

**An occupational perspective on New Zealand working
mothers' stress, anxiety and depression: An
interpretive description study**

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Abstract

Globally depression affects nearly a quarter of the world's population and is one of the leading causes of disability and morbidity (World Health Organisation [WHO], 2017a). Worldwide women are twice more likely than men to have depression in their lifetime (WHO, 2017a); with stressed working mothers significantly more vulnerable. An occupational perspective can add new understandings on how working mothers respond and deal with stress, anxiety and depression. This interpretive descriptive study aimed to uncover an occupational perspective on working mothers' mental health to inform the development of a new kind of practice aligned to prevention focused primary health interventions. The study sought to firstly understand how an occupational perspective explains working mothers' stress, anxiety and depression; and secondly, what the participants considered to be current and future solutions to managing the complexity of their lives.

Following ethics approval, participants were recruited via a purposive sampling method. Data were collected from nine working mothers of children under five years via individual interviews and a focus group. Transcribed data were analysed using thematic analysis.

The findings suggest that multiple, complex and interplaying personal and environmental challenges increased working mothers' stress, anxiety and depression. The data revealed that the struggle to find the right balance, the struggle with others' expectations and the struggle with ongoing and/or multiple events were key factors that contributed to stress, anxiety and depression. Mirroring these challenges were equally complex strategies and supports working mothers' found useful and needed. These strategies included prioritising/reprioritising, getting help/support from others, supportive activities and wishes for the future.

The study identified that working mothers do not have access to enough relevant supports to address their complex and dynamic challenges and needs.

Several new potential strategies were identified within health (including occupational therapy), social and community sectors. These strategies have the potential to more comprehensively address New Zealand working mothers' issues and subsequently contribute to the prevention/promotion of mental health for this population. However, in order to see the culmination of these changes, a broader political, social and health sector reorientation to address gender inequality is needed.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed: .

Date: 8 December 2017

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Approved by the Auckland University of Technology Ethics Committee on the 28 July 2015 reference number 15/162 (Appendix A).

Chapter One: Introduction to the Study

In 2004, I was a working mother to a child under five going through a significant transition in my life – moving from South Africa to New Zealand. There were numerous changes to navigate; new country, new job, new culture, far fewer social supports, and more financial responsibility. I experienced increased stress, anxiety, and depression. Having some understanding of what I was going through, I decided I needed extra support and so turned to primary health care services, my doctor. However, I was only offered medication, which I felt was not what I most needed at that time. I found the support from primary health care services limited and not comprehensive enough to address my needs. If I was more ill or diagnosed with a mental health illness I could have had access to more intervention options; albeit at hospital or secondary health care level. This not being the case or a sensible option for me, I felt compelled to cope on my own, with limited social supports and in an unfamiliar, new environment.

It was at this point in my journey that I began to use, and found, an occupational perspective helpful in supporting me to manage and resolve some of my issues and needs. Issues like redefining role expectations and needs such as developing the skills necessary to do the things I needed, wanted, and was expected to do within my multiple roles as wife, mother, and worker. This helped to relieve my stress, anxiety, and depression. In my personal opinion it prevented me from developing a more serious mental health condition that could have led to more complex needs, requiring more specialist support and care. It was through this personal journey that I recognised the value of an occupational perspective in the prevention and promotion of mental health. I have since published an article about my experience advocating for the health promoting role of occupational therapy in the primary health care sector (Frenchman 2014). This is what largely inspired me to embark on this research journey and investigate the possibilities for health promoting occupational therapy with working mothers' at primary health care level in New Zealand.

The remainder of this chapter summarises the significance of the research topic, its context, the aims and questions, my underlying professional values and beliefs as a researcher, and provides a detailed map of the thesis. Further in-depth analysis of these section headings is in subsequent chapters.

Research Topic

Globally, depression is one of the leading causes of disability and morbidity (World Health Organization [WHO], 2017a), with women twice more likely than men to have depression in their lifetime (WHO, 2017a). In New Zealand, women are at 20% greater risk of diagnosis compared to men (Mental Health Foundation, 2014). The multiple roles and responsibilities women have in managing and balancing paid-work and domestic responsibilities, like taking care of young children, are contributing factors to increased stress, anxiety, and depression (Gjerdingen, McGovern, Bekker, Lundberg, & Willemsen, 2000; Jansen, Kant, van Amelsvoort, Kristensen, & Swaen, 2006). This literature also indicated that working mothers with young children (under 5 years) were more likely to have increased stress, anxiety, or depression. However, there seemed to be a scarcity of research on New Zealand working mothers' experiences.

Cost analysis literature over the past 18 years concurred that the risk and incidence of depression is on the rise and in some instances doubling in economic and social costs (Ekman, Granstrom, Omerov, Jacob, & Landen, 2013; Kleine-Budde et al., 2013; Parker, Roy, Mitchell, Wilhelm, & Eysers, 2000; Sobocki, Lekander, Borgstrom, Strom, & Runeson, 2007; Tomonaga et al., 2013). Economic costs included inpatient and outpatient health and psychiatric services, as well as medication (Ekman et al., 2013; Kleine-Budde et al., 2013, Parker et al., 2000). Social costs were measured in days off work (Sobocki et al., 2007; Tomonaga, et al., 2013), loss of income (Ekman et al., 2013) or early retirement (Sobocki et al., 2007). The more severe the depression, namely mild, moderate or severe, the higher the economic and social costs were to society and the person (Ekman et al., 2013;

Kleine-Budde et al., 2013; Tomonaga et al., 2013). Therefore, depression continues to be a major public health concern and more comprehensive strategies are needed to improve and evaluate the treatment of depression (Ekman et al., 2013).

The WHO (2013) has urged public health sectors to reduce the global burden of mental disorders by implementing comprehensive mental health promotion and prevention strategies. The WHO (2015) defined health promotion as "...the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions" (p. 1). Occupational therapy is largely absent from the New Zealand primary health care sector. Primary health care is a branch of public health, raising questions regarding the comprehensiveness of the services currently being offered (Frenchman, 2014). Occupational therapy could support a primary health approach by empowering people to increase control over and improve their health and well-being (health promotion) through everyday doing (occupation) (Wilcock & Hocking, 2015), also known as health promoting occupational therapy. However, occupational therapy as a contributor to the prevention/promotion of health is an emerging body of knowledge, seemingly skewed toward physical health objectives rather than mental health issues.

Therefore, this research focussed on New Zealand working mothers' experiences of stress, anxiety, and depression and their solutions to their issues from an occupational perspective. The purpose of the study is to consider a beneficial role for occupational therapy in primary health care in reducing the incidence and risk of depression for women; and subsequent economic and social costs.

Aim of the Study and Research Questions

The two main aims of this study were to explore/highlight an occupational perspective by exploring how an occupational perspective explains New Zealand's women's experience of stress, anxiety, or depression. Secondly, to gather participants collective thoughts on potential interventions or solutions to improve their health and well-being so as to inform the potential role of occupational therapy in primary health care in New Zealand. An occupational perspective is both the essence of and guide for occupation-based and occupation-focussed practice and is therefore vital when considering the role of occupational therapy. This centrality is analysed in the literature review. The two research questions are:

How does an occupational perspective explain working mothers' stress, anxiety, and depression? and What do these working mothers identify as solutions to their issues?

The next section describes and critiques the specific health context of the research topic. It provides an overview of service delivery and the service delivery objectives in primary health care which includes primary mental health care in New Zealand.

Primary Health Care in New Zealand

Primary health care is both a division and objective of public health. Twenty district health boards (DHBs) provide and fund local health services (Ministry of Health, 2017a) within the New Zealand public health system. DHBs, as entities with objectives, were formed as a result of the *New Zealand Public Health and Disability Act 2000*. Amongst other key objectives of DHBs, two specifically include promoting the health of people and promoting effective support to those with personal health needs (Ministry of Health, 2017b). Primary health care is integral to promoting health and reducing health inequalities, as supported by the Primary Health Care Strategy (Ministry of

Health, 2001) and most recently emphasised by the New Zealand Health Strategy (Ministry of Health, 2016b).

Presently, DHBs fund 32 primary health organisations (PHOs) to ensure the delivery of necessary primary health care services. General practitioners (GP) and nurses, working in a general practice, mainly deliver the services within PHOs. However, the government supports a multidisciplinary approach where the overarching objective is to improve, maintain and restore health (Ministry of Health, 2017c); and wherein primary mental health services are specifically aimed toward health promotion, prevention and early and ongoing intervention for mental health and/or addiction issues.

Hence, people with mild to moderate mental health issues living in the community could have access to GP or nurse input and other interventions such as cognitive behavioural therapy, counselling or other psychosocial or group interventions (including occupational therapy) at primary health care level (Ministry of Health, 2017c). Where possible these interventions would be delivered by the GP practice, like a doctor, nurse or psychologist. However, most interventions were offered at secondary care level by community mental health services, particularly cognitive behavioural therapy, psychosocial, and group interventions (Ministry of Health, 2017b). Additionally, certain at risk populations such as Māori, Pasifika, people with low income and youth, have increased funding and subsequently better and faster access to additional counselling or psychosocial interventions compared to other populations.

The New Zealand primary mental health sector adopts a 'stepped care model' of service delivery, which ultimately determines the service an individual actually receives (Ministry of Health, 2017d). The overarching aim of a stepped care approach is to prescribe the most effective and least resource intensive intervention first. For example, prescribing medication before any other interventions such as cognitive behavioural therapy, counselling or other psychosocial or group interventions. The latter interventions requiring more person and financial resource. The prescriber in

most cases is the GP (Ministry of Health, 2017b). Shurer, Alspach, Macrae, and Martin (2016) recently established that standard care for mood disorders (including depression) in general practice, at primary health care in New Zealand, was mainly medication. They found that only a few clients who were categorized as disadvantaged, for example people with low income, had access to subsidised counselling. In retrospect these services would not be considered comprehensive.

The current status quo of service delivery, regarding primary mental health care, seems to create a number of limitations and barriers that are counterintuitive to the overall objective of promotion and prevention in primary mental health care. This is particularly so for several populations not mentioned in the at risk group, such as stressed, anxious, or depressed working mothers.

Firstly, the stepped care model provides and promotes the rationale of worsening symptoms before gaining access to additional interventions such as counselling or occupational therapy. Subsequently, within this stepped care approach, individuals only get access to more comprehensive care at secondary care level after a more severe diagnosis is established. This contributes to higher costs associated with more complex and enduring interventions; a more severe impact on the person, his/her life and subsequent indirect social costs, such as absence from work or breakdown in family life. This is not congruent with a health prevention or promotion approach.

Secondly, while the WHO (2017b) urges governments to implement comprehensive mental health promotion and prevention strategies, the current primary health care system largely provides access to a nurse and GP which could not be considered comprehensive. The government supports the presence of multidisciplinary teams, including occupational therapists in primary health care, to deliver the diversity of services people require to meet their health needs (Ministry of Health, 2014a). However, the role of occupational therapy in the delivery of mental health promotion programmes services is yet to be practically determined or established.

In the current system it is usually one health professional, a GP that has the power to decide what people do and do not get access to. For example, if the GP assessed a working mother as having mild depression, the GP may prescribe medication, as the most effective and least resource intensive intervention first. However, not having a more severe condition, this working mother is not prescribed any additionally funded services such as counselling or occupational therapy. She may be able to acquire such services through private means or she needs to become more severely unwell to be prescribed and have access to more comprehensive services at secondary care level. Therefore, the current stepped care approach in primary mental health seems to be perpetuating and promoting the worsening of mental health illness or conditions. This is contradictory to the ethos of primary health care, health promotion and prevention, “...*the process of enabling people to increase control over, and to improve, their health*” (WHO, 2015, p. 1). Effectively contributing to limited interventions being prescribed for, offered to and accessed by working mothers at primary mental health care level in New Zealand.

Comprehensive mental health promotion services focussed toward the prevention or slowing down of mental health illness, such as depression or anxiety, is needed. This statement is supported by the Mental Health and Addiction Service Development Plan 2012–2017 (Rising to the Challenge) (Ministry of Health, 2012) which acknowledges that while in recent years there has been much improvement in quality and access to services for people with mental health issues, more can be done. Several aspects mentioned include, improvement in earlier responses and increasing access to services for people with mental health issues were highlighted (Ministry of Health, 2012).

This research posits that the presence of occupational therapy within primary health care could contribute to more comprehensive and effective mental health promotion service delivery in New Zealand. This role is supported by the Occupational Therapy Board of New Zealand's *Scope of Practice for Occupational Therapists*

(Occupational Therapy Board of New Zealand, 2004) and the *Occupational Therapy New Zealand Primary Health Care Position Statement* (NZAOT, 2009). These profession-specific documents advocate for the right of all people to have access to interprofessional care to adequately address their personal health needs. In addition, the health promoting role of occupational therapy is guided by Wilcock's (2006) four levels of health promotion. First, interventions for the general population to prevent health damaging behaviour and illness. Second, for people at risk of or experiencing health problems to change behaviour and delay/ inhibit further disease/disorder progression. Third, for people with chronic disease and disability to improve and/or maintain health and well-being. Fourth, for people who are terminally ill to maintain quality of life. These levels are analysed in more depth in the literature review. Wilcock's theoretical underpinnings supports this research to take an invaluable step towards establishing a role for occupation therapy with working mothers at primary health care level.

Underlying Professional Values and Beliefs of the Researcher

This section outlines, and makes transparent, my core professional values and beliefs that most influenced or impacted on this research. How I managed these values and beliefs is discussed here and in more detail in the methodology chapter.

I undertook a presuppositions interview before beginning data collection. The purpose of this interview was to declare and uncover any professional or personal predispositions that could skew or influence the research, so that steps could be taken to mediate any significant bias. Some key themes emerged from this that directly and inherently influenced the research topic and design. Firstly, I have a strong desire to change practice. I have a strong belief that the addition of occupational therapy to primary health care will improve health and well-being outcomes for an array of population groups, including working mothers' or primary health care. Consequently, I envision occupational therapists being key members of all primary health care services in New Zealand. This vision drives this research.

Secondly, I realised that being occupation-focussed in my thinking and doing, is something I cannot change or easily separate from the research or researcher role. I then sought to find a methodology that would enable me to own and declare my practice lens, the occupational perspective, with the overall intent to change or influence current practice. I investigated and discovered Interpretive Description (ID), a qualitative methodology where the ethos is to develop research, based on a discipline specific rationale in order to generate appropriate knowledge for practice (Thorne, Kirkham & MacDonald-Emes, 1997). ID enabled me, as a researcher, to logically integrate and focus on an occupational perspective in this research.

Lastly, I am driven by personal experience. I came into this research convinced that some of the issues I experienced, such as role conflict and difficulty with change or transitions would also emerge for participants. Based on my experience I predicted that there would be several occupational aspects such as personal, environmental, and daily activities that would positively and negatively influence working mothers' stress, anxiety, and depression. I was certain that if these predications were realised, then occupational therapy would be able to offer occupation-focussed health promotion intervention to this population. An approach that could more comprehensively support working women manage role conflict and life changes. I was challenged by the presuppositions interviewee about my predictions. What if my findings indicated otherwise, what would I do? I said I would respect the findings and go with that even it showed there was no role or need for occupational therapy.

Defining Key Terms

There are several key terms and concepts that need to be defined in the context of this research. This study asked, "*How does an occupational perspective explain working mothers' stress, anxiety, and depression?*" and *What do these working mothers identify as solutions to their issues?*" First there is an exploration of widely accepted understandings of stress, anxiety, and depression. Followed by a critique

of an occupational perspective, and how it relates to working women and an occupation-focussed approach to health promotion. For the purposes of this research, working mothers are identified as aged between 18-55 years, have at least one child under the age of five living at home with them and working either full-time, part-time or in casual employment.

Stress, anxiety, and depression

There is a myriad of literature explaining the terms stress, anxiety, and depression. Stress can be understood as *“any circumstances that threaten or are perceived to threaten one’s well-being and thereby tax one’s coping abilities”* (Weiten, Hammer, & Dunn, 2014, p. 47). Threats can be towards physical safety, long term security, self-esteem, reputation or peace of mind (Weiten et al., 2014). Anxiety and depression can be emotional responses to stress. When someone faces a circumstance perceived as threatening, it may trigger anxiety and/or depression (Weiten et al., 2014). Stress is further categorised as acute, events of short duration and with a foreseeable end, for example a sick child or conference event at work; or chronic, events of fairly long duration with no clear foreseeable end, for example an unsupportive boss at work or insurmountable debt (Weiten et al., 2014).

Acute stress can be experienced as distress or present in psychological and psychosomatic symptoms such as headaches or stomach-aches and can leave someone feeling overwhelmed and unable to cope with daily challenges (Wilcock & Hocking, 2015). This inability to cope can result in things going wrong, rushing around or being late (Wilcock & Hocking, 2015). Chronic stress can be experienced as anxiety even when there are no challenges to face. The person might feel trapped by the insurmountable pressures and demands placed on them over time and feel hopeless about their situation, giving up on finding any solutions to the issues (Wilcock & Hocking, 2015). Accumulative or chronic stress across the life span increases the risk of depressive symptoms and clinical depression in adulthood (Vinkers et al., 2014).

Anxiety encompasses both fear of an immediate situation and future threat, and is often stress-induced (American Psychiatric Association, 2013). Anxiety differs from an anxiety disorder as anxiety is often short in duration and related to a specific event or time. An anxiety disorder is when the anxiety extends beyond what is considered a normal reaction to an event, commonly lasting for six months or more (American Psychiatric Association, 2013).

