indigenous counterparts. The authors found that while intergenerational trauma and structural issues contributed to the heightened risk of PND for Indigenous women, cultural teachings and community-based approaches could improve their mental health. Cultural connectedness has an influential impact on social support networks, highlighting another way it disrupts the manifestation of PND. Feelings of overwhelm and isolation in the postpartum period can be reduced by the shared responsibilities and communal

care offered in many cultures (Masotti et al., 2023a). Collective approaches to childcare in Indigenous cultures can provide new parents with encouragement and resources needed to navigate the complex needs of postnatal life. Additionally, incorporating Indigenous knowledge and practices into treatments for mental health has shown to be effective in addressing emotional distress and promoting wellbeing among Indigenous populations, with implications for PND support (Sjoblom et al., 2022). This underscores the significant value of integrating traditional healing and culturally relevant support not as alternatives, but as essential components to mainstream mental health care.

Traditionally, child-rearing in Aboriginal communities was considered a collective responsibility with extended family and community members contributing to raising the child. This model of shared responsibility promotes and encourages emotional support and security, which can have positive effects on maternal wellbeing during the perinatal period (Lohoar et al., 2014). Another influence on psychological outcomes is cultural identity. Dockery (2010) noted that participants with strong cultural identity had higher wellbeing scores and lower emotional difficulties. Findings such as these align with the wider research on Aboriginal and Torres Strait Islander health, which has found that access to traditional knowledge systems and cultural continuity encourage resilience when faced with vulnerability, including motherhood (Gee et al., 2014).

This suggests that cultural connectedness is a vital component in both the prevention and management of PND. When individuals foster strong cultural identities and engage with cultural practices, they can establish robust support networks and develop coping strategies that significantly reduce the risk of PND. Future research could further explore the ways cultural connectedness could be leveraged to improve the mental wellbeing of new parents.

2.6 Interventions and Support Mechanisms for PND

Support mechanisms and interventions are a crucial part of addressing PND. Studies show that various approaches, such as interpersonal psychotherapy (IPT), peer support, and cognitive-behavioural therapy (CBT), are effective in reducing the symptoms of PND (Pettman et al., 2023; Stamou et al., 2018). Interventions such as these equip new parents with tools and support needed to navigate the postnatal period

CBT has been studied extensively and is widely considered an extremely effective intervention for treating PND (Pettman et al., 2023). CBT is an evidence-based treatment that focuses on identifying and changing negative behaviours of individuals, to improve their mental health. IPT is another evidence-based intervention that addresses social stressors and improving interpersonal relationships, which are common risk factors of PND (Stamou et al., 2018). Another intervention that has had positive results in addressing PND is peer support interventions. This focuses on connecting new parents with people who have gone through similar challenges to provide a sense of shared understanding and community (Pettman et al., 2023). Peer support can provide relationships that offer practical advice, emotional support, and aid in reducing feelings of isolation, all of which are essential for someone managing symptoms of PND.

Importantly, to effectively manage PND among Indigenous populations, culturally relevant interventions are essential. Research indicates that integrating Indigenous knowledge and practices into interventions for mental health are particularly effective for Indigenous populations (Sjoblom et al., 2022). Culturally tailored interventions that blend Indigenous knowledge with evidence-based approaches offer an effective and holistic path to reducing the risk of PND and improving engagement (Mishu et al., 2023). There is increasing recognition among health care professionals of

the value of culturally competent care and the need to collaborate with cultural experts and leaders when designing and implementing mental health interventions.

2.7 Current Healthcare Practices and Effectiveness

The Aotearoa healthcare system has made significant progress in addressing PND among Māori mothers, however, there are still challenges that must be addressed. This section will analyse the practices currently in place for Māori mothers who are experiencing PND and evaluate their effectiveness through discussions around their strengths and weaknesses.

2.7.1 Screening and detection

Screening tools such as the Patient Health Questionnaire (PHQ-3) and the Edinburgh Postnatal Depression Scale (EPDS) are used in primary healthcare practices to address PND (Faulkner & Moir, 2023). These screening tools are used worldwide to identify the risk of PND among mothers and are important to implement during postnatal checkups for early detection and intervention. The screening tools are simple, easily accessible, and quick to administer. They consist of a series of questions that assess the anxiety levels, mood, and general mental health of the mother. Despite this, healthcare providers lack confidence in the cross-cultural validity of these tools, which can contribute to the under-detection of PND among Māori mothers (Faulkner & Moir, 2023).

This issue is exacerbated by the inability of current screening tools to capture culturally specific expressions of distress. The reliability and accuracy of these tools can be enhanced if cultural nuances are incorporated, which may lead to improved identification and increased support for those affected (Zubaran et al., 2010). Further, Te Whatu Ora (Health New Zealand) has emphasised the crucial nature of cultural competence in healthcare delivery by advocating for the understanding and respect of the cultural values and practices of Māori people (Ministry of Health,

2014). Despite this, there is still a significant gap in the cultural competence of some healthcare providers, which can be the cause of mistrust and misunderstandings among Māori service users. Qualitative research by Hayward (2025) recently found that Māori women often feel their cultural identity is either misunderstood or overlooked entirely during perinatal mental health assessments. The study revealed that the perception of risk Māori women hold is in direct correlation with their fears of being misunderstood or judged if they speak about their mental health struggles. These concerns are exacerbated by the fact that mainstream health services often fail to recognise cultural values and the central role they play in holistic wellbeing. This leads to a reduction of engagement in mental health services and help-seeking behaviours.

Mental health professionals commonly use the EPDS and PHQ-3 in Aotearoa, however, these screenings are not offered consistently at all primary care providers. Further, interpretation of the results can vary. This highlights the inconsistencies of screening and scoring protocols across the country. These inconsistencies are important to note as they could result in missed opportunities for early intervention for mothers in distress (Faulkner & Moir, 2023). Once distressed mothers are identified through screening, research suggests that many healthcare providers lack sufficient staff training to deliver culturally safe interventions – resulting in inconsistent care and contributing to a further erosion of trust among Māori mothers (C. Meredith et al., 2023)

The establishment of Te Aka Whai Ora (Māori Health Authority) was an attempt at structural reform under the Healthy Futures or Pae Ora Act 2022. The purpose of Te Aka Whai Ora was to address the inequitable health outcomes for Māori through the co-design and delivery of kaupapa Māori embedded health services, run in partnership with Te Whatu Ora. The overall goal was to prioritise Māori leadership in the transformation of the healthcare system. While Te Aka Whai Ora was disestablished in June 2024, during its brief operation it contributed to the elevation of

mātauranga Māori within national policy, strategic planning, and commissioning decisions (Ministry of Health, 2022). The disestablishment of Te Aka Whai Ora prompted widespread concern across the health sector. Māori health researchers and leaders warn that the hard-won gains made by Te Aka Whai Ora will be reversed. Further, this change resulted in decision-making being recentred within a system that has historically underserved Māori communities (Came et al., 2024). Important to note, is the disestablishment of Te Aka Whai Ora represents a lack of commitment to uphold equity and tino rangatiratanga on a systems level in healthcare.

One study conducted by Becares and Atatoa-Carr (2016) concluded that the level of trust Māori have in the healthcare system is directly impacted by systemic bias and racial discrimination. When care is not culturally aligned or safe, it contributes to the poorer mental health outcomes Māori experience (M. Edmonds et al., 2024). These findings align with current recommended strategies to close the equity gap in both detection and support. These strategies include investment in training clinicians in kaupapa Māori and trauma-informed care, Māori led models of care, and wānanga-based programmes for mental health (Pihama et al., 2017; Research Evaluation Consultancy and ThinkPlace & Ministry of Health, 2023; Te Rau Matatini, 2015).

2.8 International Comparisons

Postnatal depression and its relationship with cultural connectedness have been studied worldwide, revealing both unique manifestations and shared impacts globally. Comparing international research with domestic research highlights how intertwined cultural factors are with maternal mental health, and the significant role they play.

Western cultures such as those in the United Kingdom and America prioritise individualistic approaches to interventions, emphasising therapy and medication for the treatment of conditions such as PND. Approaches to interventions such as these, while effective in many cases, often do not

consider the broader cultural and social factors that contribute to maternal mental health. A study conducted by Oates et al., (2004) found that while there is a universal experience of PND, what varies across cultures is the interpretation of the condition, the perceived need for intervention, and the availability and use of healthcare services. These findings illuminate the necessity of providing interventions that are culturally appropriate. In contrast to this, research into non-Western cultures, such as Asia, show that collectivist societies mitigate the effects of PND through family connections and community networks (Qin et al., 2022). Evagorou et al., (2016) found that globally, postnatal practices and cultural beliefs can have either a positive or negative impact on the risk of developing PND. Some cultural traditions - such as postpartum rituals and extended family support – function as protective factors against PND, while others - such as stigma and cultural expectations - can contribute negatively. Therefore, building strong connections and networks within the whānau and wider community is important among Indigenous cultures.

In Aotearoa there is increasing evidence to support the Māori concept of whanaungatanga and cultural connectedness as a protective factor against PND. Kainamu (2013) investigates how mental wellbeing among Māori mothers can be fostered through strong connections to cultural identity, whānau relationships, and ancestral knowledge – highlighting the central role cultural belonging plays in maternal wellbeing. Further, Kainamu (2013) explored the vital role emotional and social supports play in easing the effects of ill mental health. This concept is reinforced by Merritt (2005) who found that maternal mental health outcomes are better for Māori women with strong cultural ties that are actively involved in community-based initiatives. This once again emphasises the protective role cultural engagement plays during the postnatal period.

For Aboriginal communities in Australia, cultural connectedness can be seen as a vital protective factor for maternal mental health. When access to cultural and community support is

limited, poorer mental health outcomes can be experienced. This was observed by Bhat et al., (2020) who found Aboriginal women residing in remote communities that faced economic hardships experienced poorer mental health outcomes during the perinatal period than those who did not. These hardships often exacerbate the poor mental health outcomes these mothers face, putting them at a further disadvantage. An article published by Murdoch University (2024) highlighted the strengthened self-efficacy and resilience seen in Aboriginal mothers when they partake in culturally grounded models of care, demonstrated in programmes such as “Baby Coming You Ready”. Thus, identifying access to culturally safe care services and programmes as a protective factor against feelings of stress, isolation, and ill mental health. This article aligns with studies conducted in Aotearoa with Māori communities. The protective nature of cultural connectedness against PND extends beyond Indigenous communities to various ethnic groups, and the mental health of their mothers. One study by Ponting et al., (2020) regarding the depressive symptoms of Latinas in low-income households in America, found that contextual and cultural factors play a crucial role in maternal mental health among this population. This study does not specifically focus on cultural connectedness; however, it does highlight the contribution cultural influences make to the mental health outcomes of postpartum mothers. Similarly, a study conducted by Patel et al., (2002) found that protective factors against PND among mothers in Goa, India included participating in cultural traditions and receiving support from extended family. These findings indicate the relevance of cultural context across the globe.

Naeem et al., (2024) found that when CBT is culturally adapted (CaCBT), higher rates of early recovery from PND are observed among South Asian communities in Canada, who often found Western-based CBT insufficiently responsive to their cultural needs. The study found that this could be due to overlooked or misunderstood cultural nuances. The research highlights therapy

outcomes from CBT can be improved through the integration of cultural beliefs, values, and practices. The results from the study indicate that participants who received CaCBT reported a more positive therapeutic experience, greater satisfaction, and greater engagement, than those who participated in traditional forms of CBT (Naeem et al., 2024). Although this study is based on findings from South Asian communities in Canada, the positive results for CaCBT could indicate the potential for success if adapted for other Indigenous populations. Through acknowledging cultural contexts and incorporating them, an approach such as this has the potential to improve the mental health outcomes of Indigenous and minority populations worldwide, foster trust in mental health services, and promote cultural competence. Ultimately providing more effective care.

These International comparisons indicate that, across diverse populations, cultural connectedness can serve as a protective factor against PND. The nature, type, and level of cultural support varies across different regions. However, common themes across regions are the importance of intertwining cultural practices and social support networks. Mental health interventions are constantly evolving worldwide, embedding cultural considerations into postpartum care ensures the mental health needs of Indigenous mothers are addressed.

2.9 Barriers to Culturally Appropriate Care

There are many significant barriers to accessing culturally safe postnatal care for Indigenous mothers. These barriers include socio-economic challenges, systemic issues, discrimination, and cultural insensitivity.

2.9.1 Socio-economic Challenges

Socioeconomic challenges faced by Māori women attempting to access antenatal and postnatal care include economic constraints, educational disparities, and cultural factors. These

challenges contribute to the inequities found in both infant and maternal health outcomes between Māori and non-Māori women.

Prevalent among Māori mothers is their limited capacity to afford essential items for themselves and their family. This is most obvious in the prevalence of Māori mothers living in inadequate housing. A study conducted by the New Zealand College of Midwives (2020) found that socioeconomic disadvantages faced by Māori women become a barrier for them to adequately use maternal health services. Disadvantages include food and income insecurity, overcrowding, and family safety concerns. These challenges are further exacerbated by educational disparities faced by Māori mothers. Research shows that Māori women have fewer antenatal visits overall and are less likely to have antenatal education, than their non-Māori counterparts (Ratima & Crengle, 2013). Insufficient educational engagement can lead to the underutilisation of healthcare services and delays in seeking timely care. Moreover, research has found that Māori women are more likely to access antenatal care later than non-Māori, with Māori women six times more likely to book late than women of other ethnicities (Corbett et al., 2014).

Lastly, cultural factors play a pivotal role in healthcare accessibility. Cultural barriers such as a limited number of Māori healthcare providers and a lack of accessibility to culturally responsive services result in lower satisfaction among Māori women in antenatal, labour, and birth care. Further, the lack of cultural safety deters Māori women from seeking the necessary care needed, further compounding existing health disparities (Ratima & Crengle, 2013).

2.9.2 Systemic Barriers

Aotearoa provides free or subsidised healthcare for all citizens; this healthcare often reflects Western paradigms that do not always align with the cultural practices of the Indigenous Māori people. When services are provided that are not culturally safe or relevant, feelings of mistrust can

develop among service users resulting in Māori women failing to seek care when needed. Ratima and Crengle (2013) found that pregnant Māori women have fewer cumulative antenatal visits and are less likely to attend antenatal classes than non-Māori, suggesting persistent systemic barriers within healthcare services. These findings are supported by the Hapū Māmā Village Project (2022) which identified financial constraints, discrimination within healthcare, and a lack of culturally safe services as systemic barriers faced by hapū Māori women accessing antenatal care. Similarly, Dawson et al., (2019) found six social determinants - physical access, political context, maternity care system, acceptability, colonialism, cultural factors - as barriers to equitable maternal healthcare and institutionalised racism as an underlying systemic barrier. These findings suggest that the current healthcare system in Aotearoa is not meeting the cultural or emotional needs of Māori mothers.

Studies on the initiation of maternity care and barriers to early initiation of antenatal care found that Māori and Pacific women are more likely to delay initiating antenatal care due to; unclear pathways, lack of information, and lack of support, they are more likely to face inequalities in accessing maternity care, and more likely to report lower satisfaction of maternity care than non-Māori and non-Pacific (Barnes et al., 2013; Clifford-Lidstone & Ryan, 2013; Corbett et al., 2014; Makowharemahihi et al., 2014). This research highlights the discouraging effect these barriers have on Māori mothers seeking antenatal care and emphasise the need for critical evaluation of the current healthcare system in Aotearoa.

2.9.3 Cultural Insensitivity

Cultural insensitivity and discrimination are two significant challenges Māori women face when accessing antenatal and postnatal care in Aotearoa. One study found that shorter gestation periods and lower birth weights were associated with experiences of ethnic discrimination during

pregnancy. Thayer et al., (2019) found that physical attacks were linked to reduced gestation length, while discrimination in housing and employment was associated with lower birth weights. This study highlights the way Māori pregnant women are negatively impacted because of discrimination. Another barrier to access is cultural insensitivity. Hayward et al., (2025) found that wahine Māori experienced a range of challenges while pregnant, including a fear of being judged, lack of relationship or rapport with their midwives, inconsistent care, and mistrust in the healthcare system. This was evident in the findings as many Māori women expressed deep concern about losing custody of their children if they disclosed mental health or mood issues. A perceived lack of culturally appropriate care compounding with the pervasive mistrust in the system leads to a disengagement of maternity care altogether for many Māori mothers.

Culturally tailored care programmes have been developed in an effort to address the identified disparities. One such programme is the He Korowai Manaaki initiative, a pregnancy wraparound care trial (Lawton et al., 2021). This initiative incorporates culturally safe and holistically supportive care through an augmented maternity care pathway (Makowharemahihi et al., 2014). The goal of this initiative is to break down the barriers to accessing evidence-informed care by creating environments that integrate and respect the cultural values of Māori women.

It is evident that culturally safe practices must be implemented within the healthcare system to improve the access and outcomes for Māori women. This involves healthcare professionals and policy makers to first recognise and then address the institutional discrimination, historical colonisation, and power imbalances evident in interactions with healthcare today, to foster culturally safe environments. By doing this, healthcare professionals can ensure wahine Māori receive antenatal and postnatal care that is equitable, accessible, and effective, boosting Māori maternal and infant health outcomes.

2.10 Gaps in Literature

Research on PND has increased in the last decade, however prominent gaps are still present – particularly in Aotearoa on the experiences of Māori mothers. The existing literature is often unable to fully capture the contextual, cultural, and systemic complexities that play a part in a mother's wellbeing in the perinatal period. This review has identified four key gaps in the literature: underrepresentation of Māori voices in research, lack of longitudinal studies, inadequate integration of Kaupapa Māori methodologies, and limited evaluation of culturally specific interventions. Highlighting these gaps and addressing the issues is an essential step to ensuring future research and interventions have a positive and lasting impact on Māori communities.

While there is an increasing understanding of mental health issues during the perinatal period, there is a lack of Māori women voices in research. Hayward et al., (2025) identified that Māori women are deterred from reaching out for help within the healthcare system as they often feel judged or misunderstood when explaining the struggles they are going through. This results in underrepresentation of Māori women as service users and in research, ultimately hindering the development and advancement of culturally appropriate approaches. Ensuring the use of Kaupapa Māori methodologies in research is important to build trust and relevance to the findings, and centre Māori perspectives in study designs and outcomes (C. G. Meredith, 2024). The lack of studies employing such methodologies highlights the notable gap in literature. Active inclusion of Māori voices in research is vital to ensure interventions are culturally relevant and effective.

Most literature on the perinatal period and mental health of Māori mothers are cross sectional. As these studies only provide a snapshot of these mothers' experiences, longitudinal studies are needed to provide a deeper understanding of both the long-term effects of perinatal mental illness and the long-term impact of current interventions. It is important to capture the ever-

changing trends of health and wellbeing over time, which is possible through longitudinal studies (Morton et al., 2015). Signal et al., (2017) concluded that Māori mothers experience higher rates of anxiety and depression than their non-Māori counterparts, however, there is limited longitudinal studies on this topic. The challenge lies in understanding how the identified disparities manifest and persist postnatally. Insights from longitudinal studies have the potential to provide information around intergenerational mental health issues and their impacts. They could also provide guidance around the development of interventions that support the whole whānau.

Research on perinatal mental health that integrates Kaupapa Māori methodology is severely lacking. To ensure alignment with Māori values and worldviews, it is essential that these methodologies are embedded within the study design (Haitana et al., 2020). This is demonstrated in a study conducted by Meredith (2024) who seamlessly incorporated Kaupapa Māori methodology and demonstrated how to facilitate research that is culturally safe with Māori mothers experiencing mental health issues. To fill this gap in literature, researchers must commit to embedding Kaupapa Māori methodologies into their research by involving the Māori communities they are working with throughout the entire research process. Further, it is important for researchers to ensure their research is beneficial to the Māori communities upon which they are studying. Taking this approach can lead to culturally meaningful and academically rigorous findings.

Culturally specific interventions have been designed and implemented for Māori mothers experiencing perinatal mental distress, however, there has been little to no comprehensive evaluation of the effectiveness of these interventions. A systematic review by Meredith et al., (2023) found the focus of many studies to be on describing the interventions rather than evaluating outcomes, creating challenges around determining best practice in Indigenous perinatal mental health care. An example of a culturally tailored intervention is the adaptation of the Mellow

Parenting tool for Māori mothers. Penehira and Doherty (2013) discussed the positive outcomes and potential benefits of culturally tailored programmes for Māori mothers. Due to the lack of research into the effectiveness of such programmes however, it is difficult to advocate for their widespread implementation. Understanding how and what works with these interventions can be beneficial to Māori communities on both a micro and macro level. Comprehension can lead to changes in policy, practice, and resource allocation to support Māori mothers more effectively.

2.11 Policy Implications and Recommendations

The disparities in health outcomes faced by Māori mothers in the perinatal period is increasingly being acknowledged in Aotearoa, however, this has not translated into culturally grounded, coherent policy action. To address inequities, it is imperative that systemic transformation takes place across healthcare research, design, and delivery. The purpose of this section is to outline the policy implications and recommendations on this topic, based on findings from current literature. Current literature has found an urgent need for Māori voices to be embedded into structural reforms, expansion of the Māori workforce, early detection, and research that is community-driven and long term.

2.11.1 Embedding Kaupapa Māori approaches and Māori-Led Models of Care

Embedding frameworks grounded in Kaupapa Māori methodology is a necessary action to achieve equitable outcomes. Haitana et al., (2020) highlight the need for interventions to align with Māori realities, values, and aspirations. For this to be achieved, these methodologies need to be at the forefront of research and service delivery. What is more commonly seen in current practices is the application of cultural competence add-ons opposed to using Māori ways of knowing and being as a foundation for practice.

It is important for policy reform to actively promote Kaupapa Māori approaches in both service design and commissioning. This can be done through onboarding Māori-led organisations such as marae and iwi to provide maternal mental health services grounded in mātauranga Māori such as whakapapa and tikanga. When interventions are adapted to be delivered through a Kaupapa Māori lens, significant improvements in maternal wellbeing can be expected. This was demonstrated by Penehira and Doherty (2013) with their adaptation of the Mellow Parenting intervention named Hoki ki te Rito. The study found that parents on the Hiko ki te Rito programme had significant improvements in cultural identity, maternal wellbeing, and parental confidence, thus affirming the effectiveness of Māori-led, culturally aligned interventions. Moreover, these findings highlight the shift mainstream services must make to ensure Māori leadership within organisations is not tokenistic. Rather it is embedded in power sharing models at both operational and governance levels. Meredith et al., (2023) argue that Indigenous leadership in health is not only important but vital. They bring to light the need for collective, community-led approaches to cultural safety, rather than placing the responsibility solely on individual clinicians.