Depression is considered to be an experience of low mood. Described as a feeling of sadness or dejection, it can be accompanied by other symptoms such as hyper/hypo insomnia, fatigue, feelings of worthlessness, weight loss/gain and general disinterest in most daily activities (American Psychiatric Association, 2013; Weiten et al., 2014). Major depression is characterised by the persistence of five or more of the above symptoms for a period of two or more weeks. Depression related to expected sadness such as grief is excluded from the major depression criteria (American Psychiatric Association, 2013).

Participants in this study did not have major depression or an anxiety disorder. Rather, participants recruited identified as feeling stressed, anxious, or depressed. This was to capture the experiences of potentially at risk women rather than those that were already diagnosed.

Often stress, anxiety, and depression are interrelated and interdependent. Studies have identified a robust and causal association between stressful life events, such as childhood trauma, major life events and daily hassles, and major depression (Heim & Nemeroff, 2001; Kendler & Karkowski, 1999; Kessler, 1997; Mundt, Reck, Backenstrass, Kronmuller, & Feidler, 2000; Nanni, Uher, & Danese, 2012; Tennant, 2002). However, Vinkers et al. (2014) argued that despite this causal relationship between stress and depression, not all people develop depression; it was the experience of accumulative stress across the life span that increased the risk of depressive symptoms and major depression in adulthood.

Coping mechanisms are understood as the active strategies people use to manage stressful events (Weiten et al., 2014). According to Weiten et al. (2014), there are three common types of constructive coping strategies. Appraisal-focussed applies rationale thinking, finding humour or using positive interpretation to deescalate the stressful situation. Problem-focussed involves active problem-solving, improving time management, and being more assertive in an attempt to fix or overcome the cause of stress. Emotion-focussed strategies seek to relieve stress or tension through relaxation, exercises or distraction. Resilience is the ability to recover from a stressful event (Oxford Dictionary, n.d.), also understood as the ability to adapt well in situations of stress (American Psychiatric Association, n.d.). Enduring and accumulative stress overuses and therefore taxes constructive coping mechanisms and depletes resilience, making someone more susceptible to developing major depression (Vercruyssen & Van de Putte, 2013; Weiten et al., 2014).

Reduced stress and anxiety have been associated with reduced risk of depression (Vinkers et al., 2014). Regier, Rae, Narrow, Kaelber, and Schatzberg (1998) found that 50% of people who experienced depression had also been diagnosed with anxiety. Depression and anxiety are likely to co-occur with increased and ongoing durations of perceived stress (Wiegner, Hange, Björkelund, & Ahlborg, 2015). Health practitioners routinely assess for stress and anxiety where depression is suspected and vice versa (Schurer et al., 2016). My research focuses on major depression as the main mental health condition of concern that requires more comprehensive prevention and promotion strategies. Stress and anxiety have been included as risk indicators due to the causal relationship between these experiences and developing major depression as outlined in the previous paragraph.

Occupational perspective

An occupational perspective first originated outside the occupational therapy profession, in political science literature, in the mid 1950s (Njelesani, Tang, Jonsson,

& Poltajko, 2014). Although not clearly defined at that time, it broadly incorporated the nature and concept of paid work with no relation to its impact on health (Lane, 1953; Njelesani et al., 2014). An occupational perspective with the notion that occupations are more than just paid work, only appeared in occupational science and occupational therapy literature in the late 1990s (Njelesani et al., 2014). This current study is informed by occupational science which is generally referred to as the study of occupation that produces knowledge to underpin occupation-based occupational therapy (Pierce, 2014). Occupational therapy is a health profession, with a client-centred focus, that aims to promote health and well-being by enabling people's participation in everyday activities (occupations), by improving their capacity to live meaningful lives or by adapting the environment (Townsend & Polatajko, 2013; Wilcock, 2006). Occupation is widely defined as everything people do to occupy themselves daily such as self-care (showering, getting dressed, cooking), leisure (going for walks, crafts, going to the movies) and productivity (paid work, volunteer activities, school) (Townsend & Polatajko, 2013). To stay focused on occupation, occupational therapy needs to maintain an occupational perspective in reasoning and practice.

Historically, the definition of an occupational perspective is obscure, even though it is a widely used term in occupational therapy (Njelesani et al., 2014). Occupational therapy literature has been criticised for failing to adequately describe what it does and how it does it, in consistent and comprehensible terms (Fisher, 2013). Firstly, E. Townsend (1997) defined perspective as a view or an eye, congruent with Njelesani et al. (2014), "*a way of looking and thinking...*" (p. 226); while Kirsh et al. (2009) articulates perspective as, "*A belief...*" (p. 393). More fully Kirsh et al. (2009) defines an occupational perspective as "*A belief in occupational engagement as a basic need and a determinant of health and quality of life*" (p. 393). Here, an occupational perspective broadly encompasses a stand, next a human rights stand, then a social determinant of health and quality of life stand. Hence when thinking about an occupational perspective, outside of paid work, it

encompasses all the activities people engage in every day and the social, economic and political influence on those occupations. In describing an occupational perspective Whiteford and Townsend (2011) identified that it,

includes examining what individuals do every day on their own and collectively; how people live and seek identity; how people organize their habits, routines, and choices to promote health; and how systems support (or do not support) the occupations people want or need to do to be healthy. (p. 67)

Here, everyday doing is further expanded by Whiteford and Townsend to include identity, habits, routines and choice, with systems encompassing the social, economic and political influences that support or hinder healthful occupations. This study aligns with Kirsh et al.'s (2009) belief that occupational engagement is a basic need and determinant of health; and Whiteford and Townsend's (2011) description that what people do and their environment play a role in supporting their health. These combined definitions fit well the concept of social determinants of health and quality of life within the health promotion sector. Social determinants are considered the varying circumstances in which people are born, grow, work, live, and age, as well as broader forces and policies that create those unique circumstances. These systems could be economic, developmental, social or political (WHO, 2017c). Therefore, from an occupational and health promotion perspective, context or environment play a key role in determining individual health, well-being, and quality of life.

Occupation-focussed health prevention or promotion

The prevention of ill-health and promotion of health and well-being (health promotion) through everyday doing (occupations) is known as health promoting occupational therapy (Wilcock, 2006). Other health promotion interventions such as building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services, may be broadly viewed rather than specifically orientated to improving people's engagement and participation in healthful occupations (WHO, 1986). Occupation-focussed means to bring to the fore, to concentrate one's attentions to occupation

(Fisher, 2013). Therefore, human doing remains the object of interest – what is the current state of doing, what is the quality of that doing, what are the challenges with the doing, what could improve or enhance people’s doing (Fisher, 2013).

Currently there are two frameworks that support and guide occupation-focused health promotion and prevention. The four levels of health promotion, developed by Wilcock (2006) to encourage better health, well-being and quality of life, and the three levels of ill-health prevention that represent the different stages in prevention developed by Wilcock and Hocking (2015). Table 1 (p. 23) gives an overview of these two frameworks.

These health promotion and prevention levels are in keeping with current health promotion levels of primary, secondary, tertiary and quaternary health promotion (Dixey, 2013). This study is focused toward level two of both the promotion and prevention levels; early recognition and intervention to prevent the incidence of mental health disorder amongst of working mothers’. The key premise in this research is that an occupational perspective has the potential to provide an in-depth examination of the everyday doing and context of stress, anxiety, and depression experienced by working mothers, to inform future occupational-focussed health promotion strategies.

Table 1: Two frameworks that guide occupation-focussed health promotion and prevention

Health promotion levels	Health prevention levels
1. Focussed to the general population to prevent health damaging behaviour and illness	1. Primary: Preventing the incidence of illness or injury
2. For people at risk of or experiencing health problems to change behaviour and delay/ inhibit further disease/disorder progression	2. Secondary: Early recognition or stopping of illness or injury
3. For people with chronic disease and disability to improve and/or maintain health and well-being	3. Tertiary: Decreasing chronicity or potential relapse
4. For people who are terminally ill to maintain quality of life	

Contributions of this Study

This study contributes an occupational perspective on working mothers' stress, anxiety, and depression; and their solutions to their issues. These findings are used to map out the potential beneficial role occupational therapy could have in the prevention/promotion of mental health of working mothers at a primary health care level in New Zealand.

Structure of the Thesis

Chapter Two provides a detailed description of search terms, search strategies, and final results of the literature search is given to clarify to the literature search process. Thereafter the chapter provides a critical review of the literature using a thematic format. It begins with an analysis of incidence and cost of depression globally and in New Zealand, followed by a critique of the general factors contributing to women's mental health. Providing more in depth analysis of the positive and negative influences on working mothers' stress from an occupational perspective. Next the focus is drawn toward the potential role of an occupational perspective in working mothers stress, analysing the concepts of occupational balance and lifestyle redesign.

Chapter Three begins by providing an overview, critique, and justification of the use of an ID methodology. Detailed descriptions of methods used include research aims, participant sampling and recruitment, data collection, data analysis, data management, ethical considerations, and the strategies taken to ensure rigour with all relevant appendices attached, are given. This is to make transparent the rationale, processes and procedures undertaken in the study from beginning to end.

Subsequent chapters Four, Five and Six, directly relate to the research questions. The findings are complex, interrelated, and wide-ranging, showing the dynamics between and within an occupational perspective that contribute to working mothers' experience of stress, anxiety, and depression.

Chapter Four, themed *The Struggles of Working Mothers* captures and analyses subthemes of *self-expectations*, *the struggle to get the right balance*, *the struggles with others' expectations* and *the struggle with ongoing and/or multiple stressful events* as key contributors to women's experiences of increased stress, anxiety, and depression. These findings were integral in answering research question one, *How does an occupational perspective explain working mothers stress, anxiety and depression?* A more detailed discussion of how the findings answered the question is explored in the conclusion chapter.

Chapter Five called *Solutions to Issues* explores the common strategies and external supports women employed that helped them to reduce or eliminate stress, anxiety, in depression in their daily life. Chapter five also critiques the limitations and barriers of these supports and strategies. The subthemes include *Prioritising/Re-prioritising*, *Getting help/support from others* and *Supportive activities*'. These findings were central to answering research question two, *What do these women identify as solution to their issues?* Again, a more detailed analysis is provided in the conclusion chapter.

Chapter Six, '*Wishes for the future*', are the wishes or future aspirations of participants. These include suggestions, creative ideas, and desires which could help them or other working mothers in similar situations. Some of these suggestions addressed the barriers and limitations critiqued in chapter four. The subthemes here are *Reorientation of Health Care Service*, *More community connectedness*, *More centralised and accessible information*, and *a More supportive work environment*. These findings were instrumental in forming recommendations for practice and future research discussed in the conclusion chapter.

Chapter Seven, the conclusion, situates the findings in relation to the research questions and existing literature, provides recommendations for practice and further research, and discusses the limitations of the study.

Chapter Two: Literature Review

Introduction

This chapter includes three sections: the search strategy, the thematic analysis of the literature, and the rationale for why this study is needed. The search strategy makes transparent the search processes, tools, terms and outcomes of the literature search undertaken. The thematic analysis centres on the main influences on working mothers' stress. A critique of the strengths and limitations of the literature from an occupational perspective shows the identified gaps in the literature and eventually forms the rationale for why this study is needed.

Search Strategy

Databases including CINAHL, MEDLINE, PsycINFO, AMED, OT SEEKER and SCOPUS were searched. These were the most comprehensive and accurate databases regarding medical, health, psychology, and occupational therapy literature. Search terms included work* mother* and stress or anxiety or depression. Other inclusion criteria were: published in the last 10 years (to capture the most recent literature), English language only, academic journals, books and reports, full text, references and abstracts were included. Due to the myriad of literature for the population terms work* mother* and stress or anxiety or depression resulting in over 100,000 hits, search terms were focussed to work* mother* and stress. Additional searches via reference lists were used. In some instances, seminal literature had to be referenced that extended beyond the 10 year parameter.

The results from the focused search terms yielded 121 studies. After reviewing the titles and abstracts of these articles, 43 were excluded as they were not relevant to the research topic. The remaining 78 articles were then fully retrieved and, after review, five were excluded. Reference list searches yielded a further 15

articles, making the total articles reviewed 88. Both quantitative and qualitative studies were included. Refer to Figure 1 for a diagram of this selection process.

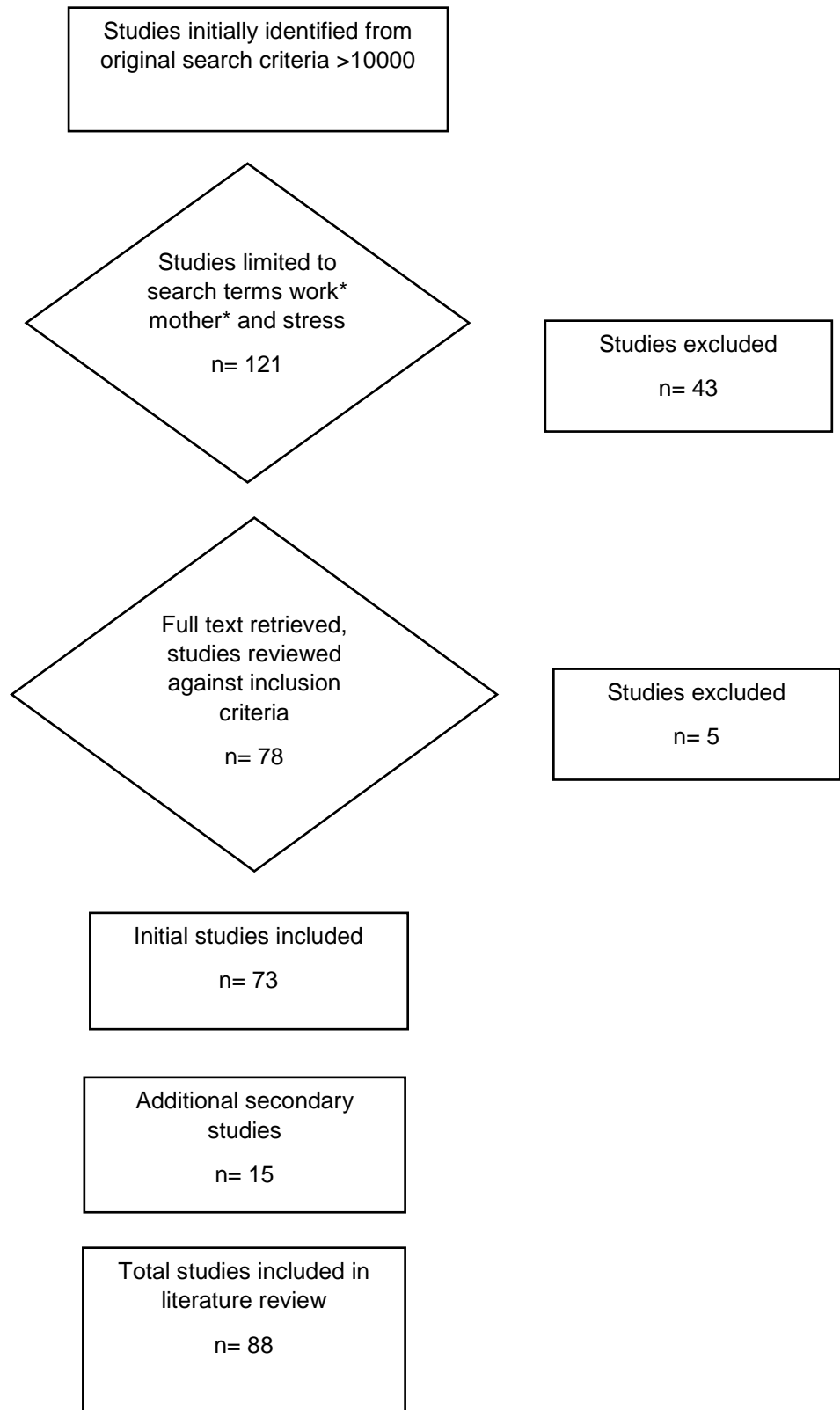


Figure 1: Selection process for included studies

The next section presents a thematic analysis of the literature review findings beginning with the incidence and cost of depression and situating the study in the global and national context. Thereafter, the factors contributing to woman's mental health in general are briefly discussed; before a more in depth analysis of the significant influences on working mothers' stress from an occupational perspective is given.

Depression Globally and in New Zealand

Globally, depression affects nearly a quarter of the world's population and is one of the leading causes of disability and morbidity with more than 300 million people affected (WHO, 2017a). Worldwide women are twice more likely than men to have depression in their lifetime (WHO, 2017d). Depression is very common and on the rise globally and in New Zealand (Mental Health Foundation, 2014; WHO, 2017b). There has been more than a 20% increase in the prescription of antidepressants for New Zealanders between 2008-2013 (Mental Health Foundation, 2014). In the most recent New Zealand statistics available (2013), the incidence of mental health disorders (including depression and anxiety) in adults had increased by 3.6% within a 5 year period between 2007 to 2012; women had a 20% greater risk of diagnosis compared to men who only had a 13% risk of diagnosis (Mental Health Foundation, 2014). In a comparison of 18 countries, New Zealand was found to be in the top four countries that had the highest incidence of major depression (Bromet et al., 2011). Table 2 (p. 21) below compares global incidences and global burden of depression compared to New Zealand for both men and women. These statistics indicate that women as a gender group are at higher risk of depression, than men.

Table 2: Comparison of Global and New Zealand women and men's depression incidence and mental health burden

Gender	Global		New Zealand	
	Women	Men	Women	Men
Depression incidence	5.1%	3.6 %	17.9%	10.4%
Global burden of mental health	41.9% cause of disability	29.3% cause of disability	22% health loss	16% health loss

Health and years of life cost

Depression contributes to a third of global disability (Bloom et al., 2011). The WHO (2008) Global Burden of Disease study (GBD), quantified the health effects of multiple diseases and injuries around the world. Depression is forecast to be the second lead cause of global burden of disease by 2020 (World Health Organization, n.d). GBD is generated through estimates of mortality and morbidity by age, sex, and region. Using the disability-adjusted life year (DALY), GBD quantified the burden of diseases based on years of life lost to early death and years in life lived in less than full health (WHO, 2008). One DALY broadly represents one lost year of “healthy” life, and the burden of disease represents the gap between current health status and the ideal, where everyone lives a full and long life, free from disease and disability (WHO, 2008). Unipolar depression, as opposed to Bipolar Depression, was in the top three causes of burden of disease across the Americas, Europe, and Western Pacific, equating to 65.5 million DALYs globally (WHO, 2008). This highlights the significant cost of unipolar depression to health and years of life lost. In New Zealand, neuropsychiatric disorders, which include depression, was the lead cause of health loss overall and specifically for women (Ministry of Health, 2016a). Alarming, the needs of people with mental health issues is overlooked by policy makers and funders worldwide (Bloom et al., 2011; Saxena, Thornicraft, Knapp, & Whiteford, 2007).

Economic and social costs

Mental health costs are the main source of global economic burden, remarkably more than cardiovascular disease, chronic respiratory disease, cancer, or diabetes. It is projected that mental illness alone will be responsible for more than 50% of the anticipated total economic burden from non-communicable diseases over the next 20 years (Insel, 2011). However, the predicted cost is said to be even higher due to the high risk of people with mental health illness for developing cardiovascular and respiratory disease and diabetes (Bloom et al., 2011).

Several international studies have captured the economic and social cost of depression using varying methods (Ekman et al., 2013; Kleine-Budde et al., 2013; Parker et al., 2000; Sobocki et al., 2007; Tomonaga et al., 2013). Most studies investigated both the direct costs, such as inpatient and outpatient care, specific interventions and medication, as well as indirect costs such as sick leave and personal costs, for example social and relationships. In some instances, the cost of depression to society more than doubled over a nine year period; with a significant increase in indirect costs such as sick leave rather than direct costs such as hospitalisation (Ekman et al., 2013; Sobocki et al., 2007).

Further, the more severe the depression, the higher the direct and indirect costs were (Ekman et al., 2013; Kleine-Budde et al., 2013; Tomonaga et al., 2013). The total cost of depression may be higher due to unreported cases of depression and age limitations of the population samples (Tomonaga et al., 2013). This body of knowledge indicated a steady increase in incidence, severity, and subsequent social and economic cost of depression.

In New Zealand, a study by Schurer et al. (2016) estimated the annual medical costs for mood disorders, including depression and anxiety, at primary healthcare level was roughly NZ\$10 million per year, excluding secondary care services which are usually more complex, long term, and costly. Further, mood disorders, such as depression and bipolar mood disorders, were the third highest cost of major illness, outnumbered only by diabetes and cardiovascular disease (Schurer et al, 2016). Most

of the documented costs incurred were related to medication for depression or anxiety. It seems that more investigation is needed into the social and health care costs of mood disorders, specifically at secondary health care level, where people's issues and the services are often more complex and enduring.

Regardless of DALY, economic and social costs, there is consensus that depression is on the rise and doubling in costs; continuing to be a major public health concern. Ekman et al. (2013) emphasised that more was needed to improve and evaluate the treatment of depression; and that while this may initially lead to increased costs, it will balance out with savings in social sectors later on. Furthermore, future focussed interventions should be evaluated in terms of available resources and the ability to decrease the social cost of depression (Ekman et al, 2013). In order to generate strategies that could decrease the incidence and improve the outcomes for people with depression, it seems vital to have an understanding of the key contributing factors. Therefore, this next section will explore the key contributing factors to woman's mental health, as identified in the literature.

Women's Mental Health

Gender is a key determinant of women's mental health (Bracke, 2000; Kueher, 1999; Lipman, Offord, & Boyle, 1997; Macran, Clarke, & Joshi, 1996; World Health Organization, n.d). Gender, in most cultures, determines differences in the power and control men and women have, in various social, economic, and cultural aspects of their lives. This then impacts on mental health, social status and position, and susceptibility and exposure to mental health risk in society (World Health Organization, n.d). Gender specific risk factors that overly impact on women's mental health are, gender based violence (Brown, Harris, & Hepworth, 1995; Byrne, Resnick, Kilpatrick, Best & Saunders, 1999; Stark & Flicraft, 1996), socio-economic disadvantage (Avotri & Walters, 1999; Kessler, McGonagle, & Zhao, 1994), low income and income inequality (Macran et al., 1996; Salsberry et al., 1999), low or

inferior social status or rank (Gilbert & Allan, 1998) and unrelenting responsibility for the care of others (World Health Organization, n.d).

Other contributing factors to women's mental health, that can cause physical and emotional stress, include major life transitions such as pregnancy and motherhood (Brown, 1998) and negative life experiences such as abuse (Bifulco, Brown, & Adler, 1991; Mullen, Martin, Anderson, Romans, & Herbison, 1993), violence (Felitti et al., 1998), unemployment or poverty (Belle, 1990; Beyond Blue, n.d.; Macran et al., 1996; Patel, Araya, de Lima, Ludermit, & Todd, 1999; Salsberry et al., 1999; World Health Organization, n.d). Psychological distress has been identified as a risk factor for depression (Kessler et al., 2003). Overall New Zealand women were 6.6% more likely to experience psychological distress compared to men, who only had a 4.5% likelihood; with women between the ages of 15-44 having a higher incidence of depression (Ministry of Health, 2012a). This is significant as these increased incidences of psychological distress occurred during child-bearing age.

Therefore, a combination of multiple role pressure, gender discrimination, and related socio-economic factors such as poverty, hunger, malnutrition, overwork, domestic violence and sexual abuse all contribute to women's poor mental health (World Health Organization, n.d). The frequency and duration of these social factors have been positively correlated with the frequency and severity of mental health problems in women (Abas & Broadhead, 1997; Broadhead & Abas, 1998; Brown, 1998; World Health Organization, n.d). Further, critical life events that lead to a sense of loss, feeling inferior, being humiliated and feeling trapped, can predict depression (Brown et al., 1995; World Health Organization, n.d).

Conversely, to prevent depression, there are three highly protective factors that enable individuals to respond well to significant life events (WHO, 2017c) which include sufficient autonomy in order to take control, access to material resources to enable choice and support from family, friends or health providers (Brown et al., 1995;

Kawachi, Kennedy, & Glass, 1999; World Health Organization, 2017c). Therefore, the WHO's focus for women's mental health includes building evidence of the incidence, risk and protective factors for women. Alongside promoting the creation and application of health policies that support women's needs and improve the ability of primary health care providers to adequately respond to gender risk factors and acute and chronic stress in women.

Working Mothers' Mental Health

The multiple roles and responsibilities women have in managing and balancing paid-work and domestic responsibilities, such as taking care of young children, are contributing factors to increased stress, anxiety, and depression, is well recognised (N. J. Allen, 2001; Eby, Casper, Lockwood, Bordeaux, & Brinley, 2005; Gjerdingen, McGovern, Bekker, Lundberg, & Willemssen, 2000; Gregory & Milner, 2009; Jansen, Kant, van Amelsvoort, Kristensen, & Swaen, 2006; Nomaguchi, Milkie, & Bianchi, 2005). In conjunction, the last 50 years had seen a significant increase of women entering the workforce; and while there has been an increase in men contributing to childcare and housework, women continue to do the bulk of the domestic labour (Maume, Sebastian, & Bardo, 2010). There has been a 50% increase in the female labour workforce in New Zealand since 1986. New Zealand's female work participation rate is above the Organisation for Economic Co-operation and Development (OECD) average (Statistics New Zealand, 2015). According to Maume et al. (2010), men and women in New Zealand participate in paid employment at a fairly equal rate; however women continue to spend twice as much time on childcare and domestic activities, compared to men (Statistics New Zealand, 2013). This gender disparity between employment rates and childcare/domestic responsibilities has remained fairly unchanged. The disproportionate relationship is known as the second shift or dual burden; women find themselves having to meet work obligations in addition to existing domestic

responsibilities (Gimenez-Nadal & Sevilla-Sanz, 2011; Hochschild & Machung, 1989).

Kodagoda (2010) emphasised that balancing work and motherhood is a fundamental challenge of the modern world. Specific role (work and family) combination stress has been identified as distinctly different from general stress and domain or role specific stress (Vercruyssen & Van de Putte, 2013). Role combination stress, also referred to as 'work-family role system stress' or 'work-family interface stress', is the stress of merging or "trying to balance multiple roles" (Vercruyssen & Van de Putte, 2013, p. 354). Several studies from America, Norway and Japan, have associated working mothers' increased stress with the ongoing challenges of trying to balance work and family domains (N. J. Allen, 2001; Eby et al., 2005; Innstrand, Langballe, Falkum, Espnes, & Aasland, 2009; Nomaguchi et al., 2005). Working mothers, especially those with young children (under 5 years), are more likely to have increased stress and experienced more stress compared to men (Eby et al., 2005). Stress from trying to balance work and family often negatively impacted on physical and mental health, quality of life, job satisfaction and job turnover, while enduring stress led to fatigue, anxiety, distress and anger (T. D. Allen, Herst, Bruck, & Sutton, 2000; Cooklin et al., 2015; Eby et al., 2005; Nomaguchi et al., 2005). No studies were found that situated this literature within a New Zealand population.

Multiple role engagement for women was not always associated with significantly higher stress; instead a positive correlation was found with life satisfaction (Sumra & Schillaci, 2015). Multiple roles develop social support and skills needed for everyday life; complex, satisfying jobs improved affect, self-efficacy, inter-personal skills (Greenhaus & Powell, 2006; Marshall & Barnett, 1993; Sieber, 1974). Here, the notion of work-family enrichment or positive work or family spill over was highlighted; where positive experiences in work and home domains interrelate to yield gains in satisfaction, health and performance (Brough, Hassan, & O'Driscoll, 2004).

The next section will analyse the key factors contributing to working mothers' stress when trying to balance work and family life. These factors will be critiqued using an occupational perspective. To recap, the occupational perspective in this research believes that occupational engagement is a basic need and a contributing factor to health, well-being, and quality of life (Kirsh et al., 2009). Therefore, it encompasses what individuals do every day or with others, how they live and seek identity, organise their lives, make choices to cope with their stress and how the environment supports or does not support their mental health (Whiteford & Townsend, 2011).

Work

For working mothers, work as an occupation is an integral part of what they do every day. Work has many protective factors – it is a source of income, can be part of self-identity and contribute to meeting basic needs, choice, control and satisfaction in women's lives; but it can also be a source of stress and create challenges when trying to balance work and family (Kodagoda, 2010). The literature identified several work related variables that contributed to working mothers' stress including the quality of the job.

High quality jobs were characterised by high skill, high income, paid family related leave, reasonable workload and working hours, flexible work hour options, work-family sensitive supervisor support, several sincere incentives for part-time roles, job security and a sense of control/autonomy (Cooklin et al., 2015; Gronlund, 2007; Strazdins, Shipley, Clements, O'Brien, & Broom, 2010). The inverse applied to low quality jobs, characterised by low skill, low income, long, inflexible work hours and little or no autonomy. In contrast, Drobic and Guillen Rodriguez (2011) found that higher job control/autonomy lead to increased work and family challenges and therefore increased stress.

Cooklin et al. (2015) posited that women in low quality jobs were likely to experience increased stress due to conflict caused by unreasonable workloads and

inflexible work hours compared to women in high quality jobs. This was disputed when their findings showed an association between high work-family enrichment and lower socio-economic position. However, previous studies have shown an association between high quality jobs and less challenges in balancing work and family (T. D. Allen et al., 2000; Eby et al., 2005; Greenhaus & Powell, 2006). The consensus is that job quality influences stress (Buehler, O'Brien, Buehler, & O'Brien, 2011; Drobnič & Guillén Rodríguez, 2011).

Further, the characteristics of high quality jobs are influenced by work-place culture and supported by the existence of family-friendly policies. Work-family culture is defined as the common values and assumptions about the amount of support an organisation should provide and has been shown to reduce stress and improve employee commitment compared to more general supports (Kossek, Pichler, Bodner, & Hammer, 2011; Thompson, Beauvais, & Lyness, 1999). While there is an increased trend of establishing policies such as flexible work options, as well as creating a more work-family support culture by organisations and employers (Brummelhuis & Lippe, 2010), the mere existence of family-friendly policies did not create optimal resources for employees to balance work and family. Organisations had to action these policies and provide the most suitable supports (N. J. Allen, 2001).

For example, Chang, Chin and Yang (2014) in their study with working mothers in Korea, showed that organisations that support working mothers' career expectations led to higher work commitment and better affect in working mothers, more so than flexible work hours. Additionally, flexible work hours created other negative spill over effects such as increasing the amount of work brought home (Grice, McGovern, Alexander, Ukestad, & Hellerstedt, 2011). Finally, work-family culture can be undermined by unmarried or childless colleagues or peers who view family-friendly policies as inequitable (Ryan & Kossek, 2008).

From an occupational perspective, job quality, job satisfaction, self-identity, life satisfaction, work culture and policy all contribute to the challenges working mothers' face in balancing work and family life. However, there was no mention of how working mothers' work habits, routines, or choices impacted on their stress. The literature reviewed also failed to explain how much control working mothers had over these influencing work factors. For instance, working mothers with a higher level of education could have access to high quality jobs, but they are unlikely to have any control over whether the employer adopts policies to support a work-family culture or whether she will have supportive colleagues in the work place. Further, not all working mothers have the same resources, skills, or time to seek or gain high quality jobs. Therefore, assuming all working mothers have the same choice, opportunities or options for jobs is unrealistic. Furthermore, the literature on work did not address the issue of gender inequality in pay. In reality, women are often in lower paid or part-time jobs and get paid less than men doing the same job, creating power and choice differentials between men and women in society (Ministry of Women, 2017). This issue of gender inequality will be explored in environment.

Environment

This section looks at how society, culture, and systems contribute to working mothers' stress, mainly in terms of family and gender influences, as these were specifically identified in the literature.

Family

Family or family life is a key factor impacting working mothers stress (Voydanoff, 2005). Like work, family is a protective factor against depression (WHO, 2017c) but it is the other domain of concern that creates challenges for working mothers. If women have more child care and household responsibility compared to men, this increases the demand on their time and can create tension between work and family (Hill, Yang, Hawkins & Ferris, 2004). Contributing factors to stress include; spousal disputes

(Voydanoff, 2005), number and age of children, childcare obligations (Hill et al., 2004), care for elders (Sumra & Schillaci, 2015), marital status and quality of family members' relationships such as marital dissatisfaction (Sumra & Schillaci, 2015; Voydanoff, 2005). Those women with a greater number of and younger children living at home, experienced more conflict and stress (Aryee, 1992; Kinnunen & Mauno, 1998). Having a spouse or partner lessened conflict and stress, but was more important to women than men (Hill et al., 2004). Family demands were associated with increased conflict, while family resources reduced conflict; and a negative relationship with one's spouse significantly increased stress for working mothers (Voydanoff, 2005). More recently, Sumra and Schillaci (2015) measured social networks, like the nature of relationships and depth of support that may help women to mitigate stress and enhance life satisfaction. Social networks, together with high quality relationships with a partner and children, and increased satisfaction and self-efficacy in work, all contributed to work family enrichment (Cooklin et al., 2015).

From an occupational perspective, while the literature above identified key family factors that increase and decrease working mother stress, it is not clear how women manage, use, develop, modify these family-related variables to influence their stress or situations. The data in these studies is mainly quantitative, with use of questionnaires, surveys and Likert scales, which limits understanding of women's perspectives that could be gained from asking them about their experiences.

Gender influences

The gender role messages society perpetuates leads to gender stereotyping, which are implied expectations placed on male and females that represent and enforce gender norms, roles and relationships (WHO, 2017d). Culture has a significant influence on gender norms by determining the role and status of women in society (WHO, n.d). It is important to highlight and acknowledge the significance of gender stereotyping on work and family roles, as those stereotypes have implications for women's choices, their behaviour and consequently their experiences of everyday life (Sullivan, 2015).

Sullivan (2015) investigated how messages in a United Kingdom women's magazines shaped power relations and influenced how working mothers feel and act in their roles. The two main findings were that multiple roles were constructed as a challenging choice for working mothers, inevitably leading to stress and guilt. For instance, women's low earning potential due to pay inequities and the high cost of childcare created stress, by making return to work economically and practically challenging. Not returning to work could jeopardise women's independence, financial and social advancements and consequently impact on social relationships between men and women (Sullivan, 2015). Guilt was perpetuated when paid work was represented as in conflict with motherhood ideologies; mothers were pressured to answer how they would personally manage working and being a 'good' mother (Sullivan, 2015).

Secondly, issues associated with multiple roles were constructed as individual problems, in a way that excluded contextual or political elements (Sullivan, 2015). The portrayal of working motherhood as a personal choice placed sole accountability on women for the challenges they faced in trying to balance work and family. Women are then compelled to try, and cope and problem solve on their own, without any expected change from society, family or employer. Successful working motherhood is portrayed as achievable but only through great adversity. These findings echo several earlier studies on the influences of discourses on women's health and gender inequality (Hinnant, 2009; Repo, 2004; Roy, 2008; Sullivan & Smithson, 2007; Worthington, 2005).

When gender norms are unequal or unbalanced, they can create gender inequality where one sex is entitled to more rights and opportunities than the other (WHO, 2017d). For instance, the unequal division of labour between paid work and family work, between men and women, has contributed to gender inequality (Gregory & Milner, 2009). Even though the last 50 years has seen a significant increase of women into the workforce, not much has changed in terms of women's child-care and

domestic responsibilities (Maume et al., 2010). This unequal division of labour has been identified as one of the gender risk factors for women's mental health (WHO, n.d).