Longterm investment into Indigenous-led initiatives is imperative to sustain Māori-led services. The current funding structure for many Kaupapa Māori health services is short-term meaning initiatives must operate within a system that is undermining the potential impact of their services (Ministry of Health, 2022b). Māori providers need to be empowered to continue to develop, evaluate, and deliver programs through policy commitment to long-term funding. This fosters a sense of trust within the community and enables services to provide a continuity of care to service users.

2.11.2 Improving Detection and Strengthening the Māori mental health workforce

While it is widely recognised that early detection of perinatal mental health concerns is critical to improving health outcomes for mothers and babies, the current screening tools fail to account for cultural nuance – an essential consideration when assessing Māori mothers. A systematic review by Chan et al., (2021) found that under-detection of PND in Indigenous women can be the result of mismatches in clinical thresholds, constructs of distress, and language. Complementing this, Hayward (2025) found that underreporting can in part be attributed to the fear of judgment Māori mothers experience during mental health screening.

The development of culturally adapted screening tools, co-designed with Māori, should be supported through policy. For screening to be effective for wahine Māori, it must be embedded in relationship-based practice. Clinicians must work beyond the realms of Western psychological models to understand Māori conceptualisations of distress. To achieve this, the existing workforce should be trained in culturally responsive, trauma-informed care, ensuring sensitivity and cultural safety during the screening process (Pihama et al., 2017).

Across all mental health professions Māori are severely underrepresented within the workforce, along with improving detection, the Māori workforce must strengthen significantly (Ministry of Health, 2023). The Māori workforce can be increased in healthcare sectors such as clinical psychology, maternal mental health social work, midwifery, and psychiatry through targeted approaches supported by mentorship, scholarships, and training environments grounded in Kaupapa Māori. Alongside growing the workforce, retention strategies must be implemented. It is imperative that these prioritise workplaces that are culturally safe, where Māori practitioners feel valued (Haitana et al., 2020).

Substantial investment into developing the workforce is crucial in shifting service improvements from superficial to transformative. Māori mothers deserve the same care their non-Māori counterparts receive. This means collaborating with clinicians who understand lived experiences, the importance of hauora and holistic health, cultural nuances, and who are committed to decolonising healthcare practices. Moreover, not only is this workforce equitable, but it is also the foundation for systemic change.

2.11.3 Commitment to Long Term, Community Driven Research

As previously discussed, the need for longitudinal, community driven studies are urgently needed to address the complex nature of perinatal mental health for Indigenous mothers and to explore the intergenerational impacts maternal mental health has on the whānau (Morton et al., 2015). Valuable insights have been gained from the Growing Up in New Zealand longitudinal study, however, future research based within Kaupapa Māori frameworks would position cultural connectedness and resilience as core outcomes, valued equally alongside standard clinical measures. To achieve this, researchers must centre Māori realities, measures of success, and aspirations within their research (Haitana et al., 2020). Moreover, both partnership and accountability to Māori communities must be the driving force behind future research. This includes involving iwi, hapū, and community providers in the entire process, including codesigning research questions, methods of data collections, and interpretation (C. Meredith et al., 2023). Further, data sovereignty is important, researchers must ensure findings are meaningful and accessible to the communities involved. A commitment to long term, community driven research is imperative to the development of sustainable interventions grounded in Māori worldviews. The alternative is the risk of reform being shallow and cyclical. Therefore, deeply disconnected from the realities of the mothers they are aiming to serve.

2.12 Conclusion

This literature review has closely examined the complex nature of the relationship between cultural connectedness and PND among Māori mothers, and the roles systemic racism, structural inequities, and the erosion of traditional support systems play in the development of PND. It has explored Kaupapa Māori theory and theoretical frameworks including Bronfenbrenner's Ecological Systems Theory, Te Whare Tapa Whā, and the Biopsychosocial Model, to gain insight into how Māori mental health experiences are shaped by social, historical, and cultural concepts.

Although there is growing literature that supports the notion that a protective factor against PND is cultural connectedness - including access to culturally grounded care, whānau, tikanga, and identity - there are still significant gaps. These gaps include the lack of evaluations of Māori-led interventions and the limited prevalence data that is Māori specific. It also includes clinicians continued use of screening and support tools that do not accurately reflect Māori realities. Longitudinal research that is community driven and centres Māori voices, as well as Māori measures of wellbeing, are critically important to the development of responsive and sustainable solutions.

This review has supplied appropriate rationale for the present study, which seeks to examine if cultural connectedness can function as a protective factor against PND for Māori mothers. As this study recognises the importance of Māori-led research, the following chapter will outline the methodological approach used, which is guided by Te Ara Tika principles within Kaupapa Māori theory. Qualitative methods are employed and prioritise whanaungatanga, relationality, and engagement that is mana-enhancing and reciprocal.

3. Methodology

3.1 Introduction

Chapter three begins by describing the theoretical frameworks of kaupapa Māori, constructivist theory and mātauranga Māori. It will then outline the design including participant recruitment and rationale, ethical considerations, and the role of the researcher. The final section will highlight the process of data collection and analysis; it will then discuss the themes that emerged and how they were developed with qualitative research standards within kaupapa Māori framework.

The research approach taken to explore the relationship between PND and cultural connectedness among Māori mothers' centres around Māori ways of being, knowing, and doing, within a kaupapa Māori framework. Due to the historical and current marginalisation of Māori voices particularly in maternal mental health research, this research does not apply Māori concepts to Western frameworks of research but rather undertakes it in a manner that is grounded in mātauranga Māori, this includes the designing of questions, forming relationships, and interpreting meanings. The methodology selected for this study is qualitative as this allows for deep inquiry of lived experience and honours relational knowledge. This study does not seek generalisable outcomes, instead it hopes to understand the interconnectedness of cultural practices, identity, and relationships and how they impact perinatal wellbeing. This research understands that Māori mothers participating in this study are the knowledge holders, with the power to inform the findings and impact transformational change within the maternal mental health space, therefore the participants are not positioned as subjects of this study.

The aim of this research was to explore protective factors, including cultural connectedness, for Māori mothers who have experienced symptoms of PND. The specific objectives were:

1. Talk to Māori women about their experiences of pregnancy, birth, and raising children
2. Talk about the process of recognising symptoms of PND and what living with that is like
3. Talk about their understandings of cultural connectedness – what it means to them
4. Explore factors that helped with their symptoms of PND
5. Talk about their perception of cultural connectedness in relation to how it influenced their mental health personally.

3.2 Research Paradigm

This research is grounded within a kaupapa Māori paradigm, which centres the research process around Māori ways of being, knowing, and doing, their values and their practices. Kaupapa Māori research aims to produce results that are beneficial to Māori, because of this kaupapa Māori research is undertaken by Māori, for Māori, and with Māori (Tuhiwai Smith, 1999). This methodology advocates for culturally responsive approaches while challenging the dominant Western epistemologies and methodologies within research. It seeks to uphold the mana motuhake and tino rangatiratanga of participants throughout the research process (A. R. Bishop, 1995).

To complement this study, it is also informed by a constructivist paradigm. This theory proposes that knowledge is constructed through the social and cultural environments of individuals. Constructivism is based on the understanding that realities and experiences, and their meanings are not fixed, they are subjective entities that are co-constructed between participant and researcher (Charmaz, 2006). Māori ways of being knowing and doing include deriving understanding from collective narratives and experiences. Constructivist theory was chosen to inform this study as it aligns with both the contextual and relational nature of Māori systems of knowledge. While the primary epistemological foundation of this research is Kaupapa Māori theory; however,

constructivism plays an instrumental role in understanding the co-construction of meaning. Constructivist theory is used only to the degree that it reflects Māori systems of knowledge, specifically around valuing contextual, relational, and co-constructed understandings of realities and experiences. The importance of highlighting the hierarchy between these frameworks is to ensure the research process accurately reflects and respects Māori ways of knowing, being, and doing through a kaupapa Māori lens and that ultimately it benefits the communities with which it is working. In essence, this study seeks to contribute to the wellbeing and empowerment of Māori mothers and their whānau.

3.3 Theoretical Framework

The theoretical framework can be described as the foundation upon which research is built, it guides the research design, data collection, and data analysis. The primary theoretical frameworks informing this research are kaupapa Māori and mātauranga Māori.

3.3.1 Kaupapa Māori

Te Aka, the Māori dictionary describes kaupapa Māori as a "Māori approach, principles, and ideology – incorporating the knowledge, skills, attitudes, and values of Māori society" (Moorfield, 2024) This framework encompasses a set of values and philisophical principles embedded in Māori culture and worldview. Kaupapa Māori research was developed in response to several factors: a commitment to honour te Tiriti o Waitangi through collaboration between Māori and non-Māori, a global push for Indigenous self-determination, and the increase of initiatives led by Māori such as health models and language schools (S. Walker et al., 2006). Kaupapa Māori research acknowledges that the research process can be shaped and guided by cultural spirituality, language, and identity, therefore it remains centred around the perspectives, aspirations, and experiences of Māori (Bishop, 1999; Hiha, 2016).

Kaupapa Māori methodology critiques the dominance of Western research methodologies and challenges non-Māori research frameworks (Walker et al., 2006). This framework rejects colonial research paradigms that have historically, and continue to, marginalise Indigenous voices and systems of knowledge. Instead, Kaupapa Māori research is collaborative and promotes reciprocal relationships between participants and researchers, ensuring Indigenous ways of knowing and being are at the forefront. It prioritises Māori control over research, adheres to Māori tikanga, and aims to reclaim Māori knowledge and agency throughout the research process. Further, it provides Māori with the opportunity for self-determination, to use their experiences and realities to address cultural, political, and social issues (Moyle, 2014). This differs from culturally safe research, which aims to respect cultural identities but does not inherently grant Māori control over the research design, process, or outcomes (Walker et al., 2006).

The five key principles of Kaupapa Māori research include tino rangatiratanga, Māori worldview, te reo, whānau, and social justice. Tino rangatiratanga emphasises autonomy, sovereignty, and self-determination. It challenges the prevailing ideologues that disadvantage Māori communities by prioritising the needs and issues specific to those communities. Recognising Māori worldview is crucial in ensuring whakapapa are incorporated to guide the research practices. Te reo Māori is encouraged as a way of accessing perspectives and histories that don't necessarily have the same meanings when translated to English. Whānau means more than just family, it means generosity, reciprocity, and cooperation. Whānau underpins Māori culture. Lastly, social justice is a goal within this framework to benefit Māori through redressing power imbalances (Walker et al., 2006).

3.3.2 Mātauranga Māori

Mātauranga Māori are Māori knowledge systems that encompass traditional, cultural practices, knowledge, and ways of understanding the world (Moorfield, 2024). Mātauranga Māori is knowledge from diverse fields - such as agriculture, navigation, astronomy, healing, and pūrākau - that has been passed down through generations from tūpuna. A theme central to this framework is the concept of interconnectedness, a holistic worldview in which all living beings and the environment are interdependent on each other. Therefore, emphasis on the importance of maintaining balance in the relationships we have with our whenua, our tūpuna, and future generations is embedded in the mātauranga Māori worldview.

Research methodology has historically been influenced heavily by Western knowledge paradigms. Due to this, efforts have been made to redefine knowledge production within Indigenous frameworks and decolonise research methodologies, which has led to the creation of Indigenous models (Tuhiwai Smith, 1999). The aim of such methodologies and frameworks is to legitimise Indigenous ways of knowing and being by disrupting the colonial power dynamics present. Challenges remain around understanding the diversity and complexity of Indigenous knowledge systems and pushing back against binary or reductionist categorisations (Tuhiwai Smith et al., 2016; Walker et al., 2006).

For this study, Mātauranga Māori provides the scope through which to explore the role of cultural connectedness, or lack thereof, in the development of postnatal depression among Māori women. By drawing on Māori ways of knowing and being, this research aims to reveal the inherent resilience and strength ever present in Māori communities. Further, it challenges deficit-based perspectives that pathologise the experiences of Indigenous people.

3.3.3 Integration of Theoretical Frameworks

These theoretical frameworks highlight the importance of having Indigenous voices and perspectives central to this research. This study strives to prioritise reciprocity, empowerment, and cultural relevance while amplifying Māori voices and experiences. This is important as it will promote positive outcomes for whānau, contribute to the decolonisation of research practices and the broader discourse on maternal mental health, and encourage holistic wellbeing and resilience among Māori mothers. The research process will be guided by the integration of these two frameworks, this includes the development of research questions, methods for data collection, and data analysis strategies. In doing so, this research endeavours to generate culturally informed, contextually relevant insights that are transformative for Māori whānau.

This section highlights the importance of kaupapa Māori and mātauranga Māori when shaping research objectives and approaches. The subsequent sections of the methodology chapter will be informed by these frameworks, which will also guide the selection of participants, ethical considerations, and methods of data collection. The thesis question will be explored through the holistic and culturally responsive lens of the kaupapa Māori and mātauranga Māori frameworks. In doing so, this research aims to challenge Eurocentric perspectives that have historically overlooked the importance of cultural factors in understanding mental health outcomes for Indigenous communities. Further, together these frameworks understand wellbeing is inherently linked to connection and identity, they reject deficit-oriented views that pathologise, and they acknowledge the interconnections between individuals and their social, cultural, and environmental contexts. Lastly, it is important to note that while this research is deeply rooted in kaupapa Māori and mātauranga Māori paradigms, there are elements of constructivist theory that have been incorporated selectively, to support the analytical process - such as the recognition that

understanding is formed through relational interactions (D. Wilson et al., 2022). This concept is not unique to, but consistent with kaupapa Māori principles (Eketone, 2008). Constructivism is drawn upon in this study as less of a competing epistemology and more as a secondary interpretive lens to aid in explaining and understanding the co-created nature of meaning derived from participant's narratives (D. Wilson et al., 2022). Constructivism is relevant within this study due to its emphasis that all knowledge is situated and the importance it places on researcher reflexivity. These features are helpful in thematic analysis as they assist in framing the analytical process while ensuring Māori ways of being, knowing, and doing stay centred. The role of constructivism is not to define, instead it is intentionally positioned to enhance the interpretive work within a methodology that is Māori centred.

3.4 Researcher positionality and reflexivity

Consistent with kaupapa Māori methodology and a constructivist epistemology is understanding the positionality of the researcher and the interpretive lens through which this research was conducted. I am a Māori mother that works closely with other Māori mothers and their tamariki within a marae setting. From conception through to analysis and interpretation, this research has been deeply shaped by my own personal, professional, and cultural identity. The motivation for this research arises from my own experience of navigating Western constructs of motherhood that felt misaligned with my inherent instincts and inherited ways of knowing. Conforming to the societal expectations and the dominant Western ideals of motherhood left me feeling isolated and unseen. This study is driven by a desire to challenge those normative frameworks and create space for Māori mothers to feel seen, supported, and empowered to parent in ways that honour their tūpuna and collective identity. I am positioned as both insider and outsider in this research. I share a lived reality with the participants as a Māori mother; however, I also occupy

the role of researcher. To ensure integrity is upheld throughout the research process, constant reflexivity and ethical care is critical.

Reflexivity throughout the research process involved regular journaling of insights, frequent revisits of my assumptions, and remaining conscious of the power dynamics between myself and the participants. I recognised the privilege and obligations that came with creating a safe and respectful space for participants to share their experiences. I was also deeply aware of the responsibility I held to honour those stories of vulnerability, grief, resistance, and healing, with integrity and care. My interactions were guided by the principle of whakawhanaungatanga, which allowed for genuine relationship building and free-flowing reciprocal knowledge exchange. Participants' voices shaped the direction and depth of this research, they were positioned as co-constructors of knowledge and never as subjects of enquiry.

As part of my reflexive practice, I recognise that my own positionality and lived experiences may influence the analysis – particularly where there is strong resonance between my interpretations and my own personal narrative. To mitigate this, I maintained critical engagement with data. This included employing a cyclical process of transcript review and thematic validation to ensure alignment with the voices and intentions of the participants. Additionally, my academic and cultural supervisors provided guidance and held space for reflection, offering crucial feedback to ensure my interpretations were firmly grounded in the data and shaped by tikanga Māori. This study is positioned at the intersection of academic enquiry and personal experience. The issues addressed in this study are not abstract concepts for me but lived realities I have encountered and navigated alongside other mothers. Occupying this shared space reinforced my commitment to undertaking research that upholds mana, centres participant dignity, and contributes to the wellbeing of Māori communities.

Aligning with kaupapa Māori principles, this research seeks to serve the community it represents. The practice of reflexivity throughout this process was more than a methodological requirement, it was an ethical and cultural obligation. This process demanded my full presence and accountability. It also required that I honour the trust participants placed in me by centring their voices and lived experiences throughout every stage of the research.

3.5 Data Collection

The data collection process was designed specifically to uphold the principles of kaupapa Māori methodology, this includes placing emphasis on the relationship between participant and researcher and their co-construction of knowledge, and importantly, cultural safety. Whakawhanaungatanga is an essential element in this approach as it lays the foundation for building and maintaining relationships through shared connections and experiences (A. R. Bishop, 1995). This approach around building relationships is a key component to ensuring the research process stays grounded in Māori values and is both respectful and reciprocal.

The primary method of data collection for this study was semi-structured interviews as they provide a consistent framework while remaining flexible. This approach allows the researcher and participants to deeply explore the participants' experiences (Gill et al., 2008). Further, this method aligns with the constructivist paradigm which also informs this study and posits that the co-construction of knowledge is achieved through shared understandings and social interactions (Charmaz, 2006). Within kaupapa Māori and mātauranga Māori research, semi-structured interviews provide an opportunity for participants to share their narratives in an empowering and culturally appropriate manner (Tuhiwai Smith, 1999).

Lastly, semi-structured interviews also affirm the relational aspect within kaupapa Māori methodology through fostering a safe, comfortable, and respectful environment for participants.

This approach emphasises prioritising the wellbeing of participants and highlights the importance of manaakitanga and wairuatanga throughout the study and research process (Cram, 2001). The structure of the interviews is consistent with Māori ways of knowing and doing, where narratives are shared through collective storytelling, korero, and purakau (Pihama et al., 2002). Every stage of the data collection process was informed by kaupapa Māori values from the first to the last interaction. A foundational part of this process was ensuring the research relationship was mana-enhancing for the participants, this was done through whakawhanaungatanga, connecting and sharing of whakapapa, food, humour, and conversation outside the formal interview questions.

To create a space that was comfortable, culturally safe, and spiritually grounded, karakia was said at the start of each interview, it was then said again at the end to close the space. Interviews were conducted on the marae which allowed tikanga to be upheld naturally and further reinforced the intentions of the kaupapa Māori principles central to this study. The purpose of these practices was to not only honour the wairua and mana of the participants but to acknowledge that their contributions extend to taonga tuku iho which is inherited, living knowledge. Incorporating these aspects into the research process reinforces the researcher's integrity and the importance of cultural respect and safety (Tuhiwai Smith, 1999).

3.6 Participants

Eight Māori mothers were recruited as participants for this study. Eligibility criteria included mothers who whakapapa Māori who experienced symptoms of PND in the postnatal period. Participants were recruited through flyers, social media posts, and word of mouth. Participants were recruited from within The Southern Initiative (TSI) catchment areas.

3.6.1 Recruitment Rationale

The 2018 census found that there are 181,194 residents in Tāmaki Makaurau that identify as Māori, this represents 11.5% of Tāmaki Makaurau's entire population, over a third (36.7%) of these residents call areas within the TSI catchment, home (Council Research & Unit, 2020). The TSI includes local boards such as Papakura, Ōtara-Papatoetoe, Manurewa, and Māngere Ōtahuhu, these areas stand out as significant for Māori communities within the wider region. Of the residents in Papakura and Manurewa, 26.8% and 26% respectively identify as Māori, emphasising the substantial presence of Māori in these localities (Council Research & Unit, 2020). Recruiting participants from within the TSI catchment area, where Māori identity and culture is deeply rooted in the communities, ensures an aim of the study to capture diverse experiences, is supported. The strategic approach to conduct research in communities where Māori residents constitute a large portion of the population enables findings of this research to reflect the challenges and realities of Māori māmā.

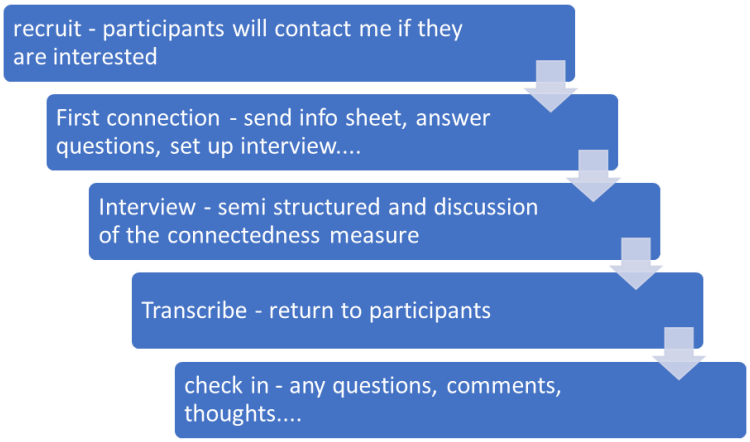
The participant numbers of eight māmā is acceptable and can be advantageous for qualitative research. Hennick & Kaiser (2022) reviewed in-depth empirical studies and found the range of participants where studies reach saturation is between nine and 17. The opportunity to facilitate deeper insights into the experiences and perspectives of participants, while applying a nuanced approach to exploring topics, is made possible with a smaller participant group. Further, the smaller group allows the researcher to stay on task while conducting data analysis, avoiding becoming overwhelmed by copious amounts of data. Thus, ensuring the examination of the findings is thorough and detailed. Therefore, this number of participants achieves goals of saturation, rigor, and depth of analysis.