Gender stereotypes also had implications for women's leisure, sleep and pay. Based on the second shift or dual burden argument, working mothers reported having less leisure opportunities and were more dissatisfied with their leisure compared to working fathers' (Gimenez-Nadal & Sevilla-Sanz, 2011). Maume et al. (2010) found that when a couple abided by traditional expectations that fathers were the main providers and mothers were the carers, regardless of the mother's role as a worker, this advantaged men's sleep needs over women's; to the extent that women were sleeping less and being disrupted more. Sleep deprivation has a huge influence on working mother's health and well-being.

Further, lack of social appreciation for household and family work proved a source of psychosocial stress for working mothers (Sperlich, Arnhold-Kerri, Siegrist, & Geyer, 2013). Lack of social appreciation has been identified as an international and national economic phenomenon contributing to gender inequality; where what women contribute to society in the form of domestic or child-care work is not politically or economically valued on a global scale (Waring, 2004). This type of gender inequality is an often hidden and uncontrollable factor influencing working mother's experience of stress.

Gender inequality regarding pay gaps shaped socio-economic issues and power disparities between men and women (World Health Organization, n.d). The gender pay gap in New Zealand was recently identified as 9.4% (Ministry of Women, 2017). While this has reduced from 16.3% in 1996, there has been no significant change in this gap for the past 10 years (Ministry of Women, 2017). It was first thought that factors such as differing education levels, certain work occupations and the sectors in which men and women worked, as well as more women working part-time, mainly contributed to the gender pay gap (Ministry of Women, 2017). However, more

recently it has been established that conscious and unconscious bias may be the most significant factor, disadvantaging women in terms of recruitment and pay increases, and ultimately influencing men and women's choices and behaviours (Ministry of Women, 2017).

Female-dominated occupations, such as nursing, were lower paid compared to male dominated occupations such as construction; men in female-dominated occupations were paid more than women in those same positions, and women tended to take lower positions or part-time positions after the birth of a child (Ministry for Women, 2015). A larger proportion of men held senior and higher paid positions than that of women (Ministry of Women, 2017). In addition, women tended to spend more time in unpaid work such as domestic and child-care responsibilities (Ministry of Women, 2017). Women also experience more career breaks that often disadvantage them from advancement and higher quality jobs (Ministry of Women, 2017). The pay gap also increases with higher paying jobs (Pacheco, Li, & Cochrane, 2017). Table 3 below (p. 33) shows some examples of gender pay gaps in New Zealand. It reveals that the average hourly paid rate for women is 11% less than what men receive (Statistics New Zealand, 2016). In the public service, 29% of women occupy low paid jobs and on average get paid 14% less than men in similar positions (State Services Commission, 2015). Further, the pay gap between male and female parents is 12% wider than the pay gap between male and female non-parents (Statistics New Zealand, 2017).

Table 3: Gender pay gaps in New Zealand

	Pay Gap	Women	Men
Average hourly paid rate	11%	\$22.40	\$25.24
Public Services included clerical, social, health and education – considered low paid occupations	14 %	29% in these positions	8% in these positions
Motherhood penalty – pay gap between male and female parents	17%		
Motherhood penalty – pay gap between male and female non - parents	5%		

Having access to less money equates to less choice, less economic and political influence or power. This is supported by Waring (2004), who exposed how unpaid domestic work carried out by women in their own homes was often, and continues to be, excluded from economic measures regarding productive activities. This economic phenomena perpetuates gender inequality at policy level and therefore directly impacts on the type and availability of resources for women globally and nationally (Waring, 2004). It is imperative to have an understanding of the often uncontrollable gender influences on women's experience and their stress, as a working mother in today's society. Improvements in women's mental health are unlikely to occur if gender risk factors are not adequately addressed.

From an occupational perspective, internalised roles are adopted through socialisation, roles hold expectations about how working mothers should act, who they should be and the beliefs and values they should hold (Kielhofner, 2008). These internalised roles then drive what needs to be done and the way it is done. This has implications for what women do every day, how they think and feel about themselves, how they live, organise their time and whether they are supported. It appears that gender stereotypes and the gender pay gap create major challenges for, and increases working mothers' stress by perpetuating gender inequality.

In summary, while work and societal factors have been highlighted as contributing factors (Gregory & Milner, 2009; Ministry of Women, 2015, 2017, Pacheco, Li, & Cochrane, 2017, Sullivan, 2015), much less is known about how working women organise their habits, routines and choices or how other systems within health, social, community or political sectors do or do not support their mental health. No studies were found based on working mothers in New Zealand. Most of the methods in the studies reviewed from overseas were quantitative; and to date there is no known qualitative study on the experiences of working mothers living in New Zealand for comparison and contrast.

No literature was found that explored an occupational perspective focussing on working mothers, nor any related to occupation-focussed studies or services in New Zealand. Some have explored the notions of life balance or occupational balance in relation to more general health, well-being, and quality of life of women, adults, and older adults, mainly from Europe and America but not working mothers specifically (Edgelow & Krupa, 2011; Eklund and Erlandsson, 2011; Hakansson, Lissner, Bjorkelund and Sonn, 2009; Hellman, Westerberg, & Jonsson, 2011). The ideas of occupational balance and lifestyle balance will now be analysed in more detail to explore the potential relationship between working mothers' stress and occupational balance.

Occupational Balance and Life-Balance Perspective

Work-life balance is seen as “the extent to which individuals are equally involved in- and equally satisfied with — their work role and family role” (Greenhaus and Singh, 2003, p. 2). Work-life enrichment or positive work-family and family-work spill over has been identified as a mitigating influence on stress (Greenhaus & Powell, 2006) and therefore has a role to play in work-family balance. Greenhaus and Powell (2006) defined work-life enrichment as “the extent to which experiences in one role improve the quality of life in the other role” (p. 73). An occupational perspective on balance

evaluates the impact of what people do and how they balance what they do as causal to health, well-being, and satisfaction (Westthorp, 2003).

The literature on occupational balance has a variety of synonyms such as life balance, lifestyle balance and work/life balance (Wagman, Hakansson, & Bjorkelund, 2012). According to the theoretical Life Balance Model (LBM), life balance is defined as “a satisfying pattern of daily activity that is healthful, meaningful, and sustainable to an individual within the context of his or her current life circumstances” (Matuska & Christiansen, 2008, p.11). This model posits that everyday activity patterns should allow people to achieve the following five key outcomes: 1) meet their basic needs, necessary for biological health and physical safety; 2) establish rewarding and self-affirming relationships with others; 3) feel engaged, challenged, and competent; 4) “create meaning and a positive personal identity” and 5) organise their time and energy in ways that enable them to meet important personal goals and renewal (Matuska & Christiansen, 2008). The model proposed that the degree to which people are able to participate in patterns of occupations that meet all five need-based aspects, will determine whether they perceive their lives as more satisfying, less stressful, and more meaningful or balanced (Matuska & Christiansen, 2008). Therefore, the occupational issues that individuals could have as a result of stress has been identified as occupational alienation or occupational deprivation or occupational imbalance. Occupational alienation includes finding little meaning or purpose in life, which links to quality of life; while occupational deprivation includes not being able to meet the basics of living and life satisfaction; and occupational imbalance is doing too little or too much, always being rushed or tired, bored or dissatisfied with life (Wilcock & Hocking, 2015).

The assumptions of the LBM are supported by Wagman, Hakansson, and Bjorklund (2012), who defined occupational balance as an “individual’s perception of having the right amount of occupations and the right variation between occupations” (p. 377) and declared occupational balance as a “subjective, multidimensional and health-related concept.” (p. 383). Further, Wagman, Hakansson, Jacobsson, Falkmer

and Bjorklund (2012) showed there were four key aspects supporting life balance, namely occupational balance, self-actualization, self-awareness, and reciprocal relationships. Each aspect is commonly underpinned by close positive relationships and the reassurance that the people with whom they had this relationship were doing well. Here Wagman et al. (2012) positioned occupational balance as an aspect of life balance rather than a synonym for it, and highlighted the importance of quality and well-being of people in those relationship as core aspect of occupational balance.

These notions of LBM and occupational balance are also supported Hakansson et al.,(2009) who found that manageability, personal meaningful occupations and occupational balance were considered occupational pattern-related health indicators for women of working age. Hakansson et al. identified that occupational therapists who focussed on these indicators could support women to develop strategies to promote health, prevent stress and subsequent sick leave. Moreover, the findings from the use of the Occupational Balance Questionnaire (OBQ) was positively correlated to self-rated health and life satisfaction; this supported the relationship between occupational balance and health (Wagman & Hakansson, 2014). Wagman, Hakansson and Jonsson (2015) identified that since 2009, intervention studies on improving occupational balance with adults was limited to therapeutic gardening for women with stress-related disorders (Hellman et al., 2011) and a time intervention for people with mental illness (Edgelow & Krupa, 2011).

As discussed earlier in this chapter, one of the main issues contributing to working mother stress, anxiety and depression is role combination stress, the stress of trying to balance multiple roles (N. J. Allen, 2001; Eby et al., 2005; Innstrand et al., 2009; Nomaguchi et al., 2005; Vercruyssen & Van de Putte, 2013). The constructs and mechanisms of occupational balance can potentially support working mothers to manage role combination stress through an occupation-focussed approach. The next section occupational therapy interventions under the broad domain of lifestyle redesign or balance is explored as a potential intervention for working mothers.

Occupational therapy lifestyle redesign

Occupational therapy lifestyle redesign programmes aim to support people to develop strategies and opportunities to increase participation in identified meaningful activities for life satisfaction; to have a positive impact on physical and mental health (Horowitz & Chang, 2004). A healthy lifestyle programme improved adults' quality of life by developing their social skills, providing information about nutrition and developing their interpersonal skills (Barnes et al., 2008). Another lifestyle programme, the Redesigning Daily Occupations (Re-DO), a 16 week occupation-based work rehabilitation intervention designed for Swedish women with stress-related disorders (Eklund & Eriksson, 2013), had the most potential for working mothers.

In this study by Eklund and Erlandsson (2011), participants with stress-related disorders, specified as depressive episodes or reaction to severe stress and adjustment disorder, were recruited to the study. This quasi-experimental trial showed no significant reduction in perceived stress between the Re-Do and Care as Usual (CAU) group attributed to an unsuitable outcome measure. However, the trial did indicate an improvement in self-esteem, and quality of life between groups in the long term. This is valuable as improved self-esteem and quality of life have been associated with reduced stress and anxiety (Sareen et al., 2006), which in turn, have been associated with reduced risk of depression (Vinkers et al., 2014).

By this association Re-DO has intervention potential to mitigate stress and support balance for working mothers. However, there are large geographical gaps identified with the lifestyle redesign studies; they are mainly from Europe and America, therefore different population, context, needs, and experiences. There have not been any studies in the New Zealand context to explore if New Zealand working mothers would benefit from an occupation-focussed lifestyle intervention. Exploring New Zealand working mother experiences of stress is needed, as a starting point in establishing and analysing their specific issues and needs, before suggesting any new interventions.

Why this Study is Needed

Depression is on the rise and doubling in economic, social and personal costs; continuing to be a major public health and subsequent primary health care concern (Ekman et al., 2013; Kleine-Budde et al., 2013; Schurer et al., 2016; Tomonaga et al., 2013). Alarming, the needs of people with mental illness is largely neglected by policy makers and funders worldwide (Bloom et al., 2011; Saxena et al., 2007). More is needed to improve and evaluate the treatment of depression as it contributes to a third of global disability (Ekman et al., 2013). Worldwide women are twice more likely than men to have depression in their lifetime (Bloom et al., 2011; WHO, 2017d).

Working mothers are a core group represented in women's mental health statistics on depression both globally and nationally. Yet, their experiences are understudied from multiple perspectives – qualitative, occupational, and contextual. Therefore, it would be naïve and unwise to offer any potential occupation-focussed interventions without first exploring their unique needs, contexts and ideas in relation to their experiences of stress, anxiety, and depression. This qualitative interpretive description study contributes to New Zealand working mothers' experiences of stress, anxiety and depression, from an occupational perspective, with the view of exploring occupation-focussed interventions in the future. The research questions are; *How does an occupational perspective explain working mothers' stress, anxiety, and depression?* and *What do these working mothers identify as solutions to their issues?*

Chapter Three: Methodology

Introduction

This study aimed to explore the subjective experiences of working mothers' stress, anxiety and depression, and their solutions to their issues from an occupational perspective. A qualitative research design was used to answer two research questions; *How does an occupational perspective explain working mothers' stress, anxiety and depression?* and *What do these working mothers identify as solution to their issues?* The methodology, Interpretive Description (ID), was specifically chosen in order to uncover women's common, as well as individual experiences of stress, anxiety, or depression to inform occupational therapy and mental health promotion practice in the future. Chapter three gives an overview of ID, its origins and core philosophy. This is followed by the methods used for participant recruitment, data collection and management, data analysis, key ethical considerations and the strategies implemented to ensure rigour.

Origins and Development of Interpretive Description

In the early 1990s, ID was spearheaded by the nursing profession which, motivated by their dissatisfaction of social science methodologies, such as grounded theory, phenomenology and ethnography, sought to go beyond theory generation and provide adequate translation of research into practice (Hunt, 2009; Thorne, 1991, 2008).

Thorne, Kirkham, and MacDonald-Emes (1997) challenged nursing researchers to build their research on nursing paradigms, theories, evidence and reasoning in order to produce knowledge relevant to their practice. ID, however, did not completely abandon traditional qualitative methodologies but added more flexibility to methods and research processes, while still maintaining rigour (Thorne, 2008). ID commonly borrows methods from ethnography, grounded theory and phenomenology and is

therefore suitable to be used in applied health disciplines such as nursing, psychology and occupational therapy (Thorne, 2008).

Being a relatively new methodology, Hunt (2009) pointed out some challenges for implementing ID, including a lack of resources and references on ID practice. At the time of Hunt's critique, only two texts on the methodology of ID existed, namely Thorne et al. (1997) and Thorne, Kirkham, and O'Flynn-Magee (2004). There was also a scarcity of research using ID methodology. Other challenges related to a lack of guidance on the depth and type of interpretation that is required of ID studies (Hunt, 2009). These challenges were subsequently addressed with the work of Thorne in 2008 (Hunt, 2011), which provided greater clarity and direction regarding methods, rationale and philosophical underpinnings. Researchers now have access to a more thorough discussion of how (and why) to design, conduct, and communicate research using ID (Hunt, 2011). In conjunction with the work of Thorne (2008, 2016) and the publication of more articles using ID, there is a growing body of literature to support the use of ID. This research is predominantly guided by Thorne (2008, 2016) with references to seminal published works on the methodology.

Philosophical Underpinnings of Interpretive Description

Philosophical underpinnings refer to the ontological, epistemological, and methodological characteristics of a research method. Crotty (1998) described ontology as "*the study of being*" (p. 10), focussed to the inherent characteristics of existence and the structure of reality; a way of understanding what is and what constitutes knowledge. Epistemology is understanding the nature of knowledge, its foundations, scope and boundaries (Hamlyn, 1995). Epistemology deals with the question "*how do we acquire knowledge*" (Crotty, 1998, p. 8), underpinned by beliefs on the nature of knowledge and how knowledge is acquired. The methodology relates to the research process, procedures or strategies to achieve new knowledge (Crotty, 1998).

The ontological and epistemological stance of ID was first articulated in Thorne et al. (2004). ID is particularly aligned with the constructivist naturalistic paradigm (Hunt, 2009; Thorne et al., 2004). Thorne et al. linked ID to three propositions within Lincoln and Guba's (1985) naturalistic inquiry paradigm.

The first proposition of ID which is related to ontology, is that an individual's perception of reality is multiple, subjective, complex, constructed, and should be examined holistically. This is similar to an occupational therapy ontology, where humans are believed to be continuously changing and responding to and being influenced by their environment; engaging in variety of occupations to meet their needs and in the process simultaneously being impacted by and on their actions, environments and health status (Hooper & Wood, 2014). This study is underpinned by the belief that working women's experiences of stress, anxiety, or depression is subjective, complex and can only be understood within the relevant historical context of the woman herself. Thus, the contextual nature of human experience is multifaceted and interdependent on a range of factors, including environmental, psychological, and biological. In analysing this complex studied phenomena, I would therefore be able to capture co-constructed, context-influenced individual experiences as a whole and investigate any commonalities, themes and patterns that emerge (Frey, Botan, & Kreps, 1999). The goal of this study is therefore to generate context-specific knowledge about the multiple, constructed experiences of working mothers.

The second proposition of ID which is related to epistemology, is that knowledge generation is co-constructed and cannot be free from individual interaction with others (Hunt, 2009). Thus, the interaction between a researcher and participants contribute to the knowledge generation of the phenomena being studied. I, therefore cannot free myself from my views, values, personal beliefs and historical events; these elements would influence the co-creation of the new knowledge (Frey et al., 1999). In addition, an occupational therapy epistemology insists that gaining knowledge of occupation is key to understanding and integrating information into practice (Hooper &

Wood, 2014). Hence the focus on an occupational perspective as explained in the introduction chapter.

The third proposition that is related to methodology is that research questions shall allow me to explore the subjective, complex construction of the reality. For individual subjective knowledge using questions like who, what, where, how and why, is preferred. (Erlandson, Edward, Skipper, & Allen, 1993). In this research there is both a 'how' and a 'what' question. While, what questions lends itself to being either exploratory or predictive, how questions are open to more exploration (Erlandson et al., 1993). Occupational therapy ontology and epistemology, questions and methods that engage directly with the subject of interest about their occupations in their natural environment is preferred, hence the use of individual interviews and focus groups with working mothers (Hooper & Wood, 2014) and this is congruent with ID data collection methods (Thorne, 2016 7). Common themes and patterns that emerge must and is grounded in the data. Further, no a priori hypothesis is established, as it is not possible to separate causes from effect, as is the case within quantitative designs.

Interpretive Description as the Best Fit for this Research

Congruent with the generic intent of ID, namely to uncover themes and patterns from individual subjective experience that can be utilised to inform practice (Thorne, 1991), this study aims to explore how an occupational perspective explains working mothers' stress, anxiety and depression; and what women identify as solutions to their issues. The intent is to develop occupation-focussed primary health interventions in the future. ID research is open and exploratory (Thorne, 2016) and seeks to go beyond simple description to in-depth interpretation to find the practical applicability to practice, but not to the extent of deep philosophical understandings such as phenomenology. The interpretation in ID seeks to uncover the relationship between phenomena or to see beyond what is merely observed, to ask the questions, what is going on here and what am I learning about this (Hunt, 2009)?

Methods

This section includes a description of the research aims, participant's recruitment process, data collection and data analysis.

Research Aims

Research questions for ID typically begin with what, how or when, and include an auxiliary verb such as would, can or do (Thorne, 2016). The auxiliary verb emphasises the focus of interest to be interpreted. For example, in the question 'How does an occupational perspective explain working mothers stress, anxiety, and depression?' the emphasis is on interpreting *how an occupational perspective explains* – it is the occupational perspective that needs to be explored and interpreted from the data. Similarly, in the second question, 'What do these working mothers identify as solutions to their issues?' the emphasis is on what these working mothers' identify. The 'how do' and 'what do' are the foci for interpretation in this study.

The two aims of this study are to firstly, gain an understanding of how an occupational perspective can explain working mothers' stress, anxiety or depression; and secondly, to gather women's collective thoughts on potential interventions or solutions to improve their health and well-being. Hence the research questions are 1) *How does an occupational perspective explain stress, anxiety, or depression in working mothers?* 2) *What do these working mothers identify as possible solutions to their issues?*

Procedures

Participant Selection and Recruitment

Sampling

Purposive convenience sampling was used to recruit the potential study participants. This is a common method of recruitment used in ID (Thorne, 2016). The literature identified women with very young children as being most vulnerable to depression, therefore working women who had one child under five, living at home with them and

residing in the North Shore area of Auckland, were purposely approached and invited to participate in this study. Reasons for choosing this group of women, were: first, having study participants from the same geographical area to make it easier for them to attend focus groups; 2) Auckland has a vast geographical area, therefore inviting participants from different geographical locations for such a small scale study would have created a logistical challenge for coordinating focus group meetings; 3) At the time of this study, due to budget limitations, it was feasible to utilise free AUT meeting rooms in North campus to hold focus groups; 4) I live and work in the North Shore area and logistically it would be easier for me to access participants of the same area.

Purposive sampling can ensure diversity within the sampling pool to more effectively justify commonalities and differences within the data (Thorne, 2016). Diversity was ensured by restricting and keeping the inclusion and exclusion criteria broad and diverse. Providing multiple employment status, a choice between experiencing stress, anxiety, or depression, an expanded age range, deliberately omitting the word mother, to include all primary carers and no specification regarding marital status. At the time of recruiting participant seven, it was discovered that thus far only married women had participated in the study. A single mother was then deliberately sought via snowballing techniques for maximum variation sampling.

Purposively, women who participated in this study met the following inclusion and exclusion criteria.

Inclusion criteria: Participants were eligible for this study if they met the following criteria:

1. Women who self-identified as feeling stressed, anxious or depressed
2. Were in paid full-time, part-time or casual employment
3. Aged between 18-55 years (so as not to exclude those women who adopted or fostered children at a later stage in life)
4. Lived in the North Shore area

5. Could speak and read English, and
6. Had at least one child aged five or younger living at home with them for whom they cared (so as not to exclude grandmothers or aunties who are primary carers)

Exclusion criteria:

1. Women with a Diagnostic and Statistical Manual Five mental health diagnosis or currently receiving any secondary health care services were excluded;
2. Those with cognitive impairments or any other health issues that may interfere with their ability to communicate effectively, may have been especially vulnerable, and may not have been able to carry out the research activities; and
3. Family, friends, AUT colleagues and students known to me to eliminate any conflicts of interest issues.

Participant recruitment

Initially, this small scale study aimed to recruit between 8-10 working women, from the North Shore area of Auckland, New Zealand. Nine participants were recruited. A decision was made to stop at nine participants as there was much diversity among the participants group and no new phenomena seemed to be emerging from the interview data. Three recruitment drives, over a period of six months, were undertaken. All recruitment drives followed the same procedure. A total of 300 information pamphlets (Appendix B) were distributed amongst 13 early childhood centres across the North Shore. Through this pamphlet, potential participants were asked to contact me via e-mail or telephone, if they wished to participate. The research pamphlet served as the first level of screening as it asked the women some key questions referring to the inclusion criteria of the study. At first contact with potential participants, by either e-mail or telephone, I would ask the following questions to determine eligibility:

1. Are you currently receiving any intervention for any mental health illness or issue?
2. Do you work or study at AUT University?
3. Do you have any physical or cognitive issues that may interfere with your ability to participate in the research?

One participant was a post-graduate student at AUT University but was unknown to me. One participant was on anti-depressants prescribed by her family doctor; however, this was considered primary health care and not secondary care intervention. Eligible participants would then be invited to participate in the study via e-mail. The follow-up emails included the participant information sheet (Appendix C) and the participant consent form (Appendix D). Participants were given two weeks to decide if they wished to continue. All participants however, at that first phone call or e-mail, were willing to set an interview date or made contact within that two week period.

Challenges and changes to recruitment

Recruitment of participants took longer than anticipated. For example, the first four months of distributing the study pamphlet in seven early childhood centres, only yielded two interested participants. To speed up the recruitment process, a decision was made to advertise the study on social media sites, including local North Shore community and swimming schools Facebook pages. An amendment to alter the recruitment strategy was approved by AUTECH (Appendix E). While waiting for the ethics amendment approval, study pamphlets were distributed to six other early childhood centres. Seven prospective participants made contact as result of that. One more potential participant was recruited through snowballing. I managed to advertise once on a local swim school Facebook page but received no responses. By the time the ethics amendment was approved, the desired number of participants had already been achieved.

From 11 potential participants, two withdrew due to time pressures or other commitments, which seemed to be the main barriers to participation in this research.

Finally, nine women participated in the study and six completed both the individual interviews and focus groups. Eight participants were either partnered or married at the time of this study.

To enable me to examine varieties in experiences of different levels of marital status in the study group, a decision was made to actively seek and recruit a single mother. Despite the use of snowballing and various study advertisements, only three prospective participants were approached, and one was recruited. This brought the total to nine participants. The interview itself could only take place after the focus groups were completed, as per the availability of the participant. The single mother's story added diversity, confirmed similarities and identified contrasts in experience and support of the findings.

Overview of Participants

Table 4 (p. 50), includes the participants' demographic profile. Pseudonyms are used to maintain participant confidentiality. In summary, participants were between the ages of 27-50 years of various ethnic background. Four identified as New Zealand European, one identified as part New Zealand European and part Māori. Other ethnicities included Chinese, English, Indian, and South African. Eight were married, one was single. The ages of the children ranged from 18 months to 9 years, with each participant having at least one child under the age of five, as per the inclusion criteria. Four participants had two children under the age of five. Only two participants worked full-time (40 hours per week). There were varied work areas such as health care, customer service, administration, human resources, health and safety, and civil servant. Seven of the eight spouses worked full-time. Three participants identified having no close extended family support such as parents, parents-in-law or siblings.

Data Collection

The purpose of data collection is to gather and measure information in a systematic way in order to answer the research questions (The Office of Research Integrity, 2017)

In choosing the data collection method, it was vital for the methods to best capture the subjective experience of the study participants to best capture the phenomena being studied (Thorne, 2016). Individual interviews and focus group were decided as the most appropriate data collection methods, as both allow for in-depth subjective investigation of the phenomena of interest (Thorne, 2016). Participants were not asked directly about the occupational perspective but rather guided by indicative questions that drew out the relevant information and experiences sought by this research.

In-depth Interviews

The individual interviews aimed to capture the first-hand and in-depth knowledge of the participant's experiences of stress, anxiety and depression. In-depth interviews allowed for open-ended questions guided by the topic of interest and enabled me to ask for clarification and in-depth enquiries (Thorne, 2016). Each interview began with participants completing the written consent form and answering some demographic questions (age, ethnicity, marital status, employment status, current medical conditions, living situation, number of dependents and any current interventions for stress, anxiety and depression). Thereafter guided questions about women's experiences of stress or anxiety or depression and factors contributing to those experiences were asked. The interview guideline included questions to determine participant's personal background, including but not limited to: Tell me about yourself? What sorts of things do you do on a day to day basis? Can you describe a recent time or times when you felt stressed, anxious or depressed? Individual in-depth interviews were completed with all nine participants.

Table 4: Overview of participants

Pseudonym	Age	Marital status	Ethnicity	Children	Work area	Work hours	Spouse job title	Spouse work hours	Family- yes/no Source of support
Nicole	34	Married	English	One child aged 18months Pregnant with second child	Health Care	Part-time Four days per week	IT	Full-time	Yes. Parents-in- law live close by
Adelaide	27	Married	New Zealand European	Two children aged 2 and 4	Retail/ Family Business	Part-time 24-32 hours per week Another part-time four days per week	Self- employed	Full-time	Yes. Parents- in-law close by
Anastasia	33	Married	Chinese	Two children aged 3 and 4	Health Care	Part-time Three days per week	Builder	Full-time	No. Parents and parents-in-law live too far away
Jessica	43	Married	New Zealand European	Two children aged 9 and 4	Human Resources	Full-time 40 hours per week	Management	Part-time Four days per week	Yes. Mother living with them and parents-in-law live close by
Sarah	50	Married	New Zealand European	Two children aged 6 and 3	Civil Servant	Part-time Four days per week	Civil Servant	Full-time	No. Parents and parents-in-law live too far away
Diana	30	Married	Indian	One child aged 2 Pregnant with second baby	Customer Services	Part-time Four days per week	Consultant Engineer	Full-time (works from home)	Yes. Parents, parents-in-law and three adult sisters live close by
Anne	43	Married	New Zealand Māori/ European	One child aged 4	Human Resources	Full-time 40 hours per week	Management	Full-time contract	Some. Parents live close by. Mother-in-law lives an hour away
Suzie	32	Married	South African	Two children aged 3 and 1	Health & Safety Industry	Two jobs 15 hours per week Officer fixed and contract extra 7-21 hours per month	IT	Full-time	No. Parents and parents-in-law live in South Africa
Rachel (Full-custody of child for past 8 months – ongoing court proceedings to review custody arrangements)	39	Single	New Zealand European	One child aged 4	Self- employed Administration Contractor	Contract 30-40 hours per week	N/A	N/A	Some. Although parents and sister lives far away

Initially, one hour was set aside for the interview; however, most interviews took an average of 90 minutes. Participants were given choice regarding place, date and time for the individual interviews. This choice, and my own flexibility, resulted in three interviews taking place in the participant's home, three at AUT University and three at the participant's place of work. Three of the nine interviews were conducted during participant's lunch hour. Home interviews tended to be longer than workplace interviews or interviews done during the lunch hour. Flexibility with place, date and time seemed to work well with working mothers, to reduce time and childcare commitment barriers. All interviews were audio recorded.

Focus groups

The focus groups were used to facilitate participants sharing and generating collective ideas derived from the interviews, as the spring board for discussion on solutions to their collectively defined issues. The focus group method was chosen to allow for comprehensive interpretations regarding the study topic (Thorne et al., 2004). Particularly, in this study, the focus group was also used as an opportunity for participants to collectively reflect on the issues being studied and to be critical of their problems and offered solutions, a key process within ID (Hunt, 2009). Focus groups enabled participants to generate ideas together, collectively reflect on their shared experiences and synergise new ways/ideas solutions to their issues. Two focus groups were facilitated at two different points in time at AUT University, on a weekend day. The plan was to have at least four participants per group, as recommended by Davis (2016). However, six participants attended the two focus groups, three in each session. Two participants were unable to attend the focus groups due to other commitments and illness. The single mother participant only signed-up to the research after the focus groups had finished. While three participants per focus group does not meet the minimum recommended by Davis (2016); delaying or rescheduling groups until a minimum of four working mothers can attend, could lead to significant delays in data collection, participants becoming disengaged due to cancellations or rescheduling or

focus groups not eventuating at all, due to the business and unpredictability of working mothers lives. Despite the low numbers attending the focus groups, rich data were captured.

Each focus groups began with the group introduction (purpose of the group and individual introduction), and a few housekeeping (i.e. reminder of confidentiality, health and safety protocol). Participants were made aware that if they were to decide to leave the group session before its conclusion, I would contact them the next day to check on them and see if they had anything more to add to the data. This was followed through with two participants and neither added new information.

Following the introduction and housekeeping, a summary of preliminary findings from the collated individual interviews were presented to the first group. Subsequently, the summary from the first group discussion was presented to the second group, as a constant comparison and member checking process. In both groups, participants were invited to review the summary, express agreement or disagreement or add new information and propose solutions. Each participant received individual copies of the preliminary findings as a point of reference and A2 poster paper was used to record or highlight any points of interest.

There were two co-facilitators in each focus group, both of whom had group facilitation skills. Each co-facilitator signed a confidentiality form (Appendix F). The role of the co-facilitators was to help set-up and tidy up the meeting room before and after the group session, and to help prepare resources, time keeping, note taking and to offer support for any unforeseen circumstances as stated in the participant's safety protocol (Appendix O). Two co-facilitators were chosen, so that one could focus on notetaking during the group, while the other could respond to any participant who became upset. This enabled efficient corroboration of the data, as well as minimized disruptions and ensured a smoother flow of the group.

Focus groups were initially planned for one hour but took up to 90 minutes. When the group neared an hour, I asked if anyone could stay. Most could stay for an extra 15-20 minutes. The 90 minutes was found to be a more realistic time frame for the focus group. Keeping in mind the busyness and stress of participants' daily life, allowing for flexibility and choice of two focus groups run on a different weekend day and a different time, aided participation in the focus groups. Focus groups were arranged one month in advance to enable participants to schedule and plan attendance. An e-mail and text reminders were sent out one week before the scheduled focus groups. All participants appreciated the reminder, but two had forgotten at that stage and attended as a result. Both focus groups were audio recorded.

Data Management

Data management included the process of tracking, organising, and sorting the data collected in a way that would make it easily accessible throughout the data collection and analysis process (Thorne, 2016). All interviews and focus group discussions were transcribed verbatim by myself or a professional transcriber who signed a confidentiality form (Appendix G) Participants were aware and consented to the audio recording of interviews and focus groups. Data were managed and stored using word documents to create individual narratives, initial coding, insert questions/comments in the margins and produce demographic, coding and thematic tables.

Data Analysis

Data analysis is a complex and dynamic process of evaluating information using logical techniques in order to find useful information (The Office of Research Integrity, 2017b). Multiple methods can be used and is recommended within an ID study, as it adds depth and robustness of interpretation within the research (Hunt, 2009; Thorne, 2008, 2016; Thorne et al., 2004), especially the use of inductive reasoning (Thorne et al., 1997). Braun and Clarke's (2006) six stages of thematic analysis was chosen because

it is an inductive data analysis method. Other methods such as memoing, diagramming, narrative construction and the conditional relationship guide were used to clarify, supplement, and deepen the thematic analysis.

Thematic analysis

Braun and Clarke's (2006) six step process of thematic analysis was employed and included the following:

Step 1: Familiarising with the data. All data were read and re-read to start gathering initial ideas, thoughts or anything of interest in that data. Words, sentences, phrases, sections were highlighted; however not explicitly named or coded (Appendix H).

Step 2: Assigning initial codes. The transcripts were more carefully re-read and initial codes were identified. An initial list of codes would cover broad aspects such as context, people, activities, scenarios, feelings, influences and time. Narrative construction was carried out after initial coding to gain a broader and more in-depth focus on participants' experience; to be able to more clearly see similarities and difference between participants. In this study, the narrative outlined and summarised the key scenarios and main internal and external influences on the participants' stress, anxiety, and depression (Appendix I). Initial codes were discussed with supervisors at this point. I was then encouraged to start thinking about the relationship between codes, clarifying and grouping codes next.

The presentation of the preliminary analysis of focus group one to focus group two was useful, as it helped to highlight the commonalities, contrasts and contexts, and added further depth and clarification regarding possible themes and subthemes. The preliminary analysis facilitated the processes of constant comparison, recurrent analysis and simultaneous data collection and analysis.

Step 3: Clarifying and grouping codes to develop potential key themes. Multiple possible themes and constructions were considered. To ensure rigor, both supervisors

and I discussed key themes and worked on up to five key messages or important aspects of the research. Following this step, information was condensed grouped and organised into themes and subthemes by me with advice from my supervisors. The memoing, diagramming and the conditional relationship guide further supported analysis.

The purpose of memoing is to document analytic thinking and it is highly recommended by Thorne (2008). A blank notebook was used to record my thoughts, questions, thematic lists, and emerging patterns from both the interviews and focus groups. In addition to recording these aspects of the research, memoing helped me to reflect on and deepen analysis by asking complex questions or making groupings, connections or highlights (see Appendix J for an example).

Diagramming was used as a process to see how codes could be merged together to develop broader themes. It helped to identify any gaps or areas for further exploration. Diagramming also assisted with uncovering the relationship between themes and identify subthemes; and supported and challenged my interpretations of the data. As the analytic process progressed, diagramming was frequently used and in conjunction with the conditional relationship guide (see Appendix K for an example).