3.6.2 Procedure

Firstly, participants were recruited using the purposive sampling method. This was carried out by putting up flyers in local GP doctor receptions, marae, and word of mouth. Individuals who were interested in participating after reading the information supplied were invited to contact the researcher via phone or email. This approach aligned with kaupapa Māori principles of tino rangatiratanga as it allowed for participant autonomy, mothers engaged on their own terms which ensured the process was non-intrusive and mana enhancing. The process is summarised in figure 1.

Figure 1

Research process



Once initial contact had been made, the prospective participants received an information sheet which provided details around the purpose of the study, their rights, the research process, and how their data will be collected, stored, and handled. They were also made aware that the researcher was available to answer any questions they had around the study before proceeding. Participants that wished to continue were told the interviews would take place in a private meeting room at the Papakura marae and a time was organised between participant and researcher. If participants were

uncomfortable with meeting at the marae they were encouraged to pick a place, they felt more comfortable, both comfort for the participant and flexibility on the researcher's part were prioritised. Semi-structured interviews were conducted kanohi ki te kanohi or face-to-face, at the Papakura marae in a space that was both private and comfortable. Each interview lasted between 60-90 minutes, and involved open-ended questions to prompt discussion, this provided participants with the opportunity to lead the direction of the conversation. This approach allowed each participant to speak about what felt most important for her in a space that was both emotionally and culturally supportive and safe. Each participant was given a voucher as a token of appreciation, reciprocity, and acknowledgement of each person's time, emotional labour, and generosity with story sharing. Kai and informal korero was offered before, after, and throughout the interview to align with the tikanga of the study and relational integrity was upheld in each encounter.

Each interview began the same with whakawhanaungatanga and a karakia to create a space that was culturally safe and respectful. This process was about relationship building between myself and participant as a way of establishing trust and reciprocity, which aligns with kaupapa Māori values (Bishop & Glynn, 1999). The format of the interviews provided the participants with an opportunity to share their experiences and narratives in great depth. This then allowed space for me to introduce the connectedness to culture measure which in turn supported a much deeper reflection around belonging and identity and how those concepts affect wellbeing.

With consent from the participants, interviews were audio recorded, then transcribed by me, the researcher. Transcripts were then given to the participants to review, providing an opportunity for each participant to amend, clarify, or confirm their responses and tones. Tino rangatiratanga was upheld throughout this member checking process as participants maintained full control of their narratives and how their voice and experiences were represented (Hudson, 2010).

Follow-up calls were made to each participant after the transcript review. This step was a space for any thoughts or feedback from the participants around the research process and served as another opportunity for me to uphold manaakitanga, relational responsibility, and the holistic wellbeing of the participants (Kennedy & Cram, 2010). Each participant received a voucher as koha for their time and experiences they shared willingly.

3.6.3 Interviews

Semi-structured interviews were conducted to collect nuanced qualitative data on a participant's feelings and experiences in the postnatal stage (Appendix C). Alongside a comprehensive interview I did explore PND symptoms. Symptoms measured in this study included persistent sadness, thoughts of harming herself or the baby, insomnia, fatigue, irritability, and difficulty caring for the baby. This was integrated into the semi-structured interviews. I drew on the Edinburgh Postnatal Depression Scale (EPDS) as a framework, which is a 10 question self-reporting questionnaire based on how the mother was feeling. However, due to the qualitative nature of this research I adapted the response format. The original EPDS scores answers on a 4point likert scale (0=absence of symptom, 1 = the symptom was experienced some days, 2 = symptom was experienced more than half the days of the week, 3 = symptom was experienced nearly every day) with a scoring range of 0 – 30 (Cox et al., 1987), my approach focused on in-depth reflections from the participants rather than a scoring system. The EPDS was used as it is comprised of questions specific to the emotions and experiences that are associated with becoming a new mother. Further, multiple meta-analyses, culturally sensitive translation, and systematic reviews have found the EPDS to be highly effective across diverse cultural contexts. These studies also confirm the reliability and validity of the EPDS across diverse populations (Shrestha et al., 2016; Levis et al., 2020). Further, studies found the EPDS is reliable against the International Classification of

Diseases -10 and Diagnostic and Statistical Manual of Mental Disorders -5 criteria (Shrestha et al., 2016; Levis et al., 2020; Smith-Nielsen et al., 2018). Various studies confirm the Cronbach's alpha coefficient is between 0.77 and 0.88 depending on the specific study. These collective findings affirm the internal consistency of the EPDS (Bunevicius et al., 2009; Montazeri et al., 2007).

Participants voiced mixed feelings about the EPDS. When discussing their use of the EPDS in the past, some participants described the process as rushed and impersonal, noting that it failed to adequately capture the depth of their experiences. Other participants noted that when they had filled the EPDS form out in the past they had done so quickly, without fully comprehending its purpose, while others admitted not feeling safe enough to respond honestly. Several mothers shared they felt the numbering format felt limiting, particularly in instances where they did not meet the threshold for support, but they were experiencing distress. In contrast, responses for the adapted version used in this study were positive. They mentioned appreciating having more time to reflect on the questions so were able to give more in depth answers and share their narratives in their own words. Participants described feeling empowered and culturally safe with the open-ended format, noting it felt more like a conversation with a friend or whānau member and less like a test to be scored and judged.

3.6.4 Cultural Connectedness

During the interview I explored the level of cultural connectedness with each participant. These interviews included questions based on an adapted version of the cultural connectedness scale (CCS), developed by Snowshoe et al., (2015) The reliability and validity of this tool has been verified in multiple studies. This scale was adapted to fit the context of both this research and Māori culture. The purpose of this adaptation is to provide a nuanced understanding of cultural connectedness and how it relates to the wellbeing of Māori mothers.

The interview questions were based on the Matariki stars. Matariki (Māori new year), is deeply rooted in the astronomy and traditions of Māori. Much like the birth of a child, Matariki is a time of celebration, new beginnings, renewal, growth, and potential. There are specific cultural meanings and teachings behind each star in the Matariki cluster, to guide and connect Māori to their tūpuna and the environment. From Tupu-ā-nuku to Waitā, the stars symbolise elements of cultural connectedness such as whakapapa, rangatiratanga, wairuatanga, manaakitanga, whanaungatanga, and kaitiakitanga. Not only are these elements fundamental in nurturing wellbeing, belonging, and a sense of identity among Māori, but they are also the guiding lights, or hinatore, that offer guidance and wisdom. Hinatore means a spark of light and refers to the way tiny organisms have a phosphorescent glow, metaphorically lighting the path of life for the next generation. Therefore, including Matariki stars in this research is an essential part of the project. The CCS is divided into three dimensions, spirituality, identity, and traditions. Each of the Matariki stars included in the adaptation fits into one of these three dimensions and represent integral aspects of Māori culture and connectedness. The stars included are Tupuānuku, Tupuārangi, Waipun-ā-rangi, Ururangi, Waitī, and Waitā.

Under the dimension of identity there is Tupuānuku which represents both connection to the whenua and growth (Ministry for the Environment, 2022), encompassing both whakapapa and ancestral links that tie individuals to their whānau and the whenua, providing a grounding experience for individuals who understand where they come from. This relates to the CCS framework which includes sense of belonging, self-identification, and community and cultural connection as the integral parts of identity (Snowshoe et al., 2015).

Ururangi represents leadership through its connection to the winds (Matamua, 2017), this is an important part of both personal and collective identity, and the pivotal roles individuals have

within their communities. Ururangi symbolises leadership, vision, and guidance, emphasising the important role rangatiratanga plays in shaping an individual's identity. Within te ao Māori, the rangatiratanga provides direction for whānau and their communities.

Waitā represents wairuatanga, which means spirituality. Spirituality includes practices, beliefs, and traditions that are sacred to articular cultures that connect individuals to either a higher purpose, understanding, or both. Importantly, Indigenous ways of knowing and being are deeply entwined and connected to spirituality, there is growing literature to show the positive relationship between wellbeing and spirituality (Valentine et al., 2017). The spiritual connection between all living things is central to Māori culture and emphasised through wairuatanga. This aligns with the connection Waitā has to salt water (Matamua, 2017) and the way it uses the phases of the moon to symbolise the interconnected and cyclic way of life while highlighting spiritual bonding.

Traditions can be defined as shared practices, customs, and beliefs passed from one generation to another, within a community. Traditions play a crucial role in the functioning of a community or society as they preserve the cultural heritage and shape its identity (Hobsbawm et al., 1983; Shils, 1971; Geertz, 1973). Tupu-ā-rangi emphasises celestial bonds and the need to nurture and preserve these relationships, embodying a tradition of unity and communal support (Matamua, 2017). Paralleling this is whanaungatanga, the tradition of cultivating and maintaining connections within a community.

Waipun-ā-rangi is associated with rain, sustenance, abundance, and the cycle of life (Matamua, 2017). These qualities are associated with those in manaakitanga, a tradition of kindness and care within the community, respect, and hospitality. An integral communal ethos of Māori cultural practice and social structure is a deeply ingrained tradition for sustaining life is sharing and giving.

Waitī symbolises stewardship over freshwater (Matamua, 2017), this represents protection, guardianship, and preservation of natural resources. Kaitiakitanga means guardianship, protection, and preservation. This aligns with traditions deeply ingrained in Māori culture of guardianship and respect for the environment, whenua, and its natural resources.

Each of these stars represents specific practices and values that are integral to Māori epistemology. Further, and importantly, these alignments focus on the universal broader themes of identity, spirituality, and tradition.

3.6.5 Recording and Transcription

Following participants' consent, interviews were audio-recorded to accurately capture the conversation which were then transcribed. Throughout the transcription process, close attention was paid to the participants' phrasing, tone, and expressions to ensure their voices were accurately reflected. This upheld the mana of each participant and maintained the integrity of their narratives throughout transcription, ensuring minimal room for misinterpretation.

To ensure this study aligned with the kaupapa Māori value of relational accountability and upheld academic rigour, participants were given their transcripts to review and validate. This process is known as member-checking, it allows participants the chance to clarify or correct what has been transcribed, to expand on their conversation, and ensure an accurate account of their experiences is represented. This strategy is used within qualitative research to improve the trustworthiness and credibility of the study (Lincoln & Guba, 1985). Further, within the context of this study, member checking aligns with the tikanga of manaakitanga, as participants are seen as knowledge holders and therefore collaborators of the research process. The participants were unidentifiable in the transcripts which were then stored securely to maintain confidentiality. This

study used thematic analysis to analyse the findings, the foundation of which were the transcripts from participants. This analysis sought to uphold the integrity of the narratives of the participants.

3.7 Ethical Considerations

A strong commitment to ethical integrity is imperative when conducting research with human participants, made even more essential when working with PND among a minority group such as Māori mothers. Both Māori and Western ethical frameworks play a part in guiding this study to ensure participants were treated with cultural sensitivity, respect, and care for the entirety of the research process. Te Ara Tika (Hudson, 2010) provided a framework to ensure the research was ethically sound from a kaupapa Māori perspective while the Belmont Report (Health & Services, 1979) laid the foundation for principles such as respect, beneficence, and justice. All ethical decisions were made in conjunction with these two frameworks, from consent to data protection, and relational responsibilities. Moreover, this framework was instrumental in ensuring relational accountability and maintained cultural safety throughout the research process, while reinforcing Māori values and epistemologies remained centred at every phase of the study. The use of these frameworks together allowed for an ethical approach that was robust, culturally safe, and both empowered and protected the participants. Due to PND being a very sensitive subject matter, I implemented wellbeing measures to support the participants. Participants were given information on the available mental health support services. Emotional safety was at the forefront and participants were explicitly told the interview can stop at any time if needed with any distress experienced being addressed appropriately (see Appendix A and B for information sheet and consent form).

To ensure security of data, all recordings and transcripts of participant interviews were stored on a password protected device, this device was accessible solely to the primary researcher. Aligning with the Belmont Report's focus on protecting the privacy of individuals and maintaining

confidentiality (HHS, 1979), each participant was assigned a pseudonym and all identifying information was removed from the transcripts. A copy of the ethics approval letter can be found in Appendix D.

To mitigate any power imbalances experienced, as is inherent in the research process, I engaged in regular reflexive practices. Such practices included journaling and consulting with Māori advisors, this also aided in bringing awareness to my positionality throughout. This practice of reflexivity assisted in upholding the integrity of Māori systems of knowledge, while honouring the mana of each participant throughout the entire research process.

3.7.2 Kaupapa Māori Principles

This research employs a kaupapa Māori framework and follows principles set out in Te Ara Tika guidelines for Māori research ethics (Hudson, 2010). These steps are vital in aligning this project with Māori ethical standards. To ensure that this research is culturally respectful and appropriate, this study incorporated the following Māori principles: ako Māori, tino rangatiratanga, taonga tuku iho, kaupapa, kaitiakitanga, and whānau, used Te Ara Tika as the guiding framework. The principles outlined were actively integrated throughout the entire research process, they guided participant interactions, methods of data collection, and how findings were interpreted to ensure cultural integrity and respect throughout.

Ako Māori (Culturally preferred pedagogy)

This principle involves practices of learning and teaching that are preferred by Māori. The methodologies employed in this research project respect the educational preferences inherent to Māori. This is seen in the way this project is collaborative, interactive, and reflects Māori knowledge systems. Further, by incorporating the principle of Ako Māori, this project reflects a diverse range of knowledge bases and perspectives, enriching the whole research process (Bishop &

Glynn, 1999). The use of semi structured interviews in this study is an example of this principle being used in practice. Collecting data in this way created a learning environment that upheld Māori values around knowing, storytelling, and meaning making, it provided participants with an opportunity to share their narratives and experiences in their own words.

Tino rangatiratanga (Self Determination)

This principle relates to Māori having sovereignty, self-determination, and autonomy. This principle ensures that Māori have control over the process and outcomes of this research project. This is upheld throughout by ongoing acknowledgement of Māori autonomy, respecting their sovereignty, and involving them in the decision-making process (Lilley et al., 2024). Participants had autonomy over their interviews and transcripts, and each participant was afforded the opportunity to review and approve the transcripts. This allowed participants to ensure their stories were respected and their voices were accurately represented.

Taonga tuku iho (Cultural aspiration)

This principle recognises the importance of upholding the cultural practices and values within this project. This is done through the integration of Māori worldviews and through the assurance that this project is beneficial to Māori communities. In order to contribute to the enhancement and preservation of cultural identity this project must respect and reflect the aspirations of Māori people (Pihama et al., 2002). The significance of cultural identity and heritage in retelling and understanding participants' narratives is woven throughout the research design which incorporated Māori concepts and language. The overarching concept of this principle is the transmission of cultural knowledge.

Kaupapa (Collective philosophy)

This principle is around ensuring that research is conducted with the collective aspirations and visions of Māori communities at the forefront. This can be implemented through community engagement to align the research with the community's values and goals. This is important as it ensures this research is for and with Māori, providing a sense of relevance and ownership among communities (Royal & Hauora, 1998). Continuous engagement with Māori organisations and mentors during the research process gave me insight into community priorities and needs. Further, it ensured the research remained aligned to the identified priorities and needs.

Kaitiakitanga (Guardianship)

This principle involves the protection and respect of Māori knowledge, data, heritage, and culture. It is important that this research is conducted in such a way that the safety of the taonga is safeguarded. Practices that ensure data sovereignty was implemented throughout this research project, ensuring the control over information and knowledge stays with the Māori community (Mead, 2003). The data collected throughout this process was stored securely on a password protected device with access available only to the primary researcher. All participants were informed of how their information would be stored, used, and protected.

Whānau (Extended family structure)

This principle encourages the researcher to adopt a holistic approach to research by acknowledging the importance of whānau within Māori society and recognising the interconnectedness of individual and whānau wellbeing. Providing whānau with an opportunity to be involved in the research process by considering their wellbeing and perspectives ensures this principle is upheld (Kennedy & Cram, 2010). During discussions about the research, I recognised

that decision making is collective in nature within Māori communities, therefore kōrero involving whānau was encouraged.

Collectively, these principles became the ethical foundation for all research decisions for this study. These guiding principles ensured the study aligned with Māori aspirations and remained culturally respectful and responsive. Lastly, these principles functioned as a guide for researcher behaviour and aided in upholding the mana of all the participants throughout the research process.

3.8 Data Analysis

This section discusses the analytical approach employed to interpret the data collected from participant interviews for this study. Thematic analysis was selected as it is a flexible approach and has great capacity for identifying patterns of meaning across participants' narratives – which aligns with both a kaupapa Māori and a constructivist paradigm. This research was able to keep the participant voice centred but also allowed cultural context and relational understanding to inform the interpretation of their narratives. The subsections that follow outline each part of the analytic process including any adaptations made to ensure the integrity of the data.

To interpret the information collected through semi-structured interviews, this study sought to use thematic analysis, in the form of the six-phase framework designed by Braun and Clarke (2006). This approach was employed for its systematic and flexible method of identifying, analysing, and reporting patterns found in collected data. Further, the six-phase framework works well in conjunction with research undertaken within a constructivist paradigm because it understands that the researcher plays an active part in both theme development and interpretation. The six phases are as follows: (1) familiarisation with data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, (6) producing the report (Braun & Clarke, 2006). While this framework was integrated within a kaupapa Māori

methodology to ensure the analysis of data aligned with Māori worldviews, it also acknowledged the contextual and relational nature of Māori systems of knowledge. This allowed for a nuanced understanding of the experiences shared by the participants.

3.8.1 Data Familiarisation

The first phase of data analysis involved becoming intimately familiar with the transcripts through reading and re-reading all collected data. An important part of this phase was going past the words to understand the meanings, cultural nuances, and emotions embedded in the participants lived experiences. Listening and re-listening to the audio recordings supported this process to pick up on emphases, inflections, and tone changes that are not always noticeable in the transcripts alone. A reflective journal was kept throughout this phase to document initial reflections, which later informed the coding phase, ensuring the participant voices remained central to the analysis.

3.8.2 Transcription and Writing Support

The transcription process for this study required a mixture of methods. Otter.ai is a transcription tool powered by AI. This tool was implemented to transcribe some interviews, while I, the researcher, transcribed others manually. I then reviewed and edited each transcription, this ensured accuracy, consistency, and cultural sensitivity. I also ensured the transcriptions aligned with the participants' narratives. In a limited capacity, OpenAI's ChatGPT was also used. ChatGPT was employed to refine structure, support sentence clarity, and simulate AI detection to ensure the writing reflected my voice appropriately and remained original. No AI tools were employed to generate data, analyse findings, or interpret the participants' experiences. The analytical and written content has been grounded in kaupapa Māori principles and remains the product of my own thinking.

3.8.3 Generating Initial Codes

The second phase of data analysis involved manually generating initial codes for the entire set of data. Generating codes manually allowed for a nuanced and flexible approach and provided another opportunity for me to stay close and reexamine the data. Each code was produced to represent a piece the data that held some significance or meaning to the research questions that were being asked.

The coding phase was both iterative and reflexive as the codes were continuously reviewed and refined when needed, as insights emerged. Choosing to code in this manner aligned with kaupapa Māori principles as well as Braun and Clarke's (2006) understanding of the active role the researcher has in theme development. Further aligning with Braun and Clarke (2006), this process highlighted that coding is more than just a mechanical process but one that involves meaning making and interpretation.

3.8.4 Searching for Themes

The third phase of data analysis involved identifying patterns and the relationships among them, then collating the codes into possible themes. The process started with the forming of preliminary themes through finding codes that shared a unifying idea or concept and grouping them together. To visualise connections found between codes, I manually created mind maps and thematic tables to assist in organising themes. An essential part of this phase was ensuring the themes identified were both culturally resonant and analytically robust and was therefore guided by kaupapa Māori principles. Attention was paid specifically to them around Māori beliefs, values, and experiences as these themes were crucial to the research aims.

The adapted CCS framework, interpreted through a kaupapa Māori lens was utilised in the thematic analysis stage to guide coding and interpretation. Once initial coding was complete, themes

were revisited in relation to the three domains of the CCS and their associated Matariki stars. Analysing the data through this lens allowed for deep engagement with the participant narratives and all the cultural layers of their experiences. This provided space for cultural nuance and inflections to be interpreted correctly. This framework aided in keeping the analysis culturally grounded and responsive to the participant story.

3.8.5 Reviewing Themes

The fourth phase of data analysis involved reviewing and refining the preliminary themes, so they accurately reflected the data captured. This was ensured by confirming the validity and coherence of themes through rigorous checking against both the coded data and the entire data set. At this point, some preliminary themes were discarded, redefined, or merged with other themes, if they were found to be lacking in sufficient supporting data. An imperative part of this phase was to consider the story emerging from the data, and to ensure the themes provided clarity and understanding of participants' experiences that was both comprehensive and meaningful.

3.8.6 Defining and Naming Themes

The fifth phase of data analysis involved defining and naming the final themes identified, to capture its scope and its essence. It also involved refining specifics within each theme to determine what aspects of data each theme would capture. To do this I wrote a detailed analysis for each theme in order to identify the underlying story it told, to then relate it back to the narrative of this study. The themes were then named through a thoughtful process that ensured they each were evocative, distinct, concise, and coherent, while maintaining the language and perspectives of the participants. This process allowed for a rich understanding of the data collected. A thematic map can be located in Appendix E showing the development of the themes.

3.8.7 Producing the Report

The sixth and final phase of data analysis involved combining the themes together to form a coherent narrative that speaks to the research objectives and questions. The report sought to ensure the findings were both analytical and accessible, it was important for this study that the participants' voice remained central in every phase. To provide depth and authenticity, direct quotes from participants were included in the report. Kaupapa Māori methodology principles such as relationality and accountability (Tuhiwai Smith, 1996) were upheld throughout this process, evidenced in the way the findings were presented. The experiences and cultural contexts of the participants were honoured and respected throughout the entire process which aligns with principles inherent to kaupapa Māori.

3.9 Conclusion

In conclusion, the entire data collection process was informed and designed intentionally to fit within a constructivist paradigm while following kaupapa Māori principles. An essential part of the data collection process was ensuring that the methods used were committed to reciprocity, cultural safety, and relational accountability at all times. Importantly, this process kept participants' voices at the centre of everything which acknowledged and prioritised the integrity of collective meaning making and lived experiences. This was achieved through following kaupapa Māori tikanga of whakawhanaungatanga and the use of semi-structured interviews as the primary method to collect data. This approach not only ensured methodological rigour, but it was also respectful and mana enhancing, appropriately aligning with Māori ways of knowing.