The relationship between codes, themes and subthemes was determined using the conditional relationship guide (Wilson Scott, 2004). The conditional relationship guide is a data analysis tool that is specifically used to understand the relationship between themes (Wilson Scott, 2004) by asking questions such as, what is the theme? When does it occur? Where does it occur? Why does it occur and how does it occur? Some grounded theory methods are compatible with thematic analysis, like the conditional relationship guide (Braun & Clarke, 2006). The conditional relationship guide also enhanced the process of constant comparison required for rigour and credibility in ID studies (Hunt, 2009). As a result, a table of the themes were generated to link to the key questions (Appendix L). This process helped to further uncover and refine themes and subthemes.

Step 4: Reviewing the data extracts. All coded data extracts were checked for coherency with key themes generated. Themes were also checked as they fit with individual data sets and to find potential gaps and refine themes. This process was done multiple times and changes were made as relevant. This constant comparison helps to keep the findings grounded in the data (Thorne, 2008).

Step 5: In this step the themes and data analysis were further refined. The key essence of each theme was articulated. The data extracts were checked to make sure they best represented the essence of that theme. Extracts were organised to represent themes. Themes were checked by me to confirm how they fitted with each other. This was done multiple times with additional support and feedback from supervisors, continually challenging me to clarify and deepen analysis.

Step 6: Final analysis and write up with continued supervisor feedback and discussion. The findings are captured in Chapters Four, Five, and Six of this thesis.

Changes and challenges to the focus group data collection and analysis procedure

The first focus group was planned to take place after a minimum of four interviews for several reasons. Firstly, to allow constant comparison, recurrent analysis and simultaneous data collection and analysis, key processes within ID methods. For example, to gain some preliminary data to analyse and prepare for the focus groups and retain the interest of participants by not waiting too long after the interviews. However, both focus groups took place after seven interviews were completed (between six and seven months after the first interview). This was partly due to slow recruitment and then a sudden influx of participants in a short span of time. Consequently, transcribing of transcripts, summarising preliminary findings, and coordinating group discussions was delayed by two months.

Managing personal and professional beliefs

My personal and professional beliefs were outlined in the introduction chapter. The occupational model of personal, environmental and occupation factors had initially

dominated my data analysis. So, on my first attempt at Steps 1 & 2 of the thematic analysis this framework was evident. Feeling unsure about my data analysis process, I initiated a meeting with Sally Thorne, the designer of ID methodology. She encouraged me to look at the data with new eyes, see what else showed itself, perhaps something was missed or something new or important could emerge. Hence, I repeated the first two steps of Braun and Clarke's (2006) thematic analysis. Confirming Thorne's advice, new and important findings showed itself. Both findings Chapters Four and Five are a result of this shift early in the data analysis. The findings are not completely free from an occupational perspective, but it is less overt and more grounded in the data. I did not go back to the initial data analysis method, as other, new and important findings became evident.

Other key processes during data analysis

Verification of analysis. My supervisors were instrumental in ensuring the credibility of the findings. There were regular supervision meetings where I was challenged and questioned on the data analysis methods used, as outlined in the description of Braun and Clarke's (2006) steps. There were debates and probing questions about the coding, analysis and interpretation of the data. Multiple sets of feedback were given by supervisors on the findings chapters to clarify and add depth of interpretation, and provide relevant data to support interpretations.

Member checking was also used in this study. Participants were asked to check their transcripts. No-one returned any errors. Focus group one served as a member checking process for all individual interviews. Focus group two served as a member checking for focus group one. This supported further exploration of individual and group experiences, contexts, needs and wants, which forms a large part of the second findings chapter on *Solutions to issues*.

Ethics

This study was approved by the Auckland University of Technology Ethics Committee (AUTEC) on the 28 July 2015 reference number 15/162 (Appendix A). A subsequent amendment to this ethics application was granted on 30 November 2015 by the same committee (Appendix E). The approved recruitment strategy amendment allowed for the advertising of the research project on social media sites.

Informed and voluntary consent. The recruitment process allowed participants to make enquiries with no obligations, thus being well informed before giving voluntary written consent to participate in this research. Participants were able to withdraw from the research up until two weeks after data collection was complete, without questions asked. No participants withdrew from the research. All participants gave written informed consent for both the interview and the focus group at the beginning of their individual interview. One written consent form was used to record participant's agreement to participate in both the interview and focus group.

Privacy and confidentiality. Pseudonyms were used in the transcripts and reporting of the research. The professional transcriber, focus group-co-facilitators, and participants each signed a confidentiality form to ensure they would not discuss the data with others (Appendices K and L). Participants' consent forms is stored in a locked cabinet at Auckland University of Technology (AUT) in the supervisor's office. Electronic data is kept in a password protected folder on an AUT computer. Paper data is stored in a locked cabinet at AUT in the student researcher's office, accessible only to the student researcher. All data will be kept for six years, thereafter paper documents will be discarded in the Recall secure document destruction bin and electronic data will be deleted.

Cultural considerations. This research was open to participants from a range of cultures. In preparation for the cultural diversity that could be encountered and expected as part of the AUTEC application, I considered the three P's framework of partnership, participation and protection (Auckland University of Technology, 2016).

These three principles support the relationships and obligations of the New Zealand government to Māori under the Treaty of Waitangi (Ministry of Health, 2014) but can also be used as framework to engage with other cultures.

I am a South African who has lived and practiced in New Zealand for the past 13 years. I am also a New Zealand registered occupational therapist with a current annual practicing certificate, so I need to comply with the Occupational Therapy Board of New Zealand Code of Ethics and as a practitioner, I have worked with people from different cultures. Through my work and professional engagement, I have gained knowledge and experiences to respectfully engage with others of different cultural backgrounds. At the same time, I am also aware of my limited knowledge on indigenous Māori culture or other cultures different to my own. Prior to commencing this study, I consulted with Dr Huhana Forsythe, Senior Lecturer, School of Education, AUT University and Gary Leaf, Senior Lecturer BEd and Māori Development, School of Education, AUT University (see Appendix M attached memo summarising key points resulting from this consultation). Such consultation gave insight into working with a range of different cultures.

Practical ideas and processes such as greetings, food and gift giving were identified as keys to engagement and were used during the research. I was reminded to inform participants that they could bring whanau/support person to any sessions. In many cultures, such as Māori, Pasifika or Asian, bringing along a trusted family member or friend is a common practice to help participants feel at ease and secure in a new environment. I had prepared a support person consent and confidentiality form. No participant took up the offer to bring along a family member or support person. All participants were offered kai/refreshments at their interviews (where they took place at AUT) and the focus groups. Each participant received petrol or food vouchers after completing the interview and focus group.

Safety and Risk. No deceit, harm or coercion occurred in this research design. Minor discomforts were anticipated, such as participants becoming upset during or

after the interview or focus group. Thus, two safety protocols were designed for this research to ensure that participants were supported, to minimise any emotional, physical and psychological risk because of the research and ensure the physical safety of myself, when conducting the interviews and focus groups both on and off AUT premises. A full description of these safety protocols can be found in Appendices N and O. Only part a) of appendix O was used during some of the interviews namely, *after taking a few moments for the participant to recover, the researcher will check if the participant is able to proceed with the interview with or without a support person, if so the interview will continue on that day or be rescheduled.* All the participants who became upset agreed to continue with the interview after a small period of comfort. Furthermore, all participants were offered three free AUT counselling sessions to provide them with addition support. I was not able to ascertain how many participants took up this offer as I did not have a clear process to follow this up.

Rigour and Credibility

When it comes to rigour and credibility, Thorne (2016) outlined four evaluation criteria as the *“basis for articulating evaluation standards in interpretive description”* (p. 235), to include epistemological integrity, representative credibility, analytical logic and interpretive authority.

Epistemological Integrity refers to congruency between the research processes, research questions with the epistemological views. Hence, the data sources and data analysis strategies should follow logically from the epistemological views and research questions (Thorne, 2016). It was demonstrated throughout this chapter how the questions, sampling, data collection and data analysis was informed by the key principles of ID, adding to the credibility of this study. Through this, I ensured that the research process, research questions, data collection methods and data analysis well reflected the epistemological stance of the constructive naturalistic paradigm.

Representative Credibility, requires that the theoretical claims of the research are consistent with sampling and data methods (Thorne, 2016). Representative credibility was achieved in several ways in this study. Firstly, the process of purposive sampling method and then maximum variation sampling was used to select participants who would represent the group of interest. Next, multiple sources of data and data analysis underpinned the emerging findings and evidenced triangulation of the data (Thorne, 2016). Like the use of interviews and group discussion which enabled me to interact with the participants in more depth. This interaction enhanced the credibility of the findings (Thorne, 2016). Constantly evaluating the data between and within data analysis methods strengthened final analysis.

Analytical Logic and Interpretive Authority, aiming to ensure interpretation of the research findings are free from my bias and experience (Thorne, 2016). Potential researcher's biases were managed with the advice from Sally Thorne, as previously discussed in this chapter, and the supervision process by the constant questioning and challenging of findings. To support transparency, consistent records of all coding and analysis decisions were maintained and are therefore, traceable. Emerging findings and the process of writing up findings were discussed and challenged in regular supervision meetings and written feedback. Preliminary findings were also checked with participants. Regular supervision and member checking ensured that findings were grounded in the data and added to the robustness of the data analysis process.

The outcome of this completed research process is described in findings Chapters Four, Five, and Six, which explore working mothers' experiences of stress, anxiety and depression, and their solutions to their issues.

Chapter Four: The Struggles of Working Mothers

I don't want to assume that every mum's got the same challenge that I have, which is really about juggling and it's about making it work and having more time for myself, but also for everything else that falls into place. (Anne)

Introduction

There are three themes that were uncovered in this study. The first, *the struggles of working mothers*, explores the diverse and complex experiences that increased or negatively impacted on woman's stress, anxiety, and depression. The second, *solutions to issues*, evaluates the key strategies women personally used to alleviate their stress, anxiety and depression or supported them through stressful events. The third, *wishes for the future*, are the desired or future needs of working mothers and includes those aspects participants felt were needed to more comprehensively support them in their role.

The above quote from Anne, aged 43, who was employed full-time and lives with her husband and four-year-old daughter, encapsulates the essence and complexity of the theme, *the struggles of working mothers* that is explored in this chapter. Overall, and overwhelmingly, participants described their experience of being a working mother as a “*struggle*” or “*it's hard*”, “*challenging*” or “*tricky*”. The word ‘struggles’ has been chosen to encapsulate this theme and the hard, tricky, and challenging experiences working mothers described in this research. The verb struggle is defined as “*make forceful or violent efforts to get free of restraint or constriction, engage in conflict, strive to achieve or attain something in the face of difficulty or resistance, having difficulty handling or coping with, make one's way with difficulty*” (English Oxford Living Dictionaries, n.d.). Strive, battle, labour, toil, strain, and endeavour are synonyms (English Oxford Living Dictionaries, n.d.). This definition of struggle suggests that participants were trying very hard to achieve in their role as

working mothers, but it was a battle for them, they had difficulty handling or coping with this role – making their way through with difficulty.

This chapter explores the struggles women face in their daily lives of being a working mother and how these struggles influence their stress, anxiety, and depression under four subthemes. The first subtheme *the self-expectations* encompasses women's personal role expectations that drives and evaluates everyday performance. The second subtheme, *getting the right balance* has five elements: *juggling time, money and energy, juggling daily tasks, to be good enough and the vicious cycle*. The third subtheme, *other's expectations* has four elements, *expectations to work, expectations at work, gender role expectations and the expectation to it all, do it right and get on with it*. Thereafter, the fourth subtheme *significant life events (ongoing and multiple)* is discussed.

All the sections presented analyse the impact these struggles had on participants' well-being, especially stress, bearing in mind that anxiety and depression are an emotional response to stress, as discussed in Chapter One. The researcher purposely sought events and experiences in participants' lives where they specifically identified being stressed, anxious, or depressed; in addition to expressing feelings of guilt, feeling down, letting people down or disappointed, failing or events that caused pressure, frustration, internal conflict, and change. Further the concept of juggling is understood as the managing of resources such as time, energy, money, and external supports such as work, spouse, and family. These resources are considered finite, in that the amount of time, money, energy and people available on a daily basis is limited and often unpredictable.

Subtheme One: The Self-Expectations

The first step in comprehending women's struggles in this research is understanding the fundamental role self-expectations play in creating the struggling and subsequent

juggling. Self-expectations included the self-perceived values and beliefs participants held about being a 'good' mother, wife, and worker. Two common values and beliefs participants had, were: the children are most important (their health and well-being needs are prioritised above all else) and to do and give their best at home and at work. It is important to note that the expectation women have of themselves is influenced by society and life experiences, as discovered in this research and explored in more detail in the subtheme '*struggling with others' expectations*'. All participants had self-perceived expectations of themselves as worker, mother, and wife; and these roles were most prevalent in the interviews. For example, Nicola (34), mother of an 18-month-old stated her expectations of herself in her role as mother, worker, and wife:

The core expectation is that I will be able to give my daughter what she needs, that I will remember to do the things that she needs, and I will remember to give her the right amount of milk and make sure she's got dinner. Make sure that she's got clean clothes to wear and make sure that she's ready for bed at the right time. So, there are core expectations of looking after a dependant. I have to make sure I've got enough energy to be able to interact with her... That is my expectation of what I need to be able to do in the evening for my daughter as a good parent... I have expectations about what I should be able to achieve at work. I have expectations of what I should be able to do for my husband.

Nicola's expectations drove the nature and quality of tasks she performed, such as giving her daughter the right amount of milk, set tasks at work, and tasks associated with being a wife. It is clear by this statement that she had very specific self-expectations of what it is for her to be a 'good' wife, worker, and mother. Performing these multiple tasks to the expected level required management and coordination of resources such as energy, as she emphasised she needed to make sure she had enough energy to interact and entertain her daughter.

Further, self-perceived expectations, also determined who and what was prioritised for the day. When Diana, aged 30, mother of a two-year-old, working part-time in sales was asked in her interview to prioritise her roles of mother, worker, and wife, she stated, "...being a mother is probably the most important, I'd put that above everything else. My son is the priority over anything." It seemed that her son's needs would always take precedence over any other role, and consequently all daily actions

and decisions would be about fulfilling his needs first. It would be what drives her everyday doing and planning.

Therefore, the self-perceived expectations participants have of themselves created specific task demands, and these created a need to coordinate time and energy and any other resources efficiently. From these examples it is seen how self-expectations drive everyday organising and doing. However, trying to satisfy and coordinate all these role expectations daily within limited resources such as time, money and energy is the '*struggle to get the right balance*' in the forms of '*juggling time, money and energy*', '*juggling daily tasks*' and '*to be good enough*' was challenging; the next key struggles in this subtheme.

Subtheme Two: The Struggle to get the '*Right*' Balance

The '*struggle to get the right balance*' is about women's efforts to meet the demands of their self-perceived, multiple role expectations. There are five elements explored here *juggling time, money and energy, juggling daily tasks, to be good enough and the vicious cycle*. These subthemes highlight the increased stress, anxiety, and depression participants experienced when trying to meet multiple, complex, unpredictable, and at times unfair expectations and demands as working mothers. Juggling describes participants' experiences of trying to meet the demands of everyday life, based on their self-expectations of the 'ideal' picture perfect motherhood, being a mother, and the good, healthy, and happy children they have. Balancing finite resources of time, energy, money, and external supports such as work, spouse, and family to achieve their expectations was necessary; but trying to get the right balance everyday was stressful and anxiety provoking. Not meeting these expectations led to self-identify and self-esteem difficulties that seemed to contribute to feelings of depression, anxiety, and frustration.

Juggling time, money and energy

This element is about *the struggle to get the right balance* between time, money, and energy resources to meet women's unique and complex self-expectations and the impact that had on their stress, anxiety, and depression. All participants described juggling these three finite resources to meet their expectations and demands of being a working mother. Juggling expectations is the process of considering how best to balance these resources to meet self-expectations. For example, Nicola (34), mother of an 18-month-old and working part-time, gives an example of the challenge that is *juggling energy* in her interview:

I want to give my absolute best to work but I can't give everything that I have to work because then I'll have nothing left for my family when I get home... So that does add stress and if my energy levels are short for whatever reason, yes, it can be very difficult to decide how best to use that energy. So that I don't let anybody down, because I don't want to let anyone at work down and I don't want to let my family down either. I don't want to tire myself out to the point where I'm no good for anything. So yes, that can be a source of stress.

At this stage Nicole has not yet actively or physically performed any task. This process was all happening in her head. She was trying to figure out how to balance and best use and coordinate her energy to meet her daily demands – concerned that if she gave everything to work, she would have nothing left for her family. It was a stressful process for her because she did not want to let anybody down, potentially causing feelings of guilt or failure, but she also did not want to be too tired and unable to perform in her multiple roles. There was a cognitive struggle with getting the right balance between her physical, emotional, and cognitive energy and meeting her multiple expectations.

Other examples of trying to juggle time, money and energy to meet everyday expectations were emphasised in the focus groups. Sarah, Diana, and Jessica were discussing trying to work more hours to gain more income. The following discussion highlighted the struggle and delicate balance between meeting their expectations to get the right balance for them:

Sarah: ... then you think maybe I should work full-time [to relieve financial pressures]. So, then there's other things, you want to see your children and take them to school pick them up from school and all these things but also how do you fit everything in?

Diana: You can't really work at home after you've done a day at work. You can't take work home.

Jessica: You can for a while, but you can dream.

Diana: It's something I discussed with my manager like doing stuff from home. But then I go why the hell would I want to do this from home? Cause you're just tired, you're knackered. After dinner and you've tidied up and all that stuff, so yeah. Time, energy, money.