This chapter has detailed the research design, theoretical foundations, methodological approaches, data collection, ethical frameworks, and procedures employed to explore the relationship between cultural connectedness and PND among Māori mothers. This research was

grounded in kaupapa Māori methodology and informed by a constructivist paradigm, with each phase of the process designed to maintain the cultural integrity and relational accountability of the research while always ensuring participant autonomy. The data collection and interpretation phase were able to stay culturally relevant and provide in-depth insights through the use of semi structured interviews, validated measures such as the EPDS and the adapted CCS, and lastly, thematic analysis. Ethical considerations were weaved throughout the entire research process which ensured the safety, wellbeing, and mana or every participant. Themes that were identified through careful, culturally informed analysis will provide the foundation for the following chapter which will present the findings.

4. Findings

4.1 Introduction

This chapter outlines the six key themes that emerged from eight semi structured interviews with Māori mothers residing in the TSI area, who are over the age of 18, have given birth in the last five years, and experienced symptoms of PND. I employed thematic analysis grounded in a kaupapa Māori framework and guided by a constructivist paradigm to examine this data and identify if or how cultural connectedness impacted their mental health postnatally. The six primary themes identified are: (1) Cultural connectedness and a source of strength, (2) Cultural disconnection and whakamā, (3) Reconnection as a healing journey, (4) Isolation and internalised pressure, (5) Structural barriers to culturally safe care, and (6) Symptom burden and emotional distress.

Each participant had a different level of cultural connection when they started their motherhood journey. P1, a mother of two, was formally diagnosed with PND at 4 months postpartum, it is self-managed without clinical treatment and became the starting point of her reconnection journey. Others, such as P4, spoke of her silent suffering and emotional turmoil about being disconnected from her whakapapa and kaupapa Māori spaces, feelings that intensified when her baby came along. Some participants were immersed in te ao Māori from birth, while others began their journey of healing and reconnection once they became mothers. The varying levels of cultural connection shaped how these participants experienced distress and how they coped. For many, motherhood functioned as the catalyst for identity and reconnection.

4.2 Cultural Connectedness as a Source of Strength

Many participants considered cultural connectedness a powerful barrier against symptoms of PND. Participants described Māori cultural practices such as speaking te reo Māori, karakia, maara kai, celebrating Matariki, wairuatanga, as tools to ground, regulate, and foster a sense of belonging.

Some of the mothers spoke about the stability and meaning that comes from taking part in cultural practices during such a vulnerable time as the postnatal period. One participant noted that "gardening isn't just a chore – it's how I talk to my tūpuna," while another one expressed, "my Reo, my rituals, they got me through when my thoughts got too loud."

Some of the participants described their cultural practices as spiritual anchors and a way of connecting with their tūpuna, such as karakia in the morning and evening of every day. P4 says her karakia twice a day every day with her tamaiti and she stated: "Even when I didn't have the energy for anything else, we would do our karakia. It made me feel like I wasn't doing this alone." Equally, some participants found implementing grounding practices such as walking barefoot on the whenua help reduce anxiety and calm the nervous system, making these practices great tools for regulating. P6 said that "Planting kai felt like planting parts of myself back into the world."

Studies highlight the protective role cultural identity offers individuals. A systematic review undertaken by Meredith, McKerchar, and Lacey (2023) noted that cultural identity can be considered a protective factor when Indigenous practices and views are reflected in service delivery. Services that provide Indigenous mothers with community connections, language, and traditional teachings in care delivery affirm the experiences of participants in this study that drew on cultural practices as emotional, practical, and spiritual support when they felt vulnerable during the postnatal period.

Further, participants with a strong cultural connectedness found they had a sense of generational strength. Participants felt that reconnecting to their culture through cultural practices strengthened their wellbeing but also restored mana to their whānau line. P6 noted: "I didn't grow up with this stuff, but my babies will. That gives me hope." The reclamation of cultural practices was described by participants as reclaiming their identity, legacy, and purpose. The rituals and

practices the participants have implemented into their daily lives have become a way for them to pass on knowledge, thereby healing intergenerational wounds which were caused by disconnection and colonisation.

Participants described how important they believed it was to raise their tamariki in environments rich in culture. Participants reflected on the fact that practicing certain cultural rituals daily felt like an act of resistance and self-determination. These cultural practices include speaking te reo Māori, participating in powhiri, attending wānanga, and tangihana. These acts of resistance then became prosocial coping methods and protective mechanisms against PND for the structure, meaning, and connection to something bigger than the self. Within a kaupapa Māori perspective, this aligns with the principle of taonga tuku iho – passing cultural knowledge, practices, and values from one generation to another (Pihama et al., 2004). In essence, through the narratives shared, participants identified that cultural connectedness was not only a therapeutic tool, but a way to step into their mana, an assertion of tino rangatiratanga, and an affirmation of collective identity.

Throughout this haerenga of research and through the experiences and narratives shared it was not surprising that this study found that the strength participants drew from cultural practices was often relational. One participant described feeling anxious, out of place, and judged in mainstream support groups, this same mother "felt like exhaling" when she attended kaupapa Māori spaces. Participants described feeling very open and trusting in kaupapa Māori spaces due to the cultural familiarity and shared values, this made it easier for them to voice their struggles and reach out for help. Not only did these kaupapa Māori services hold space for emotional connection and support, but they also provided practical support – shared kai, child minding, and a lot of awhi – further breaking down barriers around isolation and the high demands of motherhood.

The experiences of the participants are echoed in the study by Boulton et al., (2009) which found that when health services are whānau-centred and provide a space that enables trust, connection, and shared cultural understanding, the effectiveness of mental health interventions increases. These findings suggest that culturally affirming services promote wellbeing among Māori communities and enhance help seeking, aligning with the korero from the participants in this study.

Overall, based on the narratives shared by participants, there is a strong indication that cultural connectedness is not only beneficial – it is essential. Through cultural connection these participants gained a sense of identity, spiritual nourishment, strength, coping tools, and community. Importantly, participants described feeling more capable, grounded, and confident as a mother when they felt their cultural identity had been nurtured. Aligning with this discussion from the participants, broader literature suggests that services and practices that are identity-affirming can reduce isolation, support healing, and foster resilience in Indigenous mothers throughout the perinatal period (C. Meredith et al., 2023).

4.3 Cultural Disconnection and Whakamā

Feelings of cultural disconnection during the postnatal period emerged as a destabilizing and therefore emotional factor for many participants in this study. Feeling disconnected from te ao Māori – including whānau, language, and tikanga – was described by participants as more than just a personal loss, but as a contributing factor to their postnatal distress. Accompanying these feelings of instability and loss was a deep sense of shame and inadequacy, or whakamā.

These feelings of whakamā were especially prominent when participants were comparing themselves and their lives to other Māori mothers who appeared to be a lot more culturally fluent. Some of the participants described feelings of isolation, being spiritually unanchored, and of being judged, this in part is due to the emotional toll of disconnection, social stressors, and mental health

challenges the participants were facing. A narrative that was echoed by a few participants is summed up with this quote by P3, “I didn’t grow up with te reo or marae or anything. So, when my baby was born, I just felt like I was missing something – like I wasn’t being Māori in the right way. I didn’t even know what karakia to say. That made me feel embarrassed, like I was failing.” These participants explained lacking confidence in their abilities to mother due to their cultural disconnection, but also it became a barrier for seeking help. Further, several participants identified feeling internalized shame when engaging with Māori services, amplified by the fact that they could not speak or understand te reo. P7 said: “I walked into a rōpū, and they started in Reo, and I just sat there frozen. I felt like I shouldn’t be there, like I wasn’t Māori enough.”

Colonisation is largely responsible for the disconnection Māori mothers have from their cultural anchors, which has traditionally supported mothers in the past. There have been intergenerational disruptions for Māori caused by colonisation, these include displacement from whenua, suppression of language, and loss of tikanga due to the overlapping nature of tackling (Moewaka Barnes & McCreanor, 2019). Individuals who have limited access to cultural resources or feel alienated from the cultural spaces are more likely to experience feelings of disconnection, no sense of belonging, and whakamā.

The help seeking behaviour of the participants was impacted by their feelings of cultural inadequacy. The participants’ willingness to engage with kaupapa Māori services ranged from feeling like they didn’t know if they “belonged” in such spaces, to fearing they would be judged in kaupapa Māori spaces. P5 noted: “I know those services are for Māori, but I don’t want to go be that one that doesn’t know anything. It makes me feel worse, not better.” Through employing the principle of taonga tuku iho, I recognised that the participants’ reluctance to engage was not due to them being disinterested. Rather their reluctance came from internalized perceptions that access to

cultural resources was reserved for individuals who are confident or fluent in their Māoritanga. Perceptions such as this reflect broader systemic issues. A study by Houkamau and Sibley (2011) found that a critical consideration of Māori psychological wellbeing is identity validation, stating that the psychological wellbeing of individuals feeling unsure or invalidated about their identity, suffers. This exclusion from cultural spaces and invalidated identity, whether real or perceived, may entrench cycles of distress and disconnection. This could be particularly prominent during vulnerable stages of life such as motherhood.

Participants also spoke about disconnection in terms of intergenerational trauma and disrupted whānau structures. Due to colonisation and the rules and laws in place at the time, many of the participants' parents and grandparents were discouraged from speaking te reo or participating in any Māori cultural practices. This halted the transmission of cultural knowledge for generations. P8 reflected: "My nan went to school and got hit for speaking Māori. Mum never learnt. So, by the time it got to me, there was nothing left to pass on. And now I'm here, trying to figure it out with a baby in my arms." This participant's reflection highlights how deeply rooted colonisation is within this generation of mothers, and how it shapes contemporary Māori parenting. This means Māori mothers today are not receiving the parenting knowledge, guidance, support, or cultural resources that were once passed down from their tūpuna. Robson & Harris (2007) bring to light the disruption of traditional Māori structures felt by Māori communities as a result of colonisation, urbanisation, and assimilation policies, such as reduced cohesion within the whānau and intergenerational culture loss. It was evident that this loss came through as emotional pain and shame around identity for the participants in this study, made harder by the fact that they were in the postnatal period with their babies.

Wairuatanga, which is the spiritual element to wellbeing within te ao Māori, was also described as in distress. Participants noted their wairuatanga as "missing" or "dimmed" and some felt like they were "unrooted" or drifting, attributing this to their lack of cultural grounding or cultural connection. P2 said "I just felt lost. Not just as a mum, but as a person. Like I didn't know where I came from or where I was going." This disconnection from traditional collective knowledge systems, tūpuna, and whenua disrupted the participants' sense of self. Participants recalled questioning their sense of identity and their place in the world. According to Durie's Te Whare Tapa Whā model, taha wairua is one of the four essential elements to wellbeing, if taha wairua is out of balance it undermines holistic health (M. Durie, 1998). The recognition of wairua disconnection participants expressed suggests that disconnection from culture extends into the metaphysical world.

An interesting find within this study was that participants who initially felt whakamā around the lack of cultural connection, also felt this shame was the catalyst for wanting to reconnect. P6 stated: "I started feeling like I had no right to call myself Māori. But then I looked at my baby and thought, 'Nah, this has to stop with me.' So, I started learning. Slowly." While this shift will be discussed in the following section, the importance of noting it is to show that that permanent estrangement is not always the pathway from cultural disconnection. Instead, some people use it as the driver for resistance and reclamation. Further, throughout this study it has become apparent that disconnection has more to do with structural and historical forces than it does with a choice to disconnect. Reid et al., (2014) highlighted the way colonial institutions did more than just suppress expressions of Māori culture, at times they pathologised it. This resulted in generations of Māori having a negative, deficit, and shameful view of their cultural identity, which has shaped so many parenting experiences today. While some participants did not explicitly name colonisation, they provided reflections around the lasting impact cultural suppression has had.

Within perinatal services, visibility of Māori leadership or representation was close to non-existent. This was expressed by several participants in this study who described feeling culturally isolated due to the lack of Māori midwives, counsellors, and community leaders. P1 shared: “It’s hard to talk about your culture when the people helping you don’t even understand what a marae is.” The absence of cultural representation led to a lack of trust in health services, contributing to the participants’ feelings that cultural identity would be disregarded if not overlooked. Curtis et al., (2019) found that in order for healthcare delivery to be culturally safe, it requires more than just knowledge of cultural practices. For culturally safe service delivery, there must be a structural commitment to Indigenous representation, critical self-reflection, and relational accountability. This is vital when collaborating with Māori mothers particularly if they are already dealing with feelings of whakamā and identity crisis, the absence of these practices could result in services alienating the communities they are intending to serve.

In summary, many participants voiced feeling spiritually, emotionally, and psychologically distressed in the postnatal period due to cultural disconnection. Moreover, participants shared those feelings of uncertainty about their identity, feeling whakamā, and feeling unwelcome or excluded from culturally safe spaces intensified the feelings of isolation and compounded the challenges these participants were facing with motherhood. The next section will explore the possibilities of healing through reconnection.

4.4 Reconnection as a Healing Journey

Many participants in this study found that while they experienced personal and emotional struggles while living with symptoms of PND, they also experienced a cultural awakening. As previously discussed, the cultural disconnection led to feeling whakamā, inadequate, and disorientated, however, several participants recall this being the time they felt the urge to reconnect

and reclaim their cultural identity. I found that overwhelmingly, the reconnection process was deeply healing and empowering, even protective as participants found the process eased symptoms of PND. In place of disconnection, participants found a restored sense of stability both emotionally and spiritually.

Engaging with Māori culture was seen as far more than a single act, rather a constant journey of ongoing learning, re-anchoring, and reclaiming. For some of the participants that had been raised away from te ao Māori – disconnected from tikanga, te reo, and cultural spaces, becoming a mother was the catalyst to change the trajectory. P5 shared. "When I had my pēpi, I realised I wanted her to have what I didn't – to grow up proud of who she is, knowing where she comes from. That's what I started my journey." The shift from disconnection to reconnection was transformative and generative, and in some cases, it healed intergenerational trauma. Participants shared that reconnecting with their Māori culture felt like "breaking cycles," they described it as restoring their whakapapa and protecting their pēpi from the same cultural disconnection, loss, and whakamā they have dealt with. P7 shared, "My mother didn't teach us Reo because she didn't know it either. She said it wasn't safe when she was a kid. But I'm making sure my babies grow up with is – even if I'm learning at the same time as them." Consistent with these participants' experiences are the findings from Meredith et al., (2023) who conducted a systematic review of literature. In their review they found that many Indigenous mothers explained that reconnecting to their culture came as a response to the psychological distress they were experiencing, and it became a tool for healing. Research has shown that maternal distress reduces, and self-confidence improves when individuals attend group programmes that are culturally grounded and incorporate traditional knowledge, language, and community.

This journey to reconnection was not always smooth for the participants, with some of them explaining their fear and self-doubt in the initial stages of their reconnection haerenga. P2 said, “I was scared to go to wānanga. I thought, they’ll see right through me. I’m not Māori enough.” This reflects research by Houkamau and Sibley (2011), who found that the wellbeing of individuals who are uncertain of their identity, often due to cultural disconnection, language loss, or lack of cultural knowledge, is negatively affected when these feelings of inadequacy are internalised. However, this fear and self-doubt did not stop participants from persisting. Participants described integrating mana-enhancing steps into their days to reclaim their connection to culture, these included, attending te reo classes, participating in a kaupapa Māori parenting group, and learning karakia to say at home. P3 explained, “I didn’t grow up with it. But now I say karakia with my tamariki every night. It helps us settle. It helps me feel like I’m doing something right.”

Participants described feeling anchored when engaging in cultural practices. Those who participated in practices such as maara kai (gardening), weaving, pūrākau, or observing maramataka, described finding rhythm and meaning while participating in these practices. During a very disorientating time, participants used these hobbies as tools for emotional regulation, whānau connection, and regaining a sense of control. P6 said, “My garden became my therapy. Getting my hands in the dirt – I could breathe again.” Echoing these participant observations are the findings by Edmonds et al., (2022), whose research on kaupapa Māori perinatal programmes highlighted the things that support maternal wellbeing include atua Māori, traditional knowledge systems, and reconnecting with the whenua. These kaupapa Māori perinatal programmes offer spaces that are culturally affirming, allowing Māori mothers to feel seen and importantly, safe. By ensuring the transmission of ancestral knowledge is a priority, these programmes are upholding the principle of taonga tuku iho.

Participants in this study found that mainstream parenting groups often didn't fit with the realities they were living and instead found kaupapa Māori ones to be more fitting. P4 noted, "I tried a normal parenting group, but I felt out of place. No one looked like me. No one talked about the stuff I needed to hear." She felt the turning point was when she attended the kaupapa Māori support group, saying, "It felt like home. Like I could finally exhale." This aligns with research from Boulton et al., (2009), who found that Māori health services that are whānau centred with practices that are culturally aligned, may contribute to maternal wellbeing improving.

This process of reconnection was also spiritual. Participants explained feeling spiritually supported and connected to their tūpuna when they practiced things such as karakia, sitting on the whenua, or visiting the urupā. P1 shared, "When I visit my koro's grave, I talk to him. I tell him I'm trying. That gives me strength." Mason Durie's Te Whare Tapa Whā model understands that taha wairua is one of the four pillars of overall health (M. Durie, 1998). This aligns with the spiritual aspect the participants felt when on their reconnection journey. When taha wairua is out of balance, distress can be exacerbated. When an individual reconnects with their wairuatanga, it provides space for purpose and grounding and can be a protective tool against the vulnerabilities Māori mothers face in the postnatal period.

Interestingly, some of the participants in this study noted that their reconnection haerenga was not only a personal one but also a collective and political move. The participants talked about asserting their tino rangatiratanga through reclaiming their Reo, their cultural spaces, and their tikanga. This was their resistance to colonisation. This was them refusing to let colonial systems define their experiences as mothers. P8 said, "They tried to take it from us. But every time I speak my Reo or pass it to my tamariki, I'm saying, not anymore." Echoing this sentiment are the works of Tuhiwai Smith (1999) and Pihama et al., (2004), that highlight the ways kaupapa Māori

methodologies are grounded in decolonisation, resistance, and empowering Māori voices. Within the context of this study, the participants' reconnecting to Māori culture was healing, but also liberating.

The healing felt by the participants in this study was extremely meaningful, however, they wondered about the lack of structural support in place to sustain it. P5 noted, "It shouldn't be this hard to find our own ways of healing. We need more Māori spaces, more funding, more Reo in the system." This is one example that highlights the need for investment into kaupapa Māori perinatal programmes. It also underscores the importance of improving access to spaces that facilitate cultural reconnection. For this to truly benefit Māori mothers, culturally safe care must be embedded into the structure of the systems, defined by the communities it is serving. It cannot be an optional add-on, just to tick the cultural safety box (Curtis et al., 2019).

To summarise, participants described their journey to cultural reconnection as multifaceted and dynamic. This haerenga provided strength, clarity, and healing for participants during a time when they were experiencing symptoms of PND. To restore their sense of belonging and their identity, Māori mothers who participated in this study reclaimed their language, tikanga, wairua, and community. Although reconnecting to their culture was not without challenges for these participants, it served as a source of resilience for them. The reclamation journey provided participants with confidence, purpose, and hope needed to navigate the PND symptoms. From kaupapa Māori perspective, this process reflects particular principles that shaped the way participants experienced reconnection. Principles included ako Māori (learning and growing together), tino rangatiratanga (self-determination), taonga tuku iho (ancestral knowledge), and whānau (collective care). Participants reframed their experiences of cultural disconnection, shifting from a deficit view as something to be fixed, to recognising it as a legacy to be reclaimed.

4.5 Isolation and Internalised Pressure

While the perinatal period is often described as a transformational time of bonding, for many of the Māori mothers who participated in this study it was a time of deep isolation and extreme internalised pressure. For these mothers, the postnatal period was shaped by personal circumstances, cultural disconnection, and wider systemic inequities. The isolation participants felt was physical, cultural, and spiritual. They experienced strong beliefs that they were not enough, or at least, not doing enough as mothers. Some of the participants described their loneliness as more than just a lack of company, they experienced loneliness on a deeper level. Loneliness due to feeling unseen and misunderstood in their experiences. P4 explained, “everyone around me kept saying, this is the happiest time of your life, and I just felt numb. I didn’t want to tell anyone because I didn’t want to seem ungrateful.” This highlights the pressure new mothers often feel to conform to idealised standards of motherhood, which took away from the real struggles participants were going through. Unfortunately, the flow on effect from this was mothers withholding their emotions out of fear of being judged, this holds particularly true when they were working with professionals who were not familiar with Māori cultural frameworks. When participants silenced their feelings, their feelings of inadequacy and internal turmoil intensified.

For other participants, a critical contributing factor to their isolation was a lack of cultural safety in clinical settings. These participants described interactions in Westernised clinics with doctors, midwives, and nurses were pleasant and well-meaning but shallow and disconnected due to the lack of shared cultural connections, language, and understandings. P4 noted, “It’s like they hear me, but they don’t really hear me. Not the way my kuia would.” Reinforcing the cycle of isolation is this lack of relational engagement leading to participants feeling reluctant to reach out to support services. Participants experienced internalised pressure in different ways. There were participants

who felt the pressure to ‘bounce back’ after the baby was born, others who felt the burden of having to be a ‘strong Māori woman.’ Some mothers expressed their deep fear around being perceived as an unfit mother particularly if they disclosed their struggles. This fear was often then catastrophised, some of the participants believed that admitting their distress could lead to their children being removed from their care. P5 said, “I kept it all in because I thought if I said the wrong thing, they’d think I couldn’t cope. And for us, that fear goes back generations.” This fear was often rooted in whānau histories, intergenerational trauma of colonisation, experiences of state interventions, and systemic bias. Health equity for Māori requires community-defined models of care, deep relational accountability, and the dismantling of institutional structures that perpetuate harm (D. Wilson et al., 2021). To mitigate the risk of harm or the reinforcement of barriers, there is a need for services for Māori to be designed by Māori. The internalised pressure some of the Māori mothers in this study felt is a product built on the expectation to parent under systems that have never valued their lived realities. Not only is this personal, but it is also political.

To avoid judgement, stigma, or interventions, many mothers admitted to having to wear a mask every day, contributing to an already fractured sense of self. P7 noted, “I felt like I had to be two people. One for the outside world, and one who cried in the shower.” While this may be a reality for many postnatal mothers, the cultural aspects complicated it further. Namely, a lack of representation in maternal wellbeing spaces meant participants did not receive the opportunity to see themselves reflected. Despite all of this, I found that an undertone across all interviews was powerful moments of resistance. Participants utilised whānau support, marae based wānanga, and online groups grounded in tikanga to feel culturally safe. These spaces allowed mothers to be vulnerable, connect, validate, and heal. Spaces such as these provided mothers with the mana, they needed to start shedding the internalised shame and pressure they felt. P3 described, “Being around

other Māori māmā who weren't pretending either – that was everything. It made me realise I wasn't broken." Kaupapa Māori approaches played a vital role in shifting these narratives, with participants describing feeling emotionally safe and more empowered after engaging in te ao Māori models of care. Participants noted that their complex experiences were validated, and they were given tools that were culturally resonant to navigate the perinatal period. According to Wilson et al., (2021), Māori-led initiatives that are whānau centred not only provide culturally safe services, they reconfigure relationships, enable participants to rebuild trust, and provide mothers with a space to be a part of a collective legacy, opposed to the isolated individuals they had grown accustomed to being.

Through cultural validation, participants in this study were able to shift the internalised belief that they must parent and struggle in silence. These participants learned that struggling did not mean they were failing, and they were able to adjust their perspective around help-seeking. For some, they learned that asking for help is not a weakness, it is a strength. This realisation often came as a result of being exposed to Māori values of collective care and child-rearing. Participants learned the importance of whānau when raising children, P6 shared, "we're not supposed to do this alone. That's not our way. I just forgot because everything around me told me otherwise." Although their circumstances may not have changed, reframing their perspectives signalled a turning point for participants in their reconnection journey. Notably, many participants expressed not having the right vocabulary for what they were feeling, prior to finding kaupapa Māori support, they noted that Western or 'mainstream' terminology around depression and anxiety often felt insufficient, they did not feel as though the words held enough weight. However, when they were able to speak about their experiences in Māori spaces, in Māori metaphors, or in te reo Māori, their narratives became less pathologising, instead they became more accessible and relatable. Participants described feeling

validated, like they were no longer suffering alone, and there was a precedence for how they were feeling. This left them feeling hopeful about their futures.

Interestingly, this study has affirmed that while isolation and internalised pressure are symptoms of PND, they appear to manifest as a result of structural forces and loss of culture. The reasons for the lack of maternal mental health support for Māori mothers appear to be a product of decades of stigma and erasure. Another issue has been the misalignment of Western service delivery with Indigenous ways of knowing and doing. However, this provides an opportunity for Māori mothers to connect, speak, and see themselves in others, eventually shifting the internal weight they carry.

To conclude, postnatal experiences of isolation and internalised pressure were significant themes for the participants in this study. Experiences such as these were shaped by systemic exclusion, a lack of culturally safe care, and cultural disconnect. Encouragingly, the isolation and internalised pressure eased when participants were able to access support grounded in kaupapa Māori models and when they connected with other Māori mothers. Spaces that were culturally affirming provided Māori mothers with a chance to exhale, feel safe and seen, and allowed those internalised pressures and feelings of failure, to ease. Equity in maternal mental health must be a product of transforming the system to reflect Māori needs, through Māori ways of knowing, doing, and being. Equity will not come from adapting Māori to fit the system set up against them (D. Wilson et al., 2021).

4.6 Structural Barriers to Care

When conducting the analysis, I discovered a consistent theme among all of the participants, this was structural barriers to accessing and engaging with perinatal mental health services. The narratives from the participants highlighted that their experiences were not isolated incidents. These

are systemic barriers that have been embedded into the healthcare system in Aotearoa, shaped by a history of inequity and marginalisation, built off a legacy of colonisation. Participants in this study explained feeling misunderstood, judged, and "not taken seriously" by GPs, midwives, and mental health practitioners. This often left these mothers feeling intimidated and alienated by the maternity services available to them. P2 noted, "I told the nurse I'd been crying every day and not sleeping and she just said, 'Well, that's normal, isn't it?' I didn't feel like it was safe to bring it up again." This response left the participant feeling invisible and reinforced her internalised belief that she was 'failing,' and therefore that she must endure her hardships in silence.

Due to unconscious bias, institutionalised racism, and racial profiling, it is common for Māori women to experience this differential treatment, according to Cormack et al., (2020). Experiences such as these hinder trust and relationship building and discourage women from seeking help early. This undermines the very purpose of the systems in place to help, instead becoming another source of distress and exclusion for some mothers. P4 shared, "I wanted to tell someone I was struggling, but I was scared they'd think I was a bad mum and call Oranga Tamariki." This deep fear of having their children removed became a recurring theme for the participants, with several of them saying they downplayed or avoided discussing their mental health with professionals altogether. This fear was particularly high among participants who had witnessed whānau or friends having to deal with Oranga Tamariki. P6 said, "You don't talk about feeling down because you don't want them to think you can't look after your baby." This is a real fear and rational response to systems set up against wahine Māori. Research shows that Māori children are disproportionately represented in child protection agencies, with reports showing that 82 out of every 1,000 Māori children were reported to Oranga Tamariki in 2023, compared to 24 out of every 1,000 non-Māori (Oranga Tamariki, 2023).

Participants described encountering structural and logistical barriers when they did reach out to support services. Barriers included long wait times for therapy or counselling, services only available during work hours, and lack of transportation. P7 was a solo mother who reflected, “They offered me counselling, but it was at 9am on the other side of town, I had no car and two kids. How was I supposed to get there?” The broader issue at play is the design of healthcare.

Issues such as poverty and rural isolation disproportionately affect Māori communities, and the current healthcare service design does not consider the realities of these parents in the communities it is set up to serve (Graham & Masters-Awatere, 2020). Many participants found that when support was offered, there was a lack of Māori practitioners. This led to a disengagement in the relationship building stage as the mothers were unable to connect with someone that did not share the same cultural worldview, or at the very least could not understand it. P1 noted, “They asked me if I had support from my family, but it wasn’t about that. It was wairua, it was everything. They didn`t get that.” Participants felt the services available did not align culturally with them, and instead of receiving help and support, many of them reported feeling misunderstood and like their experiences were being minimised.

Mainstream models of care were described by participants as “too rigid and clinical,” there was no room for Māori values or approaches to healing. P3 shared, “They told me to do mindfulness, but I needed to go to the urupā. I needed to sit by my nan and breathe.” Examples such as these highlight the mismatch on a fundamental level between Māori approaches to wellbeing, and the dominant Western psychological models. Māori wellbeing is holistic, spiritual, and inherently relational. This is prominent in Durie’s (1998) Te Whare Tapa Whā model that illustrates the role wairua, whānau, and whenua have in overall wellbeing, elements often overlooked in Western interventions. The lack of cultural resonance reflects failure on a systemic level, to provide

culturally safe care. It is important for Indigenous communities to define what cultural safety looks like in service delivery. Crucially, this cannot be added as a superficial layer, this definition must be embedded into institutional frameworks (Curtis et al., 2019). A major contributing factor to the ongoing mistrust Māori mothers have in mainstream maternal mental health services is the lack of Māori voices in the design and delivery of said services.

While the experiences participants had with the services were less than ideal, the first step in accessing said services had its own challenges due to a lack of access to information. Some participants recall being unaware that there were even services available to support during the postnatal period, while others assumed it was not for them. P5 recounted, "I didn't know I could ask for help. I thought, you just get on with it." Participants' experiences such as this suggest services must become proactive with promoting accessible and culturally safe care. These efforts must be tailored to Māori ways of knowing, being, and communicating, in order to reach Māori communities (McIntosh & Mulholland, 2011).

The combination of cultural misunderstandings, logistical challenges, and institutional mistrust were significant factors in why participants delayed or avoided seeking help. A few of the participants only accessed care once they were at crisis point, while others had friends or family members that intervened. P8 described, "It wasn't until my cousin dragged me to a wānanga that I realised I wasn't broken – I was just disconnected." A moment of reconnection like this mother experienced demonstrates the ways culturally grounded, informal support can positively impact people who are struggling far better than the formal, clinical models of care.

For participants that managed to access kaupapa Māori or Māori-led services outlined a very different experience in care. Participants felt these spaces were relational, safe, and mana enhancing. P6 noted, "At the marae, they asked me how my pēpi was, but also how my wairua was.

No one had asked me that before." Participants in these spaces were offered karakia, te reo Māori, and whānau based approaches to healing. These participants reflected that they felt like more than just patients that were there to be fixed, they felt seen as humans and they felt supported on their haerenga. Access to such services, however, was inconsistent, relying on geographic location and service providers. P2 shared, "We have nothing like that in my area. Just the GP, and he doesn't understand." This again underscores the continuous issue of inequitable Māori service distribution and points to the need for more investment in care models that are Māori-led and whānau-led (Reweti, 2023).

Overall, participants experienced structural barriers that were cumulative and systemic. Participants felt fear over being judged and of their children being removed from their care, they found services to be inaccessible and culturally unsafe, and they felt these barriers not only hindered their healing but contributed to their symptoms of PND. These findings strongly reinforce the argument for an urgent systems change, one that puts Māori worldviews and voices at the centre, and removes the structural barriers that disproportionately affect Māori mothers.

4.7 Symptom Burden and Emotional Distress

The burden of PND is personal, emotional, physical, and structural. I found that for participants in this study, their symptom burden was more nuanced than what typical clinical language could capture. Their experiences could not fit into the boxes set out by mainstream Western clinical frameworks. The narratives in this study were shaped by cultural disconnection, internalised weight of unrealistic expectations, intergenerational trauma, and systemic racism. The distress felt was psychological, spiritual, and relational. Participants often relied on metaphors and pūrākau to define their cultural disconnection and their spiritual dislocation, unintentionally

cementing their identities as wahine Māori. The interconnectedness of all these pressures, fears, and emotional distress made seeking support incredibly hard for these women.

Some of the participants described deep and ongoing feelings of sadness, numbness, and hopelessness. P3 commented, “I cried most days. Not the kind of crying that helps, but the kind that makes you feel worse after. Like something was broken in me.” P2 recalled, “I was crying all the time, even when my baby was asleep. I couldn’t feel the love I thought I should.” The self-doubt felt by these mothers aligns with findings from Field (2010), who highlighted the ways PND can compromise the mother-infant bond. Consequences of this damaged bond include disengagement with the baby and reduced maternal sensitivity. I found that participants in this study typically internalised these feelings as personal failures which reinforced their whakamā and undermined their sense of their identity as mothers. One reason it was so difficult for participants to seek support was because this internalised pain and distress was often accompanied by shame. To add to this emotional turmoil, participants were also managing a deep fear of judgement or having their children removed from their care. An undercurrent of shame was persistent throughout these experiences. P6 reflected, “I just kept to myself. I thought if I said anything, they’d say I wasn’t a good mum.” While P7 described, “I felt ashamed for struggling. Like I was the only one. Everyone else looked like they had it together.” Although O’Hara and McCabe (2013) and Field (2010) have extensively observed the internalisation of failure with PND, for Māori mothers it is compounded with feelings of marginalisation, cultural loss, and a need to stay silent. Within the Māori communities and whānau involved in this study, there was a lack of open dialogue around maternal mental health, further contributing to feelings of isolation. Research suggests that the distrust of mental health services that was evident among participants, is not unique to this study. Came et al., (2019) found that experiences of cultural invalidation, marginalisation of Māori worldviews within

mainstream services, and institutional racism all play a role in the mistrust and disengagement from services among Māori.

Services and spaces that do not provide safety exacerbate the distress individuals feel. Participants described their physical symptoms – fatigue; and physical heaviness, which often heightened their emotional distress. P5 shared, "Even on the days I got to sleep, I still felt tired. My body ached. My mind ached. Everything felt too hard." Within a Western paradigm, these manifestations are recognised as symptoms of PND, culturally however, they run much deeper. For participants in this study, they felt their fatigue on more than just a physical level, some described it as "wairua-deep.' The participants felt exhaustion in their body and their spirit. The descriptions of wairua distress given by the participants aligns with Durie's (1998) holistic model of wellbeing –Te Whare Tapa Whā – which recognises wairua as one of the four pillars of wellbeing Participants who felt their wairua was disrupted were describing something far deeper than a mere symptom, they were describing a serious state of health imbalance that impacts their whole being. When help-seeking, participants felt they were unable to access services that shared this worldview, this led to many participants feeling like they were just a problem that needed fixing or that they were invisible, rather than individuals who needed support.

A recurring theme through this research process was participants' difficulty identifying their experiences as mental health concerns and the stoic nature of their tūpuna around parenting. P5 recalled, "I didn't think it was depression. I thought it was just how it is – you're tired, you're emotional, you get on with it." Further, several participants shared how they felt like they needed to cope, perform, and endure in silence. Some participants talked about how those feelings were shaped by their whakapapa and whānau pūrākau – participants spoke of learning about the strength and endurance of their tūpuna. P8 said, "My nan didn't complain. My mum didn't cry. So, I didn't

either. I thought I just had to handle it." These narratives align with literature that notes mothers frequently minimise or internalise depressive symptoms. This is particularly true when mothers feel that openly acknowledging their struggles is discouraged, when they feel societal expectations to cope, and when they have fears of being stigmatised (Field, 2010; O'Hara & Mc Cabe, 2013). This was then compounded by the cultural narratives and tūpuna pūrākau around resilience and the intergenerational silence around maternal distress.

Participants noted that they were self-monitoring and suppressing emotions which often intersected with their feelings of shame and inadequacy – whakanā. P1 talked about having a recurring thought, "I kept thinking I was doing everything wrong. I thought, what if my baby grows up and ends up like me? That scared me." This was a deep fear for many of the participants in this study, that their mental state somehow made them unworthy to call themselves mothers, unworthy to parent their children. The experiences of the participants reflect broader patterns discussed in literature. Wilson et al., (2016), highlight the ways in which dominant social narratives shape a Māori woman's sense of self-worth and safety. Regardless of the structural nature of the challenges Māori women deal with, when viewed through a deficit lens, it generally leads to internalised feelings of failure. These experiences reinforced the internalisation of struggle through the lack of culturally safe spaces, P3 noted, "I tried to talk to the nurse about how I was feeling, but it just didn't feel safe. I felt like she didn't get it." This experience was consistent with others' who felt like when they expressed their emotional turmoil in culturally grounded terms like feeling "off balance" or "disconnected from my tūpuna," health professionals did not take them seriously. When mainstream services refuse to acknowledge or recognise expressions of perinatal distress, it serves as a barrier to early help seeking and it amplifies feelings of alienation among mothers (Glover, 2014; O'Hara & Mc Cabe, 2013).

Participants explained that when they were offered clinical interventions, they often felt culturally out of sync. P3 noted, “Sitting with my nan at the urupā, that’s what settles me.” Experiences such as this reflect the wide disconnection between Māori understanding of hauora and mainstream Western psychological frameworks. Durie (1998) emphasised the importance of spiritual, collective, and land-based elements of wellbeing, noting that approaches that overlook these elements will likely fail to resonate completely with Māori. This is particularly true in the context of maternal care. To ensure cultural competence in service delivery, Walker et al., (2014) argue that transformative commitment to changing practice and policy is required. Indigenous knowledge systems and their ways of being and knowing must be centred.

Throughout these challenges, participants recounted glimmers of hope. When they found spaces grounded in Māori values and collective healing, they were able to imagine a life where they felt better. Two such spaces that offered these healing opportunities were wānanga and whānau-led groups. Participants often mentioned these two spaces as sources of comfort and reconnection. P2 recounted, “When I went to that kaupapa Māori wānanga, I finally felt seen. I didn’t have to explain why I felt the way I did. They just got it.” Through shared experiences and cultural strength, participants were afforded the opportunity to reframe their struggles and found the strength to challenge the stigma around distress. These experiences are consistent with the principles of Te Whare Tapa Whā (M. Durie, 1998), which highlights that wellbeing is the presence of balance and connectedness across all domains of being, not just the absence of illness. Participants described these moments of reconnection as more meaningful and therapeutic than what they were offered in mainstream services.

To summarise, the symptom burden and emotional distress participants experienced went far beyond diagnostic criteria. What participants experienced was a disconnection from wairua,

whānau, and whenua. Participants in this study described managing the psychological symptoms of PND while navigating a system that consistently invalidated them, repeatedly failed to understand their realities, and could not provide appropriate support. These experiences highlight the urgent need for culturally safe services that can respond holistically to the challenges of early motherhood.

4.8 Conclusion

The findings presented in this chapter are a collection of the lived experiences of eight Māori mothers who have struggled in the postnatal period while also navigating emotional distress, systemic inequities, and complex cultural dynamics. This chapter offers a rich and nuanced insight into the six themes uncovered from these experiences: cultural connectedness as a source of strength, cultural disconnection and whakamā, reconnection as a healing journey, isolation and internalised pressure, structural barriers to culturally safe care, and symptom burden and emotional distress. These themes provide an interwoven narrative that points to the importance of cultural identity, relational support, and accessibility to culturally safe services in shaping mental health outcomes for Māori mothers. These findings respond directly to the research question – *Is cultural connectedness a protective factor against postnatal depression among Māori mothers?* – by showcasing not only is it protective, but cultural connectedness is also an essential part of motherhood for Māori women. When participants were given the opportunity to engage with services that reflected te ao Māori values, practices, and support networks, they described feeling hopeful, safe, seen, and empowered, feelings mainstream services were unable to evoke.

Central to these findings is the tension between the protective potential of cultural connectedness and the potential of harm due to disconnection, marginalisation, and invisibility within the dominant Western psychological frameworks. Many participants felt their experiences of distress were heightened by their disconnection from whakapapa, whenua, and wairua. On the flip

side of this, participants who experienced reconnection – either on their own journey or facilitated by kaupapa Māori spaces – provided moments of clarity, healing, and affirmation. The voices of the participants powerfully illustrate how structural barriers making accessing care harder for Māori women. They also expose how these barriers perpetuate the silence, isolation, and shame many Māori mothers carry.

This chapter has demonstrated that maternal mental health is not separate from cultural, historical, and relational contexts, nor should it be. The findings reflect both the lived experiences of the participants and the interpretive lens through which they were understood – namely a kaupapa Māori methodology and a constructivist paradigm. Kaupapa Māori principles such as ako Māori, tino rangatiratanga, taonga tuku iho, kaitiakitanga, kaupapa, and whānau provided guidance around the relational nature of data collection and ensure participants' voices were centred throughout analysis. The next chapter will critically engage with these findings in relation to existing literature to explore how cultural connectedness can serve as a protective factor against PND. It will also explore how cultural disconnection, structural barriers, and institutional racism heighten feelings of distress. Further, it will consider how culturally grounded spaces offer healing and reconnection, and how systemic transformation is crucial in upholding the mana of Māori mothers. The discussion chapter will demonstrate how methodology honours the voices and aspirations of those most impacted. It will also draw on the principles underpinning this research to offer insight into how health services and policy can better serve Māori mothers.

5. Discussion

5.1 Introduction

This chapter seeks to interpret and contextualise the findings presented in the previous chapter; it will explore existing literature, policies, and theories to discover any significant relevance the findings hold in relation to them. This discussion is guided by a kaupapa Māori methodological framework and a constructivist paradigm, and projects an understanding that knowledge is relational, situated, and shaped by lived experiences. There were eight Māori mothers who participated in this study and it's their voices that have uncovered the holistic weight of PND. Further, these voices have also revealed the role systemic, cultural, and historical forces play in how distress is experienced, expressed, and responded to.

Through thematic analysis, six themes presented: cultural connectedness as a source of strength; cultural disconnection and whakamā; reconnection as a healing journey; isolation and internalised pressure; structural barriers to culturally safe care; and symptom burden and emotional distress. This discussion will draw on these themes and investigate the intricate interconnectedness of them, particularly how they collectively highlight the ways institutional racism, cultural loss, and colonial legacies contribute to the inequities in maternal mental health that Māori mothers face. On the flip side, participants offered insight into the transformative potential of whānau-centred support that is culturally grounded, and the strength they found in wairua, whakapapa, and mātauranga Māori.

This discussion begins by investigating the possibility of cultural connectedness as a protective factor against PND. Following this it critically analyses the themes of disconnection, isolation, and systemic barriers before exploring a pathway to healing through reconnection, facilitated by kaupapa Māori spaces. The methodological approach was shaped by the principles of

ako Māori, tino rangatiratanga, taonga tuku iho, whānau, kaitiakitanga, and kaupapa. The later sections of this chapter will consider how this approach influenced the interpretation of the findings and the role it played in guiding the overall research process. The chapter will then conclude by discussing how these insights can inform practice, policy, and systems change that is grounded in cultural values and Māori worldviews, overall improving the mental health outcomes for wāhine Māori and their whānau.

5.1.1 Matariki as an Analytical Framework for Cultural Connectedness

This research examined cultural connectedness through participant narratives and interpreted it through the culturally grounded framework, an adaptation of the CCS developed by Snowshoe (2015b). The CCS is comprised of three dimensions – identity, spirituality, and traditions – this study has tailored its application to use the Matariki star cluster as an interpretive lens. This approach was taken to ensure analysis remained firmly grounded in mātauranga Māori. Further, the adaptation aligns with this study's commitment to kaupapa Māori methodology, specifically the principle of taonga tuku iho, which privileges Māori ways of knowing.

Matariki is a cluster of stars, the Māori constellation that marks the new year. This constellation symbolises guidance, renewal, and intergenerational connection. Each star within the cluster holds unique cultural significance. The stars used in this framework are Tupuānuku, Tupuārangi, Waipuna-ā-rangi, Ururangi, Waitī, and Waitā, each encompassing either environmental, spiritual, or relational aspects of wellbeing. Moreover, each of the stars represents either identity, tradition, or spiritualty. These stars were used to guide analysis to ensure participants' experiences were captured through a Māori worldview.