Here participants toyed with the possibility of increasing their work hours to increase financial resource. While an increase in money might provide some financial relief, the increase in hours created a struggle to *juggle resources* and *get the right balance* between time, money, and energy to meet their expectations, such as being there to pick up children and how to fit in things like household chores and making dinner. Balancing time, energy, and money was complex and challenging in this scenario because of the domino effect it had on family life and responsibilities.

The '*struggle to juggle time, energy and money*' was present every day and throughout the day for all participants. It was done in advance, but participants were also required to re-juggle and re-organise resources on an ad hoc and daily basis. Sarah (50), mother of two boys aged five and two, who worked part-time as a civil servant described it as a state of "*constantly going two steps ahead of yourself to keep ahead,*" to meet the expectations. Being ahead, living in the future, anticipating what might happen and coordinating as required. Being in a constant state of readiness to respond to meet the expectations of the sometimes changing and often unpredictable events in the day. However, once a plan and coordination of resources were in place, this plan would be actioned and underpinned '*juggling daily tasks.*'

Juggling daily tasks

Juggling daily tasks was about *the struggle to get the right balance* between what should and is done in a day, week, month etc., to meet expectations. These tasks included activities such as supervising the children, cooking, cleaning and showering, typical work tasks, going out etc. Most activities seemed to be routine like cooking and some were ad hoc like going out with friends. These tasks were usually associated with an expectation of a role the woman held, for example worker, mother, or wife. It was identified by participants that there was an increase in volume of daily tasks that came with having dependent children. Little ones are dependent on their parents, they need to be fed, bathed, dressed; this is often a huge responsibility and emotionally demanding for parents.

Diana reiterated this responsibility, *“Probably the fact that I’m responsible for somebody, in that person is reliant on me and living. Yes, I’m responsible for this person and how they maybe may turn out in the world.”* Diana’s words are heavily weighted; she realised that as a mother her actions significantly influenced her son’s chances of living and thriving in the future. This was not a fleeting thing but a long-term commitment and responsibility. Jessica expressed a similar view and added, *“...but still providing enough for them gives me a lot of angst because there is definitely a challenge in doing that.”* Here, Jessica admits the emotional and financial demands placed on her to provide for her children to fulfil her *“vision of happy, healthy children who contribute to the world and are going to enjoy their lives.”*

The pressure of this commitment and responsibility is then reflected in *juggling daily tasks*. Jessica compared her responsibilities before versus after children in her interview

Pre-children my stress was manageable... I suppose the significant factor is you don’t just go home and go hi I’m here now, shall we order takeaways and sit down on the couch... Because there’s more to be done when you get home than just that. There’s more people involved... there’s just the daily things like there’s washing, there’s dinner to cook and I keep it pretty basic... So, there’s just more to fit in.

It seemed for Jessica, there were more tasks to do because of more dependents in the household, while the amount of time available time pre and post children remained the same. There was more laundry, dishes, and cooking to do. The more to do meant less time to relax and more stress. Another participant, Sarah said:

... it's all go, go, go... You get up, give them breakfast, out the door to go to school and I've just started catching a bus in the last six months or whatever, a bus to work to try to chill out. I do my five hours at work and it's go, go, go... Next day, next day, next day and so the stress and then the anxiety that you're not doing enough.

"Go, go, go" encapsulates the constant state of doing, the rush to do the next thing, to get things done, to meet multiple role expectations; this is experienced as stressful. It is so busy for Sarah that she uses the bus ride to work to relax or "*chill out*". It suggests that within Sarah's day there is no opportunity for her to relax, it is just so busy for her.

The increased role demands of mother were constant and it was important to all the participants to meet these demands daily, to be a 'good' mother. In addition, all wanted to meet the demands of being a worker and all that entails. This included getting ready for work, travelling to work, putting in a day's work, whether one is an administrator, professional health care worker, retail assistant, human resources manager, police officer, or medical consultant; whether the work is part-time or full-time. Then add in more tasks associated with other roles such as wife, friend, daughter, sister, and in some cases competitive sportsperson, post graduate student, and committee member. So, it is not unsurprising that most participants experienced "*rushing around all day*", to meet day to day demands.

It seemed in some instances women expressed that the weekends were just as busy trying to fit in other activities for the family and others specific to their children's needs. Diana (30), mother of a two-year-old commented, "*weekends consist of doing stuff with my child, like swimming, going to the park, beach and things to do in summer, so he [her child] takes up most of our [her and her husband] time.*" For Diana, weekend activities centred on activities with or for her son, leaving no time for anything else; for example, something to do for herself or for her husband. For some women there

seemed to no break from this busyness, day to day and week by week. Being constantly on the go, working or rushing all the time can feel very pressured and stressful.

Jessica and Sarah together summed up the stressful experience of *juggling daily tasks*, “*So there is no respite, there’s just more...*” (Jessica), “*You’re making lunches and you’re doing all of that kind of stuff... You just do as much as you can... You’re always just dah, dah, dah and you can understand how sometimes mums really fall over...*” (Sarah). From Diana and Sarah’s perspectives, for a working mother there is always more to do and not enough time and energy to do it, leaving no time to relax or take a break. This is experienced as stressful and exhausting.

Life before children was reported by most to have been much more carefree and relaxed. Thus, having to do more within finite resources of time, energy and money, trying to fit more in, created an experience of rushing around and the understanding in participants that there was always more that needed to be done – no time to rest or take a break. This created increased stress and anxiety for most of the participants.

In addition, children or mothers or fathers getting sick, added to the stress by creating an unexpected change in routine that required women to adjust quickly. This was in addition to and worsened the struggles with *juggling time, money and energy* and *juggling daily tasks*. The types of illness included in this category were physical (common cold, flu, diarrhoea, meningitis) and mental health issues (anxiety and depression). Diana gave her experience in the focus group,

I think last year having our son being in day-care was probably like the big year of getting sick. I was sick probably every four weeks. And he wasn’t really sick, I would just get the bugs and I’d have it, so it affected my being at work and also affected all the other things you have to do while you’re sick.

Multiple bouts of illness over an extended period negatively impacted on Diana’s ability to perform her daily tasks at work and at home. This was a point of

internal conflict for Diana, trying to meet the expectations daily life but not having the capacity to carry it out due to illness.

Whether it was the children, mother or father that was sick, the main struggle identified by some, was the “*disruption*” and “*re-shuffling*” of the day that needed to happen. Anne explained what she needed to do when her four-year-old daughter was sick one day and Anne needed to stay at home and take care of her.

Yes. The disruption would be that I have to care for her, which is generally most of the time, it means I have to reshuffle my day. So, if I have meetings I have to decline attending them. If I'm leading them I'm going to have to reschedule them.

Here, Anne firstly highlights the conflict staying at home can cause with work and then the additional reshuffling and rescheduling of work tasks and responsibilities she needs to coordinate to sort out or settle the day. She stated that she would need to do this most of the time compared with her husband, which may be associated with role expectations within her marriage. This is an example of *re-juggling time, money and energy* and *daily tasks*. In this situation she prioritised her daughter's needs and being mother over her worker role. This is sometimes the conflict between role demands working mothers can experience in their day. The consequences of which are not pleasant or always easy to deal with, as Anne elaborates:

I have to tell you that honestly, I'm shaking in my boots [when she knows something important is approaching at work that requires her full attention]. I just pray to everything on the planet that she is not going to be sick or I'm going to get a call from her day care saying she's got a temperature and you need to pick her up. I just have that fear.

Here, Anne explained how fearful and anxious she had become of situations where her daughter would become ill, mainly due to the disruption and reshuffling required with work. While Anne was the only participant to articulate this fear and anxiety, it is suspected that there might be other working mothers who share this experience. This may be influenced by the support and understanding they receive at work from colleagues and line managers.

So, when children or parents were sick, it required *re-juggling of resources* and *daily tasks* at a time when there was likely sleep deprivation and/or fatigue from being ill. These bouts of sickness were often unplanned and unpredictable although somewhat expected when having a child under the age of five. The participants concluded, based on their experiences that children under five get sick frequently until their immune system builds up. Participants also identified that children going to early childcare centres pick up sickness more frequently and/or pass that sickness to parents. Some bouts of illness stretched on for weeks, in which case there was prolonged “*disruption*” and “*reshuffling*” of the day with extended sleep disturbances and increasing fatigue.

Consequently, *juggling daily tasks* effectively and efficiently meant participants could feel good about meeting their expectations. Not meeting those expectations could lead to thoughts of doubt about their abilities and possible feelings of guilt. This is where the ‘*struggle to be good enough*’ appeared.

The struggle to be good enough

The struggle to be good enough is about *the struggle to get the right balance* between doing enough and feeling good enough. Doing enough is the subjective evaluation of how well women juggled resources and daily tasks to successfully meet their self-expectations. This includes a mental and emotional struggle identified by most of the participants. If their subjective evaluation was positive, it perhaps led to feelings of competence (feeling good enough) in roles and vice versa; if the evaluation was negative it could lead to feelings of guilt or incompetence (not good enough). The self-evaluation was wrapped up in meeting their self-perceived expectations.

Nicola highlighted this relationship between expectations, demands, and being good enough:

So yes, I think there are some basic expectations that if I can't achieve, then I am letting somebody [husband, child and work] down. Yes, it impacts on my self-esteem. One of my core beliefs I guess is that I'm a failure and I'm not good enough.

Here Nicola explained the relationship between expectations, meeting those expectations and self-esteem. She constantly evaluated whether what she was doing daily was meeting her expectations and those around her. If she felt like she was not, was letting someone down (guilt), then she would feel, '*not good enough*'. It is the experience of guilt that creates the thoughts and feeling of not being good enough.

Nearly all the participants identified a time when they felt "*not good enough*" or questioned whether they were doing the "*right thing*." They worried about whether they were doing enough for their children, for themselves, for their family, for their employers. Such worries often made them "*have depressed moments*" or conclude that "*it's just too hard*" to try to get the right balance", to enjoy life, meet caregiver responsibilities and work commitments. These worries, for most, seemed to be present daily. Feeling this way daily led women to doubt their self-worth despite their concerted efforts to do a '*good*' job, as mother, wife, and worker.

All participants had specific expectations of themselves as mothers, wives, workers and sisters and organised their days to meet the demands of these roles. These demands formed the baseline for measuring success or failure in the working mother role. When demands were not met, some participants experienced this as failure, disappointment, a "*letting down*" feeling or not feeling "*good enough*". This then fed back into how they valued themselves as working mothers, wives, friend's and in other roles.

To add to the multiple and complex struggles working mothers faced with *juggling time, money and energy, juggling daily tasks* and *to be good enough*, some participants identified a struggle with a "*vicious*" cycle (keeping well).

The struggle with the vicious cycle (keeping well)

The struggle with the vicious cycle is about *getting the right balance* between women taking care of others and taking care of themselves. This struggle emerged alongside *juggling time, money and energy* and *juggling daily tasks and the struggle to be good*

enough. The vicious cycle represents a cycle of keeping well or staying well. For example, Sarah stated, “*after everyone else [family and work], you don’t look after yourself, you get stressed, you don’t sleep properly, and your health suffers, then that becomes the vicious cycle.*” Sarah explained that this pressure to take care of everyone else leads to her neglecting her own needs, leading to increased stress, poor sleep and poorer health, which in turn makes meeting daily expectations even more challenging. This vicious cycle of keeping well or staying well seemed to be disrupted by the busyness and demands created by *juggling time, money and energy* and *juggling daily tasks*. This disruption was discussed more in depth in focus group one.

Those things like a good diet, exercise, good sleep and happy health relationships pre-children were always there.... but again, got myself to a point where it would either continue [not seeing to those things] and go on a downward spiral [poor health and well-being] or I had to reintroduce those things [diet, exercise and sleep].

Firstly, Jessica highlighted how before children those good health principles of diet, exercise, and sleep were easier to maintain versus after children, likely due to the increased demands as outlined in *juggling time, money and energy* and *juggling daily tasks*. Similar to Sarah, Jessica explained a downward spiral regarding her health. She realised when she was much more stressed, she stepped into this spiral of not taking care of herself and this had a negative impact on her health and well-being. She recognised that to break out of the spiral, she needed to start taking care of herself again, modify her expectations, juggle her resources and juggle her daily tasks to include taking care of her health and well-being needs.

This value of prioritising everyone else’s needs over women’s own needs, in the planning and organising of *juggling expectations* and the busyness of *juggling daily tasks*, resulted in working mothers not having time for themselves (to rest, do something they enjoy) and/or neglecting their own health (not enough sleep, not eating properly). In general, most participants reported that they stopped doing hobbies or projects and reprioritised things that were once important to them. Not taking care of

themselves like doing exercise, eating healthily and sleeping well, were all activities that they had little or no time for.

It is important to note that this *vicious cycle* made it harder for participants to *find the right balance* (meet the expectations and demands of daily life); and if demands were not met, could have exacerbated feelings of failure. Conversely some participants identified that they were feeling good and healthy when they started to engage in things they enjoyed, and for their health and well-being.

This is highlighted by Suzie (32), mother of two children aged three and one, working part-time in health and safety. Suzie reflected on when she started to feel more relaxed in her life, *“So three years later, I’m slowing getting back to that less stressful - well I’m slowly getting a bit more relaxed... I’m slowly but surely starting to look at doing things I used to do.”*

It had taken Suzie three years to be more relaxed or less stressed. It was possible only after the house was less chaotic, she had a well-established routine with both her children, the children got along really well, work was more settled, there was a second income and she could plan ahead a bit better. It seemed Suzie had achieved *getting the right balance between juggling time, money and energy, juggling daily tasks and feeling good enough*. However, the amount of time it took was shocking and contributed to the experience of chronic stress.

Another key factor influencing the *vicious cycle* was sleep. It can be episodic as for Diana or chronic as for Anastasia. Diana (30), mother of one child aged two, described her experience of lack of sleep and the negative impact that had on her stress and anxiety and her daily performance:

And the sleepless nights will be three weeks... my son’s had two good nights last weekend... but then after that he’s been waking up and crying out for me... I’m so tired in the mornings and I don’t want to open my eyes and they just sting... It probably stresses me out - how am I going to cope that day with having a sleepless night? I try and focus a lot more, I know I’ve had a sleepless night and I just not to be, when I’m doing stuff on the computer and start making

mistakes, so I'm a bit more vigilant when I'm at work when I haven't had a good sleep.

Diana's two-year-old had been giving her sleepless nights for the past three weeks, she had not quite figured out what the problem was, and she did not know when the sleepless nights would come to an end. Another cause of temporary sleep disruptions were illness or sickness of self or children. Diana explained that she was more tired and worried about how she would “*cope with the day*”, “*anticipating another sleepless night*”, questioning what she would “*encounter tonight?*” and “*how many times will he wake up?*” She worried that because she was tired she might make a mistake at work. Hence, she put more effort into being focussed and “*vigilant*” at work. The state of being sleep deprived increased her stress and anxiety about having sleepless nights and she questioned her capacity to perform her daily tasks. This negatively contributed to her health and well-being.

Due to the severity of the sleep deprivation, Anastasia (33), mother of two children aged four and three working and studying part-time, reflected that she was “... *a terrible sleeper...*” She believed that the quality of her sleep irrevocably changed since the birth of her first child, four years ago.

I have to sleep with grade 5 industrial earmuffs. Literally the one my husband uses for digging and construction work... but with the earmuffs I can still hear my children, even if they move in bed, through one door, landing, and their door closed. So, my sleep quality, I don't know when that will recover, and I forgot, I actually just forget about recovering it because I don't want to set goals I can't achieve. So, I have to put the earmuffs on just to try and get an extra hour or two if I'm lucky. (Anastasia)

Anastasia seemed to have become hypervigilant and hypersensitive to listening for her children and this had disrupted her ability to fall asleep and have quality sleep. She does not believe this is something that can be changed or fixed now and has rather adapted to this chronic state of lack of sleep, but it does impact on her performance and her ability to perform her daily tasks, “*I don't have the same amount of energy that people can put in the tank. Just going on sleep alone I will never have quality sleep again*” (Anastasia).

She felt that due to this chronic lack of quality sleep, she did not have the same amount of energy and felt more fatigued compared to those who experienced quality sleep. Then when she falls behind with daily tasks Anastasia explained, *“Then I feel guilty spending time with the children, I feel guilty going to work, I feel guilty not doing any work, yet I’m so fatigued.”* This chronic state of lack of sleep potentially diminished her capacity to *juggle resources* and *juggle daily tasks*, thereby contributing to feelings of guilt and potentially encouraging *the vicious cycle*.

Sleep deprivation was very common among participants. Suzie stated, *“It becomes a norm not sleeping and being stressed and having to cope with it. I think it’s a standard way of living now for working mums and it’s really, really, really hard.”* Suzie seemed to think that lack of sleep was the collective experience, a standard way of living of being for working mothers. Perhaps reinforced by themselves, peers, their own mothers or society, or perhaps because of not really having any control over sleep disturbances, Suzie emphasised that she felt working mothers were constantly sleep deprived and that this was considered usual or normal. This is a very disempowering, helpless, and hopeless situation to be in for women, a sense that they could do nothing to change that or expect it to be any different.

Sleep deprivation is fundamental to the struggles of these participants. It increased their stress and anxiety, made them tired or fatigued, thereby decreasing their capacity to *juggle expectations* and *juggle daily tasks*, potentially contributing to feelings of *not being good enough* and encouraging a *vicious cycle* with no seemingly helpful solutions other than they must accept and deal with it.