Under the identity dimension are the stars Tupuānuku and Ururangi. Firstly, Tupuānuku was a representation of connection to whenua and whakapapa. It is the star associated with root

vegetables, food from the Earth, which symbolises nourishment, growth, and rootedness (Ministry for the Environment & Stats NZ, 2022). Within the context of this study, this star reflected the grounding that emerged for participants through reconnecting with their tūpuna. Participants reflected that these experiences strengthened sense of identity and belonging throughout the postnatal period. Secondly, Ururangi, which is linked to the winds (Matamua, 2017), represents direction, vision, and leadership. Further, this star aligns with the kaupapa Māori principle of tino rangatiratanga. The participants' reclamation journey and how they navigated their mental health challenges were interpreted through a lens of self-determination and visionary guidance.

Under the dimension of spirituality are the stars Waitā to represent wairuatanga and Waitī to represent kaitiakitanga. Waitā symbolises the ocean and is linked to several spiritual Māori values - cycles, moon phases, and interconnectedness (Matamua, 2017). Participants' pūrākau around finding healing in visiting the urupā, practicing karakia, and feeling the presence of their tūpuna were interpreted through the symbolic lens of this star. Waitī is associated with fresh water (Matamua, 2017) and symbolises protection and guardianship of natural resources. This star reflects the intergenerational aspects of emotional and spiritual care. In this context, it echoes the principle of kaitiakitanga, demonstrated in the participants' motivation to protect and uplift future generations.

The final dimension of the CCS is traditions. This study linked the stars Tupuārangi and Waipuna-ā-rangi to this dimension. Tupuārangi is connected to food from the sky such as berries and birds, symbolising growth, nourishment, and spiritual connection (Matamua, 2017). This star represents communal gatherings and reciprocity in shared, whānau-centred spaces such as wānanga. I used this lens to interpret the pūrākau shared by participants around their healing experiences and practices within kaupapa Māori spaces. Waipuna-ā-rangi is associated with rain (Matamua, 2017).

This star symbolises abundance, renewal, and emotional expression. Within the context of this study, it represented manaakitanga and the power of practices and traditions rooted in culture – such as feeling replenished and cared for.

The Matariki star cluster acting as a guiding framework for this analysis gave opportunity for a deeply textured interpretation that included the spiritual, relational, and ecological dimensions of maternal wellbeing. Moreover, it provided a culturally sound framework within which the participants and I could co-construct meaning together. The Matariki adaptation of the CCS expanded the scope of the framework to include te ao Māori and to meaningfully reflect Māori worldviews. This also enabled me to link participants' experiences to ancestral and environmental conceptions of identity and wellbeing. Interpreting the research in this way is reflective of the kaupapa Māori principles that inform the entire research process. This is evidenced in the incorporation of taonga tuku iho (interpretation was shaped through cultural knowledge systems), tino rangatiratanga (this was upheld in the way participants' meaning making processes became the guide for framing the findings. External clinical definitions were not imposed on them), ako Māori (seen in the reciprocal learning between participant and researcher through shred cultural metaphors), and kaitiakitanga (reflected in the participants' commitment to heal for themselves and for their whānau and future generations).

Naming and applying the Matariki framework in this chapter ensures the discussion remains appropriate for both kaupapa Māori methodology and the constructivist paradigm. This approach respects the cultural expressions of the participants, acknowledges their epistemologies, and provides an interpretive lens that deepens understanding of their realities. Aligning the findings with the CCS domains offers a framework that acknowledges Māori ways of knowing and being and captures the depth and complexity of cultural identity and connection. Incorporating the CCS

allowed for an analysis that was holistic, it honoured the interconnectedness of the emotional, relational, and spiritual aspects of postnatal wellbeing, opposed to isolating symptoms and ultimately reducing experiences.

From a researcher's perspective, the Matariki framework was a culturally meaningful lens through which to interpret the data, there was space for participant voice to stay centred. Each star provided both a symbolic and thematic anchor for the corresponding CCS domain. This strengthened both the relational and spiritual integrity of the analysis. The flexibility of this frameworks supports both thematic and narrative analysis while ensuring Indigenous values and systems of knowledge and meaning are central. Further, other researchers may find value in this framework, particularly if they are working with communities where cultural connection, identity, or healing are an integral part of their research. The sections that follow will identify how each of the core themes identified in the findings connect to the CCS framework.

5.2 Cultural Connectedness as a Protective Factor Against PND

A pattern that emerged consistently throughout this research process was the role of te ao Māori practices as a critical source of strength, identity, and healing for participants. These findings validate that cultural connectedness does serve as a meaningful protective factor against PND (Penehira et al., 2014). Echoing this is Shepherd (2024), who found that Māori mothers will often engage in cultural practices and connection as a part of their healing journey. For the mothers in this study, cultural connectedness was more than an abstract concept, it became a lived experience, a relationship to their tūpuna, their communities, and their spiritual wellbeing. Essential to this wellbeing were the mothers' identity and their wairuatanga, represented by Tupuānuku and Waita in the adapted Matariki CCS framework. These findings also reflect the Te Whare Tapa Whā model (1998) which emphasises the interconnectedness of whānau, wairua, hinengaro, and tinana

for overall wellbeing. This resonated with participants who felt the interconnection was foundational to their wellbeing in the postnatal period as shown in a kōrero with P6 who reflected, "When I started going back to the marae and doing karakia again, I felt stronger. Like I could breathe for the first time in ages." While participating in cultural practices affirmed these participants' identity, connectedness became anchors during emotionally stressful times. As outlined by Durie (1998) it is vital for Māori that cultural identity and wairua are included in health frameworks. When these dimensions are excluded, the individual's well-being suffers. Reconnecting with their cultural roots and traditional knowledge served as pathway for transformation and healing among the participants. The process enabled them to re-establish balance across the dimensions of Te Whare Tapa Whā, ultimately restoring their wellbeing.

Taonga tuku iho – cultural values and practices handed down through generations – was an important aspect throughout the research process. This was particularly evident in the ways participants sought out traditional ways of being and knowing as a means of coping. P3 embodied this in the way she described her healing journey as coming through her whakapapa: "I went and sat on my whenua, at the urupā, and felt her (her nan) with me. That grounded me more than anything the counsellor ever said." The significance of pūrākau such as this being shared is that it demonstrates the role connection to tūpuna and whenua play in healing. The interweaving of identity and tradition is reflected in Tupuānuku and Tupuārangi, which represent both ancestral grounding and preserving relational bonds. These dimensions are often invisible within Western psychological paradigms that generally focus on talk-based therapies. This aligns with Shepherd's (2024) research of the experiences of young Māori mothers, which emphasised the way young Māori mothers often healed through reconnection with whakapapa, whenua, and wairua, rather than from clinical interventions. Further, the findings from this research present a picture of reclamation,

of tino rangatiratanga for participants, a reclamation of autonomy over their healing and wellbeing. The Māori mothers who participated in this research took charge of their healing by actively seeking ways to both define and respond to their distress. They looked beyond the deficit-based Western frameworks and instead drew from their cultural knowledge systems. Penehira et al., (2014) argue that cultural connectedness and identity are more than protective factors, they are integral parts of Māori wellbeing models. It is argued that tino rangatiratanga encompasses the right for Māori to define health and wellbeing in their own terms (McIntosh & Mulholland, 2011). Within the context of this study and through cultural connectedness, participants were empowered to reframe their experiences as cultural grief, spiritual dislocation, and wairua fatigue. These insights align with Masotti (2023), who found that Indigenous mothers are often healed in cultural reclamation and relational spaces that mainstream services overlook.

For participants, cultural connectedness facilitated a sense of whānau, in the relationality sense that underpins Māori worldviews. This was identified throughout the participant interviews who described feeling supported and validated in kaupapa Māori spaces that underpinned Māori values. These spaces aligned with the principle of ako Māori, where the sharing of knowledge was reciprocal among culturally safe, respectful, and mana-enhancing relationships. This was highlighted by P1 who spoke about the differences between mainstream services and whānau centred support: “There, I didn’t have to explain myself. They knew where I was coming from. That made all the difference.” This highlights the nature of Māori healing in that it is relational and collective. Mirroring this is Waipun-a-rangi, the star that represents manaakitanga and nurturing the community wellbeing. Further, within a constructivist paradigm, the experiences of the participants demonstrate both the contextual and subjective nature of reality. This is emphasised throughout the interviews that highlighted the way meaning was co-constructed within specific relational and

cultural contexts. An example of this is the way mothers in the study understood their well-being and distress. These mothers did not make meaning from standardised tests, instead, they found meaning through daily interactions, tūpuna knowledge, and experiences. Noted by Field (2010) the interpersonal, ecological, and Indigenous settings and contexts must be considered to fully understand maternal mental health. This is particularly important in communities where colonial legacies have disrupted traditional support systems. The co-creation of meaning was described beautifully by P2 who said, "I wasn't depressed. I was disconnected. When I started going to the Reo classes and wānanga, I started remembering who I was." Moreover, the process of reclamation, resistance, and reconnection aligns with the principle of kaitiakitanga. These mothers felt the responsibility to protect and sustain themselves for their personal healing journey and they felt the calling to preserve their whakapapa for the generations to come. This understanding of reclaiming wellness for their tamariki and mokopuna was felt by several of the mothers in this study. P5 recalled, "I don't want my daughter to grow up thinking being strong means staying quiet. I want her to know you can be Māori and ask for help." This illuminates the way cultural connectedness can also contribute to intergenerational change. Similarly, Masotti et al., (2023) explain that the maternal mental health of Indigenous mothers is intergenerational, culturally grounded healing practices can disrupt the cycles of silence and trauma.

While the participants found tangible benefits in culturally safe and affirming spaces, they described the barriers to access that they faced. Some mothers described the following barriers - a lack of transport, no childcare, and geographically cut off from kaupapa Māori services. Other mothers reflected on experiences of being judged in culturally unsafe environments, their fear of re-traumatisation created a deep mistrust and discouraged help seeking. Barriers to early help seeking have been documented both nationally and internationally in research. For example, Sivertsen et al.,

(2025) found that Indigenous women often have experiences that are culturally unsafe causing them to be dissatisfied with the care they receive from mainstream services. Reflecting these findings, is a study by McNeil et al., (2024) who highlighted reports of improved maternal and infant outcomes for Indigenous mothers that received culturally safe midwifery care. This included a reduction in stress and enhanced satisfaction regarding the care they received. Further affirming the notion that cultural connectedness is not only protective, but also foundational to mental wellbeing. This is resonant for colonised communities. This study, however, is unique in its grounding in kaupapa Māori principles, which shed light on both the structural and relational aspects of the protective effects of cultural connectedness. Shepherd et al., (2024) noted that culturally aligned research methodologies privilege Māori voices and reveal relational patterns and structural barriers that mainstream frameworks often miss. There is deep meaning behind the symbolic and practical alignment with Matariki stars – such as Waitī for kaitiakitanga, or Ururangi for rangatiratana – which illuminates the practical ways in which these values are present within the participants' experiences. This cultural connectedness was not in isolation; it was nurtured in spaces where relationships were able to be built. In spaces where manaakitanga, whanaungatanga, and mana Motuhake were openly and actively practiced. The kaupapa Māori programs the mothers participated in were described by them as the beginning of their cultural and spiritual awakening.

To summarise, cultural connectedness was more than just support for the participants in this study – it provided a framework to understand their experiences, spaces to connect with their identity, and the opportunity to grow their resilience through whakapapa and wairua. Further, it enabled participants to enact tino rangatiratanga, upheld the responsibilities of kaitiakitanga, and through lived practice, brought taonga tuku iho to life. These findings illuminate the reasons why

cultural identity must be centred in addressing maternal mental health. Further, they confirm the notion that that connection to te ao Māori and one's culture is an essential aspect of wellbeing.

5.3 Cultural Disconnection and Whakamā

One theme that emerged prominently throughout the participants' pūrākau was the profound source of distress felt by the mothers due to cultural disconnection. Many participants described deep feelings of whakamā rooted in their disconnection from Māori culture. This perceived sense of dislocation is broader than their own personal struggles, it stems from within a historical context of colonisation and intergenerational trauma (Graham & Masters-Awatere, 2020). Participants reflected on when they felt their cultural disconnection was most noticeable during the postnatal period, such as during naming ceremonies and when engaging with healthcare professionals. P4 shared, "I didn't even know how to do a karakia for my baby. I felt I wasn't Māori enough to be doing things the way." This sentiment of feeling whakamā about their lack of knowledge around their own identity, and their inner conflict of who they are, is echoed by several participants that grew up away from their culture but were eager to connect. Relevant here is the dimension of identity in the CCS framework, represented in this study by Tupuānuku and Ururangi. Tupuānuku represents grounding and stabilising through whakapapa and whenua, something that was disrupted for the mothers in this study. This destabilisation and lack of grounding is seen in the participants reflections of being "urban Māori" (McIntosh & Mulholland, 2011). Participants reflected on feeling disconnected and alienated from their iwi and marae. Ururangi symbolises leadership and guidance. This was evident in the participants' discussions around the lack of cultural role models and guidance on their reclamation journeys. These discussions shed light on the enduring effects of colonisation, including the disruption of cultural transmission between generations and its impact on the lives of these mothers (Theresa & Shepherd, 2024).

Amplifying these mothers' whakamā is the perceived expectation that they must inherently possess cultural knowledge, despite the systemic barriers. P6 explained, "It's like people expect you to just know it all the Reo, the customs – but no one taught us. Then you feel dumb or fake for trying to learn it as an adult." This illuminates the problematic social and structural pressures Māori mothers face while simultaneously navigating the internalised shame that is exacerbated by said pressures (Graham & Masters-Awatere, 2020). These compounding factors undermine the mother's abilities to gain the confidence needed to reconnect. Waitā represents wairuatanga in the spiritual dimension of the CCS. Participants often noted this was the "missing piece," with mothers describing a "spiritual emptiness" and a loss of connection to their tūpuna, as well as no cultural guidance. P7 reflected. "I couldn't feel her (my kuia) anymore. It was like my wairua had gone quiet." This reflection highlights the consequences on a spiritual level of cultural disconnection and the grief tied to the felt absence of intergenerational knowledge. The disrupted cultural inheritance is also felt in the lack of traditional practices passed on to the mothers in this study. Tupuārangi and Waipuna-ā-rangi represent the traditions dimension of the CCS framework This dimension focuses on collective cultural rituals as a way of nurturing belonging, however, participants in this study described often feeling estranged from such rituals and practices. Wānanga, hui, and gatherings at the marae all became inaccessible – because of physical distance, absence of culturally safe spaces, or lack of confidence – leading to isolation and increased feelings of loneliness for these mothers during the postnatal period. The lack of traditions contributed to their maternal distress and cultural grief (Theresa & Shepherd, 2024).

The principle of taonga tuku iho holds particular significance in this context, the disconnection from traditional knowledge systems was perceived as a loss for these mothers that extended beyond themselves to their children. Several mothers reported feelings of guilt and grief

over their inability to pass on knowledge such as tikanga and te reo Māori. Several of the mothers highlighted the significant emotional weight they felt due to this disruption. P2 said, “I worry my baby won’t grow up knowing who she is. I don’t want her to feel as lost as I did.” Another prominent principle within this study was kaitiakitanga, however, it came as a sense of anguish for these mothers. Participants in this study felt the burden of guardianship for this knowledge but lacked support, access, resources, and the community needed to protect and pass it on. This situation further reinforced these mothers’ feelings of inadequacy and contributed to their postnatal distress (McIntosh & Mulholland, 2011). The lived experiences of these mothers align with current research that explores the intersections of postcolonial identity trauma and maternal mental wellbeing. Literature by Graham and Masters-Awatere (2020) found that when health services neglect the cultural disconnection in delivery, they can contribute to the marginalisation of Māori clients and exacerbates the health inequities present for Māori communities (McIntosh & Mulholland, 2011). Similarly, McIntosh and Mulholland (2011) emphasise the meaning of tino rangatiratanga includes the right to reclaim identity. One way of exercising this reclamation is for individuals to define what wellbeing looks like through culturally grounded frameworks, something the mothers in this study attempted to do despite facing structural barriers (McIntosh & Mulholland, 2011).

In line with the principle of kaupapa, which advocates for the critical examination of structural injustice and the pursuit of transformative change. Through a kaupapa Māori lens, disconnection from culture is much bigger than an individual deficit, it reflects the collective historical loss and continued structural marginalisation. Central to this study is the understanding that the whakamā felt by mothers is a symptom of cultural disconnection. This plays a crucial role in shifting the perception away from individual failure to the broader issues of collective and historical disruption (Penehira et al., 2014). In conclusion, this section illuminates how the absence of cultural

connectedness - across the three dimensions of the CCS framework – was a key contributing factor to distress for Māori mothers during the postnatal period. This study found that the participants not only lacked support, but they were also grieving the loss of cultural connection that sustained wellbeing. The following section will explore the ways in which reconnection, resistance, and reclamation provided a pathway from this pain and acted as a foundation for healing and ultimately transformation.

5.4 Reconnection as a Healing Journey

Although participants in this study felt a lot of whakamā around their cultural disconnection, they also described the transformative journeys they took to reconnect, which ultimately became the catalyst for their healing. Each participant had a deeply personal reconnection pūrākau, these were diverse and rich in detail and aroha and allowed each mother the opportunity to reframe their narratives and lived experiences from deficit to strength. The mothers in this study all reclaimed their culture in different ways: some through learning te reo Māori, others through attending wānanga, some of the mothers went back to their marae to reconnect, while others engaged with elder kaumātua and kuia to reconnect. Shepherd et al., (2024) highlight the powerful key cultural reconnection can be for young mothers who are looking to reclaim their identity. A significant framework used to understand these journeys was the CCS and its three dimensions. Within the dimension of identity, participants embodied groundedness, whenua, and leadership – symbolised by Tupuānuku and Ururangi – through their desires to understand their whakapapa and go back to their marae, the lands of their tūpuna. P3 reflected, “It felt like the ground was holding me. Like I finally knew where I belonged,” when talking about her experiences of going back home to her iwi. Not only did this deepen her sense of belonging and identity, in a broader context, it affirmed the protective potential of grounded cultural practices. Echoing this is work by Graham and Masters-

Awatere (2020), who argue that culturally grounded practices can counter the alienation caused by colonisation. Representing the values of Ururangi – leadership and direction – were the mothers who desired modelling cultural confidence and sought knowledge for their children. P6 shared, "I want my son to see me learning. Even if I don't know it all, I want him to know it's something to be proud of." These behaviours of intergenerational motivation speak to the principle of tino rangatiratanga in that these participants have maintained leadership and sovereignty over their own healing and reclamation journeys. The actions of these mothers align with Reid and colleagues' findings, who argue that the wellbeing of Māori is fundamentally linked to structural autonomy and cultural self-determination (J. Reid et al., 2014).

Another critical component of the reconnection journeys of the participants is spirituality, represented by Waitā in the CCS framework. Several of the participants noted the role spirituality played in their journey, acknowledging that spiritual practices – such as karakia and waiata – became a source of strength, grounding, and clarity for their wairua. P2 described, "When I light the candle and say karakia, I feel like my nanny is with me. Like I'm not doing this alone." These practices provided participants with a renewed connection to their tūpuna, which became a comforting anchor when receiving care that was perceived as often cold and clinical in alienating environments. Echoing the sentiments of the participants' spiritual revelations is the work from Mikaere (2011), who emphasises that the exclusion of Indigenous spiritual concepts perpetuates disconnection as wairuatanga is foundational to Māori worldviews. Under the dimension of traditions – represented by Tupuārangi and Waipun-a-rangi – mothers engaged Māori cultural activities in collective spaces such as wānanga, kapa haka, and hui at marae. These spaces allowed mothers to learn and participate in tikanga. Important to acknowledge is the potential these spaces have to generate meaningful and positive outcomes through shared learning, reduced isolation, and

facilitated peer validation. P4 said, “I felt dumb when I started, but other māmā were the same. We learnt together, laughed together. It was healing in ways I didn’t expect.” Through these reflections, the significance of whanaungatanga and collaborative learning in supporting emotional and spiritual wellbeing is evident. These revelations are reinforced by the work of Pihama et al., (2014), who argue that collective and relational healing processes are essential to Māori models of wellbeing.

Collective healing aligns with the principle of whānau, encompassing more than the nuclear family but also the wider support networks these mothers have. Throughout this research process, it was apparent that healing occurred through connection with others, it did not happen in isolation. Through collaborating and sharing experiences in spaces that felt safe and fostered trust for these mothers, cultural discovery and connection was normalised. This had a positive effect of the whakamā many of the participants had previously felt and they were able to shift some of that shame. Reweti (2023) affirms the transformative potential of healing environments that are culturally grounded and whānau-based. Health initiatives anchored in Māori values, such as mana motuhake, significantly improve the holistic health outcomes for Māori communities. Mothers in this study embodied the principle of taonga tuku iho when they began integrating tikanga in their daily home life. These acts of reclamation not only broke the cycle of disconnection for these wahine, but it contributed to a sense of fulfilment, evidenced when P7 noted, “When my girl counted to ten in te reo, I cried. She’s growing up with that I didn’t have.” Noticeable from P7’s experience is the transformative nature of reconnection. Individuals were able to restore cultural ties and importantly, they were empowered to become intergenerational carriers of cultural knowledge and practice. Through the retelling of their journeys, a central thread was mana motuhake – participants were not merely passive recipients of help, but active agents expressing and asserting their autonomy and self-determination. Echoing this sentiment is Smith (2012) who articulates that

the reclamation of knowledge is a political act as well as a cultural one, aimed at restoring the wellbeing of the collective.

To summarise, a powerful counter-narrative to the alienation felt by participants, due to cultural dislocation, is reconnection. Mothers in this study were able to find a way back to themselves, their communities, and their histories, after engaging in whakapapa, wairua, and collective practices. The stories shared demonstrate the power of cultural connection as a personal and political act – one that could have lasting implications for how maternal mental health is conceptualised and delivered in Aotearoa.

5.5 Isolation and Internalised Pressure

Significant and interrelated themes that emerged from this study were isolation and internalised pressure which contributed to the participant's experiences of PND symptoms. Exacerbating the experiences of PND were cultural disconnection and disruption of cultural identity, lack of support systems, and internalised societal pressures of how motherhood is supposed to be. Within a kaupapa Māori context, these experiences become symptoms of broader structural and cultural dislocation, they are not viewed as individual failings (Graham & Masters-Awatere, 2020; McIntosh & Mulholland, 2011).

Participants described having intense feelings of physical, emotional, and cultural isolation during the postnatal period, exacerbated by the limited access to spaces grounded in kaupapa Māori or trusted whānau (in the wider sense of the term) networks. P2 described, "It was like everyone had their own lives, and I didn't want to be a burden. I felt like I was the only one going through it." This sentiment conveys a reluctance to reach out and social withdrawal, both often linked to PND. Systemic marginalisation can be linked to the internalisation of deficit thinking, which is the belief that struggles are a result of personal inadequacy, this often discourages help-seeking behaviours

(Goetz et al., 2023). This recurring theme of internalised pressure to be seen as a "good mother" was common among all participants. Mothers reflected on the pressure to conform to unrealistic standards of motherhood, shaped by colonial influence and dominant cultural ideals. The internalised expectations participants adopted were often at odds with their lived realities, leading to further distress. P5 noted, "I thought I had to be everything – the perfect mum, the perfect partner. But I was falling apart inside." Further contributing to the mental distress experienced by these mothers was the significant emotional labour associated with attempting to meet these standards while in isolation. Compounding the internalised pressures of unrealistic mothering standards these participants are managing, is the erosion of traditional collective parenting structures seen in pre-colonial Māori communities. Māori women have been disproportionately impacted by the dismantling of communal caregiving through colonisation. Māori mothers have been left to navigate motherhood within the dominant Western societal constructs of parenting that directly contradicts the inherent nature of Māori motherhood, which involves collective caregiving and culturally grounded support systems that no longer exist (Simmonds, 2014).

Represented by Tupuānuku in the CCS framework, the dimension of identity was notably missing for mothers who were experiencing high levels of isolation. Disconnection from whenua and community deepened participant's experiences of disorientation and added to their diminished self-worth. Several participants explained feeling "adrift" from who they were. P1 expressed, "I didn't even know who I was anymore. I was just this crying, tired mess. Not a daughter, not a niece, not a mother, not Māori – just broken." The identity loss felt by the mothers illuminates the interconnectedness of mental distress and cultural disconnection. Spirituality emerged as an important dimension of wellbeing. In the absence of practices for their wairua – such as collective reflection and karakia – participants described a sense of emotional and spiritual depletion. P3

stated, “I used to do karakia with my nan, but when she passed, I just stopped. I didn’t have anyone to do it with, and I didn’t feel right doing it alone.” A key source of resilience identified in this study as intergenerational knowledge transmission – taonga tuku iho. Where cultural rituals have been abandoned, the transmission of knowledge is disrupted, contributing to a sense of spiritual loneliness. Participant’s reflections on their parenting illuminated the effects of internalised pressure, often expressed through self-criticism and self-judgement. Participants relied on comparing themselves to the dominant Pākehā norms for parenting competence. P6 reflected, “I thought being strong meant never asking for help. But it just made things worse. I was trying so hard to be what I thought a good mum looked like, but I didn’t even know where the idea came from.” This reflection reveals the tension between inherited cultural values and dominant societal expectations, resulting in deep feelings of self-doubt (McIntosh & Mulholland, 2011).

Aligning with the findings from this study is broader literature on the intersection between cultural identity, isolation, and wellbeing. Berghan et al., (2017). propose that one barrier to engagement is the lack of Treaty-based, culturally safe environments within mainstream healthcare, exacerbating feelings of isolation among Māori. This affirms that, for Māori mothers to feel safe expressing their vulnerability and seeking support, access to culturally safe environments within the healthcare system is essential. Participants disclosed that they felt they could not be honest about their struggles due to the absence of whanaungatanga and manaakitanga in the healthcare environments they were in during the postnatal period. The lack of reciprocal relationships and cultural care intensified the mothers’ feelings of whakmā and contributed to their hesitation to be open about their experiences. This is echoed in work by Wilson (2008) who emphasised the importance of culturally respectful and appropriate environments in fostering safety and engagement in maternal health services for Māori women. Conversely, for some participants, the

journey toward reconnection began when isolation could no longer be endured. Finding and accessing kaupapa Māori spaces allowed some participants to shed the internalised pressure, instead they were able to focus on embracing the culturally safe models of care. P4 described the shift, "At the wānanga, I cried for the first time in ages. No one looked at me weird. They just hugged me and said, 'we get it.' That was the moment I stopped pretending." This became the turning point for several mothers. Aligning with the CCS dimensions, when mothers reconnected with identity, spirituality, and tradition, their distress was alleviated, and their cultural integrity was restored. This ultimately facilitated a shift from internalised shame toward self-compassion and shared understanding (Graham & Masters Awatere, 2020; Theresa & Shepherd, 2024).

In conclusion, the theme of isolation and internalised pressure reflects the profound psychological burden of disconnection from cultural and relational support systems. The participant's pūrākau highlights that healing is not only individual resilience, but also fostered through culturally aligned relationships, affirmation, and reconnection. These findings add to the growing evidence of the urgent need for culturally grounded, whanau-centred approaches within maternal mental health care in Aotearoa, to disrupt the isolation and challenge the internalised narratives of deficiency.

5.6 Structural Barriers to Care

Participants in this study experienced structural barriers that reflected deeply ingrained systemic inequities. Among these barriers were experiences of racism, financial hardship, and inaccessible services. Aligning with a kaupapa Māori framework, these issues were not isolated, rather, they were intricately linked to colonisation and the continued marginalisation of Māori within Aotearoa's health system (Came, 2014; McIntosh & Mulholland, 2011). To fully understand the health inequities faced by Māori, the historical and ongoing effects of colonisation must be

acknowledged, particularly the loss of tino rangatiratanga, and the devaluation of mātauranga Māori in mainstream healthcare practices in Aotearoa (Graham & Masters-Awatere, 2020; J. Reid et al., 2014). Participants mentioned cost of services, lack of transport, and no childcare, as barriers to accessing mental health services. P3 said, "I wanted to go to counselling, but it was too expensive. I couldn't afford petrol, let alone a babysitter." These obstacles hindered the participants' ability to prioritise their own mental health, particularly when considered alongside the immediate demands of caring for tamariki.

Participants were recruited from areas within the TSI catchment, where kaupapa Māori services are readily available. However, their experiences indicate that availability does not always equate to accessibility. Participants reported long wait lists, inconsistent service delivery, and unclear pathways to care. For some mothers, the complexity of accessing support – such as completing forms, meeting eligibility criteria, or navigating multiple agencies - was itself a barrier, particularly when layered with whakamā or previous negative experiences. P1 described, "I just gave up. Every form I filled out led to another one. It was easier doing nothing." For others, past experiences – both in mainstream and kaupapa Māori settings – left them feeling judged or misunderstood. P6 described, "They said it was kaupapa Māori, but I didn't feel like I could be myself there. It felt like there were still rules I didn't understand." This insight points to a subtle but significant aspect of structural accessibility: services must be culturally and emotionally safe, as well as physically available. When relational or systemic failures occur, potentially beneficial services may be underutilised (Pitama et al., 2014; Theresa & Shepherd, 2024).

Another barrier to access for Māori mothers was the deep mistrust of services that arose from aforementioned prior negative experiences – of judgement, minimisation, and fear around punitive consequences. P2 reflected, "I didn't want to tell the nurse how bad it was because I was

scared, they'd call Oranga Tamariki." This reflection echoes the concerns raised in the Māori Health Review (Q. Smith & Stevens, 2022), which documents the number of Māori whānau who have engaged with Oranga Tamariki and find them culturally unresponsive. Notable gaps were seen in communication, partnership, and trust. This added another layer to the lack of help seeking seen in Māori communities. Not only were mothers battling to overcome internal resistance, but they also had to learn how to navigate an environment they perceived as risky or unsafe. Some participants felt as though their worries were minimised and their distress treated with indifference by health professionals. P5 shared, "They just said I was tired. But it was more than that. I felt like I was drowning, and no one was listening." Experiences such as these shared by participants are congruent with existing research that highlights the implicit bias and structural racism faced by these mothers resulting in Māori mothers being less likely to have their distress acknowledged or addressed adequately (Came, 2014). Acknowledging this literature is important as it aids in contextualising these mothers' experiences within a broader pattern of structural inequities within healthcare. When continued experiences of dismissal or misrecognition accumulate, they often result in mothers disengaging from formal services, leaving mothers to manage their own emotional wellbeing or to rely solely on informal networks.

Analysing this through a kaupapa Māori lens aids in clearly identifying these barriers. When services fail to centre te ao Māori in practices, the result is often the exclusion of culturally grounded language and practices, and a diminishing of mana for those seeking support (McIntosh & Mulholland, 2011; Theresa & Shepherd, 2024). P4 noted, "You get told to ask for help, but when you do, they make you feel like a burden. So, I stopped trying." The pūrākau shared throughout this research process illustrates the logistical, emotional, and relational layers of the systemic issues they were facing. Moreover, when mainstream services do not uphold basic kaupapa Māori principles

such as whanaungatanga, manaakitanga, and tino rangatiratanga, the cultural disconnection and whakamā can deepen further (Graham & Masters-Awatere, 2020). However, when participants received care from services that upheld kaupapa Māori principles in process and practice, they described having positive experiences. P7 reflected, “At the wānanga, they asked how my wairua was – not just my mood. That made me feel seen.” Narratives such as this align with the growing body of research that, when delivered authentically and with sufficient support, kaupapa Māori services can provide relational, strengths-based care that boosts whānau engagement and improves health outcomes (Came, 2014; Pitama et al., 2014). While participants reported positive experiences with kaupapa Māori services, other mothers found these services hard to access due to inconsistent or scattered information. P6 described, “It was good, but I had to wait months. And then it was only one session only one session every few weeks.” Participants noted this was, in part, due to the lack of clear information around the eligibility and referral processes, resulting in questions around availability, pathways, and additional paperwork required. Participants reported feeling overwhelmed and confused about how to access services that were hidden behind mazes of forms and disconnected agencies.

The CCS framework aids in understanding what impact these structural barriers have. Without access to care that affirms identity, nurtures wairua, and honours tikanga, Māori mothers are effectively deprived of a fundamental dimension of their wellbeing. Further, when wairua is disrupted, relationships are not mana-enhancing, and there is a disconnection from kaupapa Māori services, the risk of PND is enhanced (Graham & Masters-Awatere, 2020, Theresa & Shepherd, 2024). This ultimately limits opportunities for Māori mothers to access culturally grounded recovery. The disconnect between the current system and kaupapa Māori services is illustrated by kaupapa Māori principles. Upholding tino rangatiratanga requires Māori-led services and demands

Māori-defined measures of success, safety, and wellbeing. Complementing this is the principle of kaitiakitanga which underscores the duty of health systems to extend beyond individual health outcomes to protect the collective wellbeing of whānau and hapori Māori (McIntosh & Mulholland, 2011). To mitigate the impact of the structural barriers that continue to disproportionately affect Māori mothers, sustained investment in kaupapa Māori services is a necessity. Systemic transformation is crucial to address these barriers. This includes policy changes that are focused on equity, investment into kaupapa Māori services, and ensuring mātauranga Māori principles are embedded throughout the health workforce. Structural barriers perpetuate colonising systems that disproportionately harm and marginalise Māori mothers. Ensuring access to mental health support that is culturally grounded and equitable is more than just improving services – it is a matter of reclamation, restoration, and justice (Simmonds, 2014; L. T. Smith, 2012).

5.7 Symptom Burden and Emotional Distress

Participants described the distress they felt during the postnatal period as a complex interweaving of spiritual, emotional, psychological, and physical symptoms. These experiences cannot be reduced to individual pathology; rather, they are embedded in the broader structural and cultural conditions that shaped the lives of these wahine – a reality made visible through the narratives shared and the themes that emerged in this study. Within a kaupapa Māori context and through a constructivist lens, distress encapsulates more than the biomedical model. Within these contexts, distress reaches deeper and includes historical trauma, cultural marginalisation, and relational disconnection (Graham & Masters-Awatere, 2020; McIntosh & Mulholland, 2011). Further, the CCS framework proved a valuable analytical tool for exploring the ways in which identity, spirituality, and tradition shaped and informed these experiences. Mothers commonly described persistent feelings of sadness, hopelessness, and whakamā. These feelings reflect deep internalised feelings of inadequacy.

P2 reflected, “There were days I just couldn’t get out of bed. I felt like the sadness was inside my bones.” Framing these narratives as merely physiological reactions to childbirth, overlooks the profound influence that systemic barriers and cultural dislocation has on Māori mothers. The experiences shared by the participants during this study align with literature from Signal et al., (2017), who found that Māori mothers present with higher rates of both antenatal and postnatal mental distress than their non-Māori counterparts. This disparity is attributed to the structural inequities and enduring impact of colonisation – factors that extend well beyond individual cases.

Together with the emotional experiences of distress, participants described the physical symptoms they navigated daily, such as sleep disturbances, fatigue, chest tightness, and trembling. All of these symptoms created a holistic burden that often went unrecognised in mainstream services, P5 shared, “It was like my body was on all the time. I couldn’t catch a break, even when I finally slept.” It is important to note that narratives shared by the participants are consistent with the Te Whare Tapa Whā model (1998). Participants noted that within the mainstream services they accessed, there were no conversations that addressed all of the pillars of health. Instead, care was framed within a biomedical model, overlooking the spiritual, relational, and cultural dimensions critical to their wellbeing. Further, these experiences highlight a profound gap between the holistic understanding of wellbeing within Māori health models and the fragmented nature of mainstream services. Symptom burden and emotional distress resulted in some participants experiencing suicidal or self-harming thoughts during the postnatal period, admissions that were made hesitantly due to stigma and fear of being judged. P7 shared, “There were nights I wondered if it would be easier for everyone if I wasn’t here.” Given that Māori maternal suicide rates are over three times higher than those of New Zealand European mothers (PMMRC, 2021), the participant accounts highlight the critical gaps in care and must be taken seriously as evidence for systemic change.

Moreover, participant experiences underscore the urgent need for culturally grounded, responsive interventions that work with wairua and identity, not just symptom management (Penehira et al., 2014).

Another source of emotional distress was cultural grief – these mothers felt pain in knowing they may be unable to pass on cultural knowledge, language, and tikanga to their children. This became an internalised failure which further intensified their suffering. P2 noted, "I felt like I was failing as a Māori mum – I wasn't passing on tikanga, I wasn't providing wairuatanga." Highlighting these narratives illustrates an emotional burden that cannot be captured by mainstream tools for assessing PND such as the EPDS. This limitation is echoed in international research, which affirms the notion that cultural disconnection influences perinatal distress. Marriott et al., (2019) conducted a scoping review examining maternity services for Indigenous women in urban settings. Their findings are consistent with the experiences of the mothers in this study. Cultural insecurity - including culturally safe care - disconnection from traditions, and the absence of Indigenous languages are linked to negative emotional and psychological outcomes in the perinatal period. In a similar vein, participants voiced their frustrations around how their distress was assessed and treated, particularly their dissatisfaction with standardized health screening measures, describing them as 'inadequate' and 'superficial.' P4 reflected, "They asked me to tick boxes. But how do you measure mana?" This further reinforces what the literature says, such as the findings by Pitama et al., (2007), who argue for the integration of Māori models, such as the Meihana model, into clinical processes. This would aid in closing the gap between Western diagnostic frameworks and Indigenous experiences. The mothers in this study illuminated the ways their pain was invalidated, and they were left feeling unseen within the mainstream biomedical models of health.

By comparison, participants who accessed kaupapa Māori services or who were able to re-engage in cultural practices, described feelings of relief. Further, they named these moments as turning points in their healing journeys. P6 said, “I want my son to see me learning. Even if I don’t know it all, I want him to know it’s something to be proud of.” Within a kaupapa Māori context, these practices of reconnection were the participants embodying tino rangatiratanga and resistance against the erasure of Māori identity through colonial structures. Further, the CCS provided a framework to reflect how connections with identity (Tupuānuku), spirituality (Waitā), and tradition (Tupuānuku and Waipunarangi) fostered healing and reduced stress.

In summary, the emotional and psychological burdens these mothers experienced were profound and closely linked to both cultural disconnection and structural inequities. The lived realities of distress these participants experienced were not solely individual issues. These narratives were shaped by cultural alienation, institutional invalidation, and systemic racism. To effectively address symptom burden for Māori mothers, clinical intervention must be grounded in kaupapa Māori principles that honour the realities, values, and healing pathways of Māori mothers.

5.8 Innovative Responses and Opportunities for Change

Throughout this research process, mothers opened up about the challenges they faced during the postnatal period. What stood out among those challenges were the moments of resilience, transformation, and hope. These narratives and lived experiences shed light on where the current system often fails to meet the need of Māori mothers. It also illuminates the ways participants use their reclamation of tino rangatiratanga as innovation. Three interconnected strands were interwoven throughout the participants’ pūrākau – wānanga, tuakana-teina support, and kaupapa Māori services embedded in everyday care – which highlighted both potential and systems-level gaps.

Firstly, throughout participants' narratives, wānanga run at marae emerged as transformative spaces. P3 recounted, "At the wānanga I could finally breathe – my whakapapa was wrapped around me." These experiences are echoed in the findings from Barrett et al., (2022), who evaluated a Hapū Wānanga programme that engaged over 1,100 whānau in a by Māori-for-Māori childbirth education course in Waikato. This study found that collective learning immersed in tikanga and te reo Māori resulted in significant improvements in cultural connection, maternal confidence, and parenting self-efficacy for Māori mothers. Within the framework of the adapted CCS, wānanga for hapū māmā engage the dimensions of Tupuānuku (identity) and Waipun-a-rangi (tradition) to demonstrate the ways culturally grounded spaces can serve as protective factors against the symptoms of PND. Further, participants reflected on the reciprocal nature and flow of knowledge transmission in wānanga. It was noted that this way of teaching challenged the mainstream "one-way transmission" of knowledge in antenatal classes and reinforced whakapapa bonds for participants.

In addition to organised wānanga, participants talked about the restorative power of peer connection. P6 said, "Talking to another Māori māmā who'd been through it made me feel normal." Reflecting this sentiment are findings from the recently published Kotahitanga study conducted by Meredith et al., (2025), who explored a kaupapa Māori intervention. The study highlighted the transformative potential of tikanga-driven dialogue and whanaungatanga to uplift mana, foster psychological safety, and enable collective problem solving. Reinforcing these findings is international research showing that peer programmes embedded in relational reciprocity reduce isolation and stigma. Despite this evidence, participants highlighted the lack of Māori-specific peer roles in perinatal health teams. Implementing a trained tuakana with lived experience into clinical pathways offers culturally safe and supportive spaces for mothers who fear being judged by mainstream providers.

For many participants, the process of screening and diagnosis became a point of contention where cultural safety was compromised. This process was described by mothers as "tick—box" tools that could not capture their mana or wairua. The qualitative study by Hayward (2025) provides empirical support to these concerns. Interviews with wāhine Māori throughout Aotearoa found inconsistent use of screening tools like the EPDS and PHQ-3, a deep mistrust of clinicians, and a fear of child protection involvement. These experiences combined made it difficult for mothers to feel safe enough to speak openly about their experiences. Moreover, Chan et al.'s (2021) systematic review found that using EPDS tools, which have not been adapted, among Indigenous mothers can over- and under-identify perinatal distress. The study illuminates the urgent need for alternatives that are Indigenous-validated and culturally grounded. Narratives of the participants indicate the need for a dual remedy. First, screening tools that are co-designed to express Māori expressions of distress, incorporate whakapapa, and allow females to articulate disruption of wairua. Secondly, clinician training in kaupapa Māori frameworks such as Te Whare Tapa Whā and the Meihana Model. This ensures assessments honour the dimensions of hinengaro, wairua, whānau, tinana, taiao, and iwi and avoids reducing distress to individual pathology.

Participants mentioned envisioning holistic services coexisting with biomedical input. P4 said, "Learning my pepeha with my pēpi wasn't just language; it healed something in me." A critical interpretive synthesis conducted by Meredith and colleagues (2023) found that Indigenous perinatal interventions are most engaging and effective when mātauranga Māori is embedded throughout all layers of service delivery – governance, workforce, environment, and practice – rather than being added as a superficial or tokenistic add-on. The efficacy of the interventions increased when mātauranga played an active role in shaping care. However, this review found limited evaluation rigour, most studies relied on small sample sizes and follow up periods were minimal. This concern

was reflected in participant narratives as they described the ways kaupapa Māori initiatives are often discontinued after the pilot funding expires or charismatic leaders move on. This results in fragmentation of service delivery which erodes trust among service users. Ultimately, Māori mothers are forced back into the mainstream system they had attempted to avoid. Participants proposed that long-term funding would be a crucial factor in sustaining these initiatives.

The experiences of participants in this study mirror the work by Oetzel et al., (2017), specifically the He Pikinga Waiora implementation Framework that identifies four key pillars – cultural centredness, systems thinking, community engagement, and integrated knowledge translation – anchored in Indigenous self-determination. Within the context of perinatal mental health, this framework allows Māori mothers to become more than service users or "clients" and situates them as co-designers and co-governors. Moreover, it brings focus to the need for braided funding streams to protect the kaupapa programmes from budget cycles in order to provide relational continuity and sufficient evidence for long-term evaluation. The absence of such investment leaves promising wānanga, peer networks, and kaupapa programmes vulnerable to institutional volatility.

Collectively, peer-reviewed evidence and participant experiences align around a practical, actionable agenda. To begin, kaupapa Māori initiatives can be expanded through evaluations that capture relational, cultural, and spiritual outcomes alongside the mainstream clinical metrics. Next, qualified Māori peer support workers must be integrated into multidisciplinary teams, with their remuneration for cultural labour reflecting that of their clinical counterparts. Then, Māori-centred screening tools must be developed through co-design and implemented alongside mandatory training in kaupapa Māori frameworks such as the Meihana model, to ensure holistic care from clinicians. After that, it is essential that mātauranga be embedded in all antenatal and postnatal

pathways, this could include appointments that align with maramataka and te reo Māori parenting courses. This guarantees that cultural safety is central to service delivery as opposed to an optional extra. Lastly, it is imperative to secure long term governance and funding to avoid kaupapa initiatives from stalling in a perpetual pilot phase.

In summary, the mothers in this study framed innovation not as something entirely new, but as a process of restoration. To realign perinatal services to include the realities of Māori motherhood, identity, spirituality, reciprocity, wānanga, peer-led supports, culturally valid assessments, and mātauranga Māori services, must be central to service delivery. Further, sustained Indigenous governance has the potential to transform recovery efforts from fragile, short-term initiatives into dependable, rights-based systems of care.

5.9 Implications for Practice and Policy

The findings from this study offer a compelling call to action for service designers, health practitioners, and policy leaders: Māori-led, culturally grounded, and relational models of care must be embraced in Aotearoa perinatal mental health services. There is a disconnect between the participants lived realities and the mainstream models of care, further highlighting the need for transformational change. Implications are outlined below and offer a pathway for implementing these insights into practice and policy.

As outlined earlier, sustainable funding of kaupapa Māori initiatives is a priority. Current literature supports the integration of Māori-led initiatives not as supplementary programmes, but as critical components of antenatal and postnatal care. This is demonstrated in the evaluation of Hapū Wānanga, which found that collective learning grounded in tikanga and te reo Māori increased maternal confidence and strengthened cultural identity (Barrett et al., 2022). Participants in this study described wānanga as both identity-affirming and restorative. For initiatives to move

beyond one-off pilots, policy frameworks must reflect these needs. This includes recognising cultural indicators as valid measures of service outcomes and committing to long-term, multi-year funding. Further, embedding Māori peer-support workers into multidisciplinary teams is another actionable step. Participants reflected the ways peer relationships aided in reducing stigma and fostering a sense of normalcy. This is echoed in recent qualitative research conducted by Meredith et al., (2025), who found that emotional safety and mana was enhanced when individuals participated in peer-led kaupapa Māori groups. Supporting these roles with adequate training, fair remuneration, and culturally grounded supervision would give health services a meaningful way to bring whanaungatanga and manaakitanga to how their teams work together.

Also requiring urgent attention are mainstream assessment practices. Participants in this study critiqued standardised screening tools and questioned their relevance, noting they are superficial and culturally inadequate. In place of reiterating these critiques, this study draws on national and international research that reinforces this dissatisfaction. Nationally, Hayward et al., (2025) found that under-reporting of stress was a result of Māori women often feeling misunderstood, judged, or silenced during screening. Internationally, Chan et al., (2021) determined that widely used tools such as the EPDS typically lacked cultural validity for Indigenous populations. This demonstrates a critical need for assessment/screening tools to be co-designed with wahine Māori, grounded in Māori worldviews, and delivered in relational, culturally safe spaces. Further, complementary training in Māori health frameworks, such as the Meihana model (Pitama et al., 2007), would provide clinicians with the tools needed to provide care that is both culturally safe and clinically sound.

Participants expressed a vision of services where mātauranga Māori was not treated as an add-on but woven throughout the design and delivery of care. Participants' narratives revealed a

shared aspiration for cultural practices to be fully integrated into everyday care, encompassing language, scheduling, and connection to whenua. This was reinforced by Meredith et al., (2023), who emphasise that meaningful engagement and equity in perinatal mental health care can only be achieved when Indigenous knowledge systems are woven throughout all aspects of service design, delivery, and evaluation. To ensure this is achieved, policy mechanisms must mandate cultural integration across all layers of care – governance, workforce, environment, and outcome measurement.

A critical concern that emerged among participants was sustainability. To ensure long term viability structural reform in funding models. Participants shared their frustrations around culturally safe kaupapa vanishing after short-term pilots – experiences echoed throughout Indigenous health literature. Embedding Māori governance and adopting frameworks like He Pikinga Waiora, which emphasise systems thinking and Indigenous self-determination, can help ensure that Māori-led solutions are effective and enduring (Oetzel et al., 2017). Moreover, this move is supported by international commentary. A recent Lancet editorial underscores Indigenous self-determination as a key, central determinant of Indigenous health equity worldwide (The Lancet, 2023). In Aotearoa, this calls for embedding Māori governance within policy and funding decisions, protecting dedicated resources for kaupapa Māori initiatives, and reorienting accountability toward outcomes defined by whānau.

In conclusion, the implications of this study point to a paradigm shift towards dedicated, structural systems that are Māori led. Actionable steps include resourcing kaupapa wānanga as primary interventions, creating peer-support roles within maternal mental health services, developing screening tools that are culturally valid, ensuring mātauranga Māori in embedded throughout all care systems, and aligning national policy with Indigenous self-determination

frameworks. By addressing the current gaps, these changes would centre identity, spirituality, and whānau in the ongoing journey towards healing for Māori mothers. In doing so, the visions these mothers articulated – to have their wellbeing actively protected and nurtured – would be honoured.

5.10 Strengths and Limitations

Valuable insights into the postnatal experiences of Māori mothers and the protective potential of cultural connectedness are found within this study. The research was guided by kaupapa Māori methodology within a constructivist paradigm and shaped by Indigenous ways of knowing. A key strength of this study is that it provides insight into an under-researched area with relevance both practically and within policy.

A further key strength of this research is its culturally grounded approach. Trust between researcher and participants was fostered by the relational and respectful nature of kaupapa Māori methodology, it also provided a safe space for participants to speak openly and honestly about their deeply personal and emotional experiences. The methodological approach of this study enabled the integration of values such as whanaungatanga, manaakitanga, and wairuatanga throughout both the data collection and interpretation phases. My lived experience as a Māori mother positioned her as an insider within the research which likely enriched the kōrero and facilitated the development of nuanced and contextually meaningful themes.

The application of the CCS framework is another strength of this study as it allowed for the interpretation of the data to be holistic and culturally valid. The mainstream measures for wellbeing often omit qualities valued within Māori culture. The CCS provided a platform that accounted for identity, spirituality, relationality, and resistance as measures of wellbeing. This study adds to the growing body of Indigenous research that elevates Māori-led solutions and restores mātauranga Māori as a central framework for health and wellbeing.

Although this study offers important strengths, it is not without its limitations, which must be acknowledged. Firstly, while eight participants are consistent with qualitative research and allowed for in-depth exploration of participant's stories, it was relatively small. Therefore, findings from this study could not be generalized across all Māori mothers. Further, as recruitment was based on voluntary self-selection, participants were likely those already engaged with, or drawn to, kaupapa Māori spaces – making them more inclined to share their experiences. As a result, the study may underrepresent individuals who are culturally disconnected or who have experienced harm in kaupapa Māori spaces.

Secondly, as this study was situated within a distinct regional and cultural context, the findings may not fully reflect the diverse experiences of Māori mothers across other rohe. This is particularly true for mothers whose access to services, living environments (rural or urban), or iwi affiliations differ from those represented in the study. Moreover, data collection took place during a time of growing attention around Māori maternal health inequities, which could have played a part in shaping participant perspectives considering evolving public discourse and health system responses. Finally, my positionality was noted as a strength due to my cultural alignment and relational depth, however, this positionality also must be discussed reflexively. While reflexivity and oversight from a supervisor helped ensure that interpretations were both data-driven and aligned with tikanga Māori, the inherent subjectivity of thematic analysis cannot be fully eliminated. It is possible that another researcher, shaped by their own positionality, may have drawn attention to different elements of the kōrero or interpreted the themes from a different analytical perspective.

While limitations exist, this study offers an important contribution to perimental health research, particularly in the context of Indigenous-led approaches. These findings highlight the

value of culturally grounded care and provide a platform for future research, policy, and service design that responds to the lived experiences of Māori mothers and their whānau.

6. Conclusion

This study aimed to examine cultural connectedness as a protective factor against PND for Māori mothers. Anchored in a kaupapa Māori methodology and informed by a constructivist paradigm, this study centred the voices of eight Māori mothers navigating the postnatal period. Participants lived experiences revealed that cultural connectedness – when expressed through language, identity, whānau relationships, and engagement in tikanga – is not only protective, but also an integral part of healing and recovery. These elements emerged as essential components to understanding the psychological, emotional, and spiritual realities of the mothers in this study, however, they are often overlooked within Western frameworks of perinatal care.

The symptoms of PND experienced by the participants brought to light the broader social, historical, and cultural forces at play. Participants' experiences were shaped by structural inequities, ongoing impacts of colonisation, cultural disconnection, and a health system that often invalidated or overlooked their realities. Experiences of whakamā, marginalisation, and misrecognition were frequently described, particularly in clinical settings that relied heavily on biomedical assessments and standardised screening tools such as the EPDS. Participants expressed that these tools failed to fully reflect the emotional and spiritual weight carried by Māori mothers. The mothers described a lack of culturally safe services and characterised the tools as superficial and culturally misaligned. This contributed to institutional mistrust and created additional barriers to accessing support.

Although these barriers existed, participants found powerful ways to support their wellbeing. This included kaupapa Māori wānanga, tuakana-teina-based peer support, and everyday acts of cultural reconnection – including learning pepeha and karakia. Participants described these supports as deeply transformative in their healing journeys. These experiences provided validation, emotional safety, a renewed sense of agency, and affirmed their identities. Reflections from participants

revealed a sense of being “wrapped in whakapapa” and emphasised that reconnecting with mātauranga Māori brought healing to themselves and in turn, their whole whānau. These supports were characterised by a holistic and relational approach, underpinned by values such as manaakitanga, whanaungatanga, and wairuatanga. The CCS framework encompassed key dimensions – Tupuānuku (identity), Waipunarangi (tradition), and Waitā (spirituality) – which together shaped a culturally grounded model of recovery.

A growing body of evidence underscores the importance of Indigenous-led interventions for perinatal mental health, rooted in cultural values, and aligned with Māori worldviews. This study adds to that momentum by reinforcing the notion that Māori mothers play an active role in their recovery. Far from being passive recipients of care, they are knowledge holders and agents of change, envisioning, co-creating, and generating solutions grounded in the realities and aspirations of their communities. Given this reality, the system bears a responsibility to transform services, policy, and research in ways that centre Māori maternal wellbeing, reflect whānau aspirations and uphold tino rangatiratanga. Adapting Western models is not the solution. The solution lies in embedding kaupapa Māori approaches from design to implementation, approaches that authentically reflect the lived experiences, cultural values, and relational dimensions of Māori maternal wellbeing.

While this study offers valuable insights, it is important to acknowledge its limitations. The findings are from the lived realities of a small group of participants who may have already been engaged with or open to kaupapa Māori approaches. Although their experiences were rich and insightful, they were not intended to be generalisable. However, the depth of the narratives, the consistency of emerging themes and their alignment with existing Indigenous literature lend credibility and strength to the findings The strengths of this study lie in its cultural integrity,

relational research practices, and the use of kaupapa Māori methodology. This approach enabled the collection of rich, in-depth kōrero in a way that upheld participants' mana, honoured their knowledge, and centred their realities. Ultimately offering valuable and meaningful insight into the experiences of Māori mothers navigating symptoms of PND.

In conclusion, this thesis argues that cultural connectedness is not merely a protective factor against PND - it is a vital source of strength, resistance, and healing. The findings illuminate how whānau, wairua, whakapapa, and mātauranga Māori serve as anchors for wellbeing in the postnatal period, particularly when clinical systems fall short. When these elements are embedded into services, Māori mothers reassert tino rangatiratanga and reshape the narrative of what maternal mental health care is in Aotearoa. The challenge lies with health professionals, researchers, and policymakers to uphold the vision these mothers articulated: a system that sees, values, and walks alongside them. True equity can only be achieved when Māori voices, values, and visions lead the design, delivery, and governance of the services intended to support them.

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Appendices

Appendix A: Participant Information Sheet

A Māori Mother's Journey: Is Cultural Connectedness a Protective Factor Against Postnatal Depression?

Participant Information Sheet

Kia ora,

My name is Paige Moki. I am a Massey University student. I am conducting research for my thesis as part of a Master of Health Science in Psychology. You are invited to participate in a research project that investigates the role cultural connectedness plays in protecting Māori māmā against postnatal depression. The study seeks to understand if and how cultural identity and practices can positively impact the wellbeing of Māori mothers during the postnatal period. Your participation in this study is entirely voluntary. Please read this information sheet and ask any questions that arise before deciding whether to participate.

Purpose of the Study

The main goal of this project is to explore if and how cultural connectedness impacts the mental health of Māori mothers after childbirth. We aim to identify key aspects of cultural practices and support systems that could contribute to impacting positively on the maternal mental health of Māori mothers.

Who Can Participate?

We are seeking mothers who:

- Whakapapa Māori
- Have given birth in the last 5 years
- Are willing and able to be interviewed for up to 90minutes (about one and a half hours) in English
- They are in a safe space mentally and are willing to share their experiences.

What will participation involve?

If you choose to participate, you will be asked to:

- Complete a screening questionnaire relating to your background, mental health status, and cultural practices
- Complete a cultural connectedness questionnaire and the Edinburgh postnatal depression questionnaire
- Participate in a conversational interview with me, the researcher, lasting approximately 60 – 90 minutes, within which I will ask open ended questions pertaining to your experiences with symptoms of postnatal depression and cultural connectedness • Optionally, you will be given the opportunity to read the transcript and make any changes you need regarding your wording to ensure your experiences are portrayed accurately.

Your safety and comfort are of utmost importance to me; I want these interviews to be relaxed and comfortable. If there is anything I can do to help achieve this, please let me know.

Confidentiality

Your privacy is important to me, therefore any and all data collected will be anonymised. You will not be identified in any publications or reports that result from this research. Data will be stored securely in a lockable filing cabinet and a password protected laptop, only the research team will have access to the information.

Voluntary Participation

Participation in this project is completely voluntary. You have the right to withdraw your consent and end your participation in this study at any time, with no consequences. If you choose to withdraw from the study, the information collected up to that point will either be destroyed or retained, depending on your preference.

Potential Risks and Benefits

There are no direct benefits to you, however, your participation will contribute valuable insights that may help in developing culturally appropriate interventions and support systems for Māori mothers. There are minimal risks associated with this study, however, discussing personal experiences of cultural disconnect and postnatal depression may be distressing for some. If you experience discomfort of any sort, you can take a break or stop the interview at any time. We will provide information on support services available to you.

Support Services

Should you need any support during or after your participation, we recommend contacting:

- Papakura Marae – 0800 TAMARIKI

- Depression Helpline – 0800 111 757
- Need to talk – 1737

Contact Information

If you have any questions or need further information, please feel free to contact:

- Researcher Name: Paige Moki
- Email: paige.moki@gmail.com
- Phone: 027 391 7719
- Supervisors Name: Kathryn McGuigan
- Email: k.mcguigan@massey.ac.nz
- Phone: 09 414 0800 ext. 43115

Thank you for considering participation in this research project. Your experiences and insights are invaluable in helping us understand and support the maternal mental health of Māori mothers Ngā mihi nui

Paige Moki

Appendix B: Participant Consent Form

A Māori Mother's Journey: Is Cultural Connectedness a Protective Factor Against Postnatal Depression?

Consent to Participate in a Research Project:

Researcher: Paige Moki

University: Massey University

Department: School of Psychology

Supervisor: Kathry McGuigan

Contact Information: paige.moki@gmail.com/ k.mcguigan@ac.nz

Consent Form:

1. Purpose of Study

I have read and understood the information sheet about the study titled "A Māori Mother's Journey: Is Cultural Connectedness a Protective Factor Against Postnatal Depression?" I understand that the purpose of the study is to investigate if and how cultural connectedness impacts the mental health of Māori mothers postnatally.

2. Voluntary Participation

I understand that my participation in this study is completely voluntary. I can withdraw from the study at any given time without any consequences. If I choose to withdraw, I can decide whether my data collected up to that point will be retained or destroyed.

3. Confidentiality

I understand that all information I provide will be kept confidential. My identity will not be revealed in any reports or publications resulting from this research. Data will be stored securely and only be accessible by the research team.

4. Participation Involves

- Completing initial screening questionnaire about my background, mental health, and cultural practices
- Completing a cultural connectedness questionnaire and the Edinburgh postnatal depression questionnaire
- Participating in an interview lasting between 60 – 90 minutes (about one and a half hours), about my experiences with cultural connectedness and postnatal depression
- Optionally, reading, reviewing, expanding, and changing the transcript if needed.

5. Recording of Interviews

I consent to having the interviews audio-recorded to ensure the accuracy of the information collected. I understand that these recordings will be used solely for this research and will be destroyed once they are completed.

6. Risks and Benefits

I understand that there are minimal risks associated with this study, and discussing my lived experiences may be distressing. I can take a break or stop the interview at any time if I feel uncomfortable. I understand that there are no direct benefits for me, but my participation will contribute valuable insights for supporting maternal mental health for Māori mothers.

7. Support Services:

I have been informed about the support services available should I need assistance during or after my participation.

Consent

By signing this form, I acknowledge that:

- I have read and understood the information provided
- I have had the opportunity to ask questions and have received satisfactory answers
- I voluntarily agree to participate in this study
- I consent to the audio recording of the interview

Participant name:

Signature:

Date:

Name:

Signature:

Appendix C: Interview Questions

A Māori Mother's Journey: Is Cultural Connectedness a Protective Factor Against Postnatal Depression?

Interview Questions

Note to ethics panel:

This is a semi-structured interview, these questions will be a guideline for the interview, however, actual questions will be based off the answers and the direction/flow of the interview.

Rapport Building

1. Can you tell me a little about yourself and your whānau?
2. How many children do you have?
3. Do you have any special interests? Do your children? Tell me about them

This will be balanced with me sharing experiences about myself and my own life.

Experiences with Postnatal Depression

1. Can you describe what it was like becoming a mum? What sorts of feelings did you experience?
2. In the postnatal period, did you find you were able to laugh and see the funny side of things?
3. In the postnatal period, how often did you look forward with enjoyment to things? 4. In the postnatal period, how often did you blame yourself unnecessarily when things went wrong?

5. In the postnatal period, how often were you anxious or worried for no good reason?

6. In the postnatal period, how often did you feel scared or panicky for no good reason?

7. In the postnatal period, how often did you feel like things were getting on top of you?

8. In the postnatal period, were you ever so unhappy that you had difficulty sleeping?

9. In the postnatal period, how often did you feel sad or miserable?

10. In the postnatal period, how often did you feel so unhappy that you would cry?

11. In the postnatal period, how often did you think of harming yourself?

12. How have these symptoms affected your daily life, relationships, and overall wellbeing?

Cultural Connectedness

Tupu-ā-nuku (connection to whenua and growth)

13. How often do you engage in activities that connect you to the land? (e.g. gardening, harvesting)

14. To what extent do you teach or plan to teach your children about the importance of the whenua and its role in growth and sustenance?

Tupu-ā-rangi (celestial bonds and community relationships)

15. How often do you participate in activities to celebrate celestial events or acknowledge the stars?

16. How important is it for you to nurture and preserve relationships within your community, and how do you cultivate these connections?

Waipunarangi (kindness, care for the community, hospitality, and respect)

17. How frequently do you engage in acts of manaakitanga and care for your community?

Ururangi (leadership and guidance – Rangatiratanga)

18. How do you involve your children in activities that teach them about leadership and vision for the future?

Waitī (protection, guardianship, preservation of natural resources – kaitiakitanga)

19. How often do you engage in activities that protect and preserve natural resources? (e.g. community clean-ups, conservation projects)

20. How do you teach your children about the importance of kaitiakitanga and preserving the environment?

Waitā (spirituality, sacred practices, beliefs, and traditions)

21. How often do you participate in spiritual practices or rituals?

22. To what extent do you share and practice sacred beliefs and traditions with your children?

23. (If they don't engage in any cultural practices) Can you tell me a little bit about why you don't engage in any cultural practices?

Support Systems

24. Can you describe the support you receive from your whānau and how it has impacted your postnatal period?

25. Are there any Māori community groups or health providers you interact with for support? How have they been helpful?

Perceived Impact of Cultural Connectedness

26. How do you feel your identity as a Māori mother influences your mental health?

27. Do you think there are ways that being connected to your Māori culture has helped protect you against postnatal depression? OR do you think your disconnection from Māori culture has had an impact on you in the postnatal period? If so, how?

Coping Strategies

28. What strategies or practices have you found helpful in managing your mental health during the postnatal period?

29. How has your cultural background influenced the coping strategies you use?

Barriers and Challenges

30. Are there any challenges you have faced in maintaining your cultural practices and connections during the postnatal period?

31. Are there any barriers that have made it difficult for you to access cultural or mental health support?

Reflections and Recommendations

32. Based on your experiences, what advice would you give to other Māori mothers who might be experiencing postnatal depression?

33. What do you think could be improved in terms of support systems and services for Māori mothers experiencing postnatal depression?

Closing

34. Is there anything else you would like to share about your experiences or suggestions for this research?

35. Would you be willing to participate in a follow up interview if needed?

Appendix D: Ethics Approval Letter

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

23/08/2024

Dear: Paige Moki

Re: Ethics Application - OM1 24/35 - A Māori Mother's Journey - Is Cultural Connectedness a Protective Factor Against Postnatal Depression?

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Ohu Matatika 1 at their meeting held on **Tuesday, 9 July 2024**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Tracy Riley,
Acting Chair, Research Ethics Chair's Committee

Appendix E: Thematic Development Table

Initial Codes	Code Clusters	Connections Between Clusters	Final Theme
Cultural self-doubt; shame; loss of spiritual connection; intergenerational loss of knowledge	Cultural disconnection Loss of wairua Identity anxiety	Disconnection → whakamā → reduced participation in tikanga	Cultural disconnection and whakamā
Healing through language; grounding through whenua; ritual connection; collective learning	Reconnection practices Whānau/peer support Spiritual restoration	Reconnection → strengthened identity → emotional stability	Reconnection as a healing journey
Leading by example; peer validation; cultural pride	Whanaungatanga Strength-based identity	Validation → confidence → cultural connectedness	Cultural connectedness as a protective factor against PND
Financial barriers; cultural gatekeeping; bureaucratic overwhelm; fear of judgment	Structural barriers Access and equity issues	Barriers → reduced help-seeking → whakamā	Structural barriers to culturally safe care
Emotional exhaustion; hyperarousal; sadness; suicidal ideation	High symptom burden Distress cluster	Fatigue → isolation → severe emotional distress	Symptom burden and emotional distress
Suggestions for kaupapa Māori spaces; wraparound support models	Innovative solutions Community-led supports	Identified needs → systemic opportunities	Innovative responses and opportunities for change