While these women battled *juggling time, money and energy, juggling daily tasks, to be good enough, the vicious cycle with sleep deprivation*, additional external factors influenced working mothers’ stress, anxiety, and depression in various situations. These factors were different for each participant. These are called *‘the struggle with others’ expectations.*

Subtheme Three: The Struggle with Others' Expectations

The struggle with *others' expectations* is about trying to get the right balance between what others expect them to do and what they want to or need to do in their role as working mother. Included in others were family, like husband, mother, father, and sister; friends or people from coffee group. *Others'* also included people on the street, in the mall, at school, at work or people they did not have a close relationship with but interacted with during their day. Each participant had an example of one or more of the expectations these others placed on them that negatively impacted their stress, anxiety, and depression. There were four key elements here, *the expectations to work, the expectations at work, gender role expectations* and *the expectation to do it all, do it right and just get on with it*. Jessica identified this in her interview:

It's really interesting when I look at some of the beliefs that I held around working full-time and what was required of me as a mother, were not necessarily my own beliefs at all. They were beliefs that are coming from my fabulous family, the society that we live in and I realised that I could make a change.

Here Jessica highlighted that at one stage in her life she recognised that the beliefs she held about being a working mother were not her own, but they were learnt and observed in society or her family. Beliefs she did not seem to agree with and decided she could change if she was dissatisfied. This took insight and courage, as potentially going against society or your "*fabulous family*" could not have been easy. All working mothers may not have developed this insight on their own and may need support to change the beliefs impressed upon them by their families and society.

Some participants identified the influence of *others' expectations* on how they perceived what being a 'good' mother, worker, or wife was and the expectations and demands they then placed on themselves. For example, Sarah (50), mother of two boys aged five and two, expressed her beliefs about being a mother and the idea of relaxing, which influences the vicious cycle, "*I can't relax; mothers don't know how to relax. I don't know how to relax. I learnt from my own mother that there is no relaxing.*"

You're always doing something, cleaning the house and managing." Sarah has internalised beliefs about being a mother that she learnt from her own mother, to the extent that even if she wanted to relax, she feels she is unable to do so, as it goes against what it means to be a mother. This belief could encourage the rush and busyness of everyday life for Sarah, as well as encourage the *vicious cycle*, if she does not take time out for herself. In addition, participants identified others' expectations that influenced what they do, how they feel about their roles and how that impacted on their stress, anxiety, and depression.

The expectation to work

The expectation to work encapsulates both the internal and external influences on women to work in today's society. Sarah explained, *"It's good to have children and you want the very best for the children, but reality dictates and society dictates that you've got to work and maybe [because of that] we put too many expectations on ourselves..."* Here Sarah identified the need to work to earn an income which is the *"reality"*. Money is needed as a basic requirement of health and well-being, to provide food and shelter; this is the internal drive for survival. But Sarah also identified how *"society dictates"* order her to work and expects her to obey. The use of the word 'dictate' signals how pressured and obligated she felt to work, to be accepted as part of society. The need to work and expectation to work created the working mother role, which Sarah admits influences working mothers' placing too many expectations on themselves.

Suzie explained:

Not working would have been less stressful definitely because I would have had more time with the kids, but in saying that, we had the Christmas before where I was at home after that year and not having money is almost, it's also stressful.

This is the struggle working mother's face, to work or not to work after having children. Each has its pros and cons as Suzie explained. Not working could mean more time with children but then there is the financial stress that comes with that. For Suzie not having enough money is also stressful when compared to the juggling. So, it seems to be a conundrum that each woman has to deal with.

In most cases, mothers expressed the need to go back to work or find work because of financial pressures to earn or maintain a living. Sarah, highlighted the need to work and the challenges that follow as a result, *"It's important [money] because you need to work to afford the stuff, so it's just trying to juggle all of those balls..."* For Sarah, on the one hand living on a single income created financial pressure in terms of living costs, but on the other hand, going back to work created all the stress, anxiety, and possible depression associated with *trying to get the right balance*.

Money also played an important role in *juggling time, money and energy* and *juggling daily tasks* as it is one of the main resources needed by working mothers to fulfil their role expectations and demands. Being able to keep up with the standard of living in Auckland, *"I think being in Auckland doesn't help because it's extremely expensive"* (Suzie), to help pay the mortgage and bills *"We have to work to pay our bills, so purely from that perspective and to pay our mortgage"* (Anne); be able to provide for the best for their children *"You just want them [the children] to get the best in life and give them what you didn't have..."* (Sarah) and take opportunities for part-time work as there were few of these options for them and afraid they might not get work if they were too long out of the work force. *"I wanted to stay in contact with what's happening [at work]... It is really difficult to find part-time work so that's part of the reason that I went back to work a bit earlier with my daughter"* (Suzie); were some pressing reasons women went back to work after having children. Jessica explained how she went back to full-time work perhaps sooner than she would have liked or wanted after the birth of her second child due to financial pressures.

I suppose working part-time the other thing I suppose was a key stressor for me.... so, for my husband finance was important... but his potential thoughts around that [finance] was different. So, I felt like I'd placed us under a huge amount of financial stress and so therefore I took the baton [to go full-time] as well. (Jessica)

Jessica explained that financial security was important to her husband and he had different expectations about that compared to her. Because of her husband's expectations, she felt like she had placed them under a huge amount of financial

stress, by only working part-time. This then led to her feeling pressured to return to full-time work sooner than she may have liked or wished. Going back to work meant she needed to take the “*baton*”, take on the increased responsibility and commitment of working full-time. Thereby potentially facing the increased stress, anxiety, and depression of *juggling time, money and energy, juggling daily tasks, to be good enough* and *the vicious cycle*, which she later admittedly did struggle with.

As outlined in this subtheme, under *the expectation to work*, women face many internal and external pressures to work which increased their stress. In addition, even more pressure is placed on working mothers in the work place in the form of others ‘*expectations at work*’.

The expectations at work

The *expectations at work* women felt at work came from colleagues or line managers and this influenced their stress, anxiety, and depression. Sarah expressed in her interview, “*People’s attitudes at work have an influence on you and the decisions that you make.*” Sarah acknowledged the vital influence work colleagues and line managers have on the daily decisions she makes. This is a significant influence and since the need to work is driven by the basic needs such as food and shelter, it would be important for working mothers to work well with colleagues to maintain or sustain employment. However, this was not always easy due to negative or unsupportive attitudes from colleagues.

In her interview Suzie described she felt some people at work did not really understand the context of being a working mother, “*they just expect you to be on top of it, whereas sometimes you’re not.*” Suzie alluded to the fact that perhaps those colleagues without children did not understand the struggles working mothers faced and often had unfair or unrealistic expectations of her performance at work. This may have caused frustration and guilt for Suzie potentially increasing stress, anxiety, and depression.

This frustration seemed to be echoed by Anne in her interview. Anne, described her dread at hearing the following comments from colleagues when she tried to reshuffle her work day to take care of her sick four-year-old daughter,

...but I think that from a work perspective it is hard because unless you're working with people that have children they tend not to [understand] - oh yeah okay, they're pulling the kid card, you know... So that can put pressure [on you] because they're just less understanding and so there are comments, so we need to reschedule, oh great, that's because your child's sick, oh okay. Don't worry about anybody else.

Anne explained how unsupportive attitude and comments from colleagues can create pressure for her when trying to reshuffle her day. These are comments from colleagues who potentially do not understand the struggles working mothers face in trying to meet the multiple, complex, demanding, competing, and sometime unpredictable demands of being a working mother. It must be hard hearing and dealing with those comments every time her child is ill, when all Anne is trying to do is be a 'good' mother and take care of her sick child.

Anne had an additional stressor of an unsupportive line manager. She explained how she had to manage her line manager when trying to reschedule her day because her child was sick:

But one of those other meetings, which I knew wasn't really even important or even urgent, but just knowing the personality of the person [her line manager] I was going to be having to give the news to that I'm sorry, I'm going to have to cancel this meeting, I just know because his attitude is very dated. So, it's just ugh, you know. So, I felt that I had to go in on a positive to try and lighten it a bit but unfortunately, you can't change the way that people - their own issues and their beliefs. You can only change how you respond to it and that was really the best way that I could respond to it without giving myself an anxiety attack.

Anne, acknowledged that she cannot change others' attitudes, but she can change how she responds and she tried to do this by bolstering herself and facing her line manager in a productive and assertive manner. This could not have been easy under the circumstances. To provide a contrast, here is an example from Diana:

It's a really supportive workplace. Everyone's got children, so everyone understands, most people do, so everyone's really understanding, which makes it

so much easier. Yes, because I don't have that guilt that if I have to call in and say my son's sick I can't come in they wouldn't be like oh no, so-and-so is going to be angry or anything. There's none of that, there's nobody that's going to be annoyed that you didn't come to work so they're really supportive and it makes it very easy having that.

The contrast between an unsupportive and supportive work environment is clearly highlighted by Anne and Diana's experiences. Understanding colleagues means less guilty feelings having to respond to a sick child. It seemed other working parents were more empathetic and, as a result, more supportive and understanding, perhaps based on their own experiences of being working parents and the struggles they face daily. There are no unsupportive comments and it "makes it easy" sums up the significant influence colleagues and line managers play in trying to juggle work and motherhood.

Anastasia, aged 33, mother of two children aged four and two, worked part-time in health care and studied part-time reflected in the focus group about the expectation of the workplace and being reprimanded by human resources for taking too many sick days.

It's like being told by HR that hey, excuse me, you had 12 sick days in the last 6 months. Then I talked to another person who actually had the same chat by HR saying that, hey you had 15 days over the last 6 months or guess what the difference is? You only work two days a week; she works five days a week. But they use the same tone and same approach. So, it looks really bad when I had to take sick leave. It seems strange now. I would never see it this way before I had children because I thought well you're an employee, you must perform the same task, without realising how much of a strain it is to raise a family alongside. Basically, you're still an employee but it looks so much worse... I wonder if that's another thing. It's the structure of employment... your kind of almost have to have two separate rules about sick leave because all of a sudden you have two children at home, you have four people to get sick, compared to someone who just comes in and out for work by themselves or has a husband or a wife at home. What am I going to do with that? I can't prevent any of us getting sick.

Applying the human resource policy in a one size fits all way perhaps discriminates against working mothers by unfairly labelling them problematic when it comes to taking sick leave. Anastasia questioned whether working mothers should have two sets of sick leave instead of having to take their own sick leave to take care of sick children. She felt the human resource's criteria to caution should be different for people with and without children. She realised that she probably would not have felt

this way before having children but since becoming a working mother and experiencing the associated challenges. She questioned the structure of sick leave policies to be unfair toward working mothers; that women had to take their own sick leave to take care of their children, but also that she was accused and received a caution for taking too many sick days when there was nothing she could do to prevent her children from becoming ill. This seemed very unfair and discriminatory to her.

Sarah reflected in the focus group about the unfair comments she sometimes received from colleagues who work full-time, when she leaves work earlier because she is part-time.

...but also, so when you go to leave at the end of your day – eh it must be, nice? And you go, well, no my pay check is not the same as your pay check. So, you try to let it brush off. So, I suppose those funny little things can be funny and after a while then it becomes annoying, and then you think, maybe I should work full-time? So, then there's other things you want to see your children and take them to school pick them up from school and all these things but also how do you fit everything in.

When Sarah leaves at the end of her day, her colleagues respond sarcastically with 'eh, it must be nice', indicating that leaving early is some sort of privilege or luxury that they do not have as full-time employees. In reality, Sarah works part-time hours, a choice and sacrifice she has made to help her balance her need for money and family responsibilities. While she defended herself, persistently hearing this same comment made her consider taking up full-time employment just to stop those comments. However, being a full-time employee would create a new set of challenges with trying to *juggle resources* and *juggle daily tasks* such as pick up and drop offs and other responsibilities that come with having dependent children. These comments from full-time colleagues towards her seemed unfair and discriminatory.

Many participants reflected on the unfair and unrealistic expectations people at work had of them. It showed mainly in comments people made to participants in the workplace when they had to disrupt or reshuffle their work day, take sick leave to take care of their children or leave early due to part-time work hours. It highlighted the lack of understanding some people in their workplaces had about the role and demands of

being a working mother. Another *struggle with others' expectations* experienced by participants were gender role expectations.

Gender role expectations

Another perspective on the influence of others on participants' stress was discussed in focus group two. The participants in focus group two questioned others' beliefs about the role and expectations of being mother. They discussed babysitting and taking the children shopping when compared to the role of father. Adelaide commented, *"Expectations... you sort of have people who are just like wow, the noble father... Like dad's babysitting - actually he's parenting. Do I babysit my children?"* Anastasia agreed with Adelaide and gave her own example to back up their experiences, *"Same goes when my husband takes the two kids to go grocery shopping, other people are like wow. You can see a mum in a supermarket with three kids not batting an eyelid."*

Anastasia and Adelaide reflected on how when fathers do the same things mothers do, it is evaluated differently by society. A father babysits while a mother just takes care of her children as she should and is expected to do by society. Mothers get no accolades for taking the children shopping with her, but the father does. It seemed men get glorified for doing jobs women traditionally and routinely do. This hints at the double standard of role expectation of parenting and caregiving between men and women in society. These women suggested that society has different expectations of the role of mother versus the role of father. They highlighted the unfairness of this double standard toward themselves and the pressure it creates for them to meet or fulfil these unfair and gender bias expectations.

Most of the women in this study struggled with the sometimes demanding, unrealistic and/or unfair expectations of their mother role as dictated and reinforced by others. This created pressure and conflict for them. Anastasia gave another example from her life when she spoke to people who were her friends. She was talking to them about playing a competitive sport. Her friends then questioned and disapproved of her involvement in sport:

Interestingly in isolation my husband is happy...But then when you are with other people they will comment and say, "Oh so when does he get to play Frisbee?" Then lucky for me his response would be, "I work five days a week, I get two days with the kids, I'm happy." But people's perception and how they feel free to make comments about "Oh so when does he [Anastasia's husband] get to play Frisbee?... well that's not very fair for him, when does he get to play sports?" It puts the doubt in your head that you don't deserve to be out doing all those things. (Anastasia)

Anastasia expressed that she felt "attacked" by her friends; and even though she really had nothing to feel "guilty" about, she made herself feel guilty and thought that maybe she did not deserve to be playing competitive sport. Anastasia felt this way even though she and her husband were happy with their arrangement. Yet, in this instance, the expectations of her friends influenced her to undermine her self-worth.

Jessica, Diana, and Sarah identified how the expectations from other mothers were sometimes unhelpful, out of date, and unfair.

When you've got all this advice coming left, right and centre... I think for me because it was being a new mum and having too much advice. Nothing's ever right. (Diana)

.... I could relate ... expectations of other females. (Sarah)

It's actually really hard isn't it when it is not congruent with who you are. I think that's what I found, best advice, but the generation I was getting it from was a quite a different generation to bring children up in and a lot of it is really good stuff but you kinda yeah if it didn't fit quite right. (Jessica)

This was about other women imposing their advice and in a sense judgement on participants about what they should be doing to be a good mother. Here, the women reflected on how challenging it was to try to conform to the standards and advice about mothering given by peers or their own mothers, especially when it did not seem to fit with who they were as women or mothers in the present day. How they managed or coped with this was unclear.

The constant bombarding of others with their expectations and demands was about what it is to be a good mother in society created pressure and conflict.

Why hasn't she been potty trained? Why isn't she sleeping through yet? Why is she using a dummy? Why do you want to work? Why do you not want to stay at home? Just thinking about it makes me... I find this not supportive at all, I find this not supportive [others' expectations] and this is really stressful." (Suzie, Focus Group Two)

This bombardment by others' is unhelpful and influenced Suzie to feel attacked and guilty about her role and performance as a working mother. This may have caused her to question herself and her abilities, worry about whether she was doing a "good enough" job or the "right thing". Undermining her self-worth and self-esteem. This all feeds in to wider societal messages and consequent beliefs working mothers have about themselves, which is *to do it all, do it right, and just get on with it*.

The expectation to do it all, to do it right and just get on with it

Based on these experiences and messages from others, some participants developed collective views and beliefs about society in general. One of these collective beliefs was highlighted by Suzie, who believed society in general expects mothers to work and struggle, that this is the social norm.

People don't look at you and go, oh I really feel sorry for you because you're working and you're a mum. It's a norm and that is what is expected [from society] nowadays. Yes, you have to clean, you have to cook, you have to do the garden, you have to walk the dogs, you have to be friendly and nice and formal and professional and healthy and sleep well... I think it has become the norm to deal with it [on your own]. It becomes a norm not I think it's a standard way of living now for working mums and it's really, really, really hard. (Suzie)

Suzie described an expectation from society in general for working mothers to do it all and struggling to do it all was the norm; because of which she believed she could expect little or no empathy or support from society in general. While Suzie held this belief about society in general, Jessica experienced the lack of support and understanding from her close family (husband, parents) and GP at a time when she felt very stressed and unwell.

...Earlier my doctor she was like nah it's just normal you know, get on with it. And I just go okay I'm normal I just better get on with it... And it wasn't until about 12 months later that I just said I can't get on with it. There's no more getting on with it... I don't think they understood the gravity of it really. I was really surprised at how they [family] viewed what I'd been going through and their view of what I'd been doing or feeling or whatever was very different, they didn't actually know. My husband knew it wasn't quite right, but they didn't realise the extent. I mean I got to a point where I thought oh God, I've got to have some kind of thing like cancer, I just feel so absolutely awful... For me I just realised you've just got to smack them round and go this is it (laugh) and also just share the load a little bit more... (Jessica)

Jessica's experience supported what Suzie had said, the lack of empathy, understanding and subsequent lack of support Jessica received from her doctor and family, signalled a blindness or nonchalant attitude toward her and her struggles, despite her clearly voicing them. She had to be persistent and amplify her voice and actions before they took notice and stepped in to help. This attitude of get on with it or expecting working mothers to do it all, can lead to working mothers' experiences worsening – getting support later rather than sooner and ultimately negatively impacting their mental health.

Some working mothers perceived and experienced others as not understanding their struggles and, as result, expected or experienced little or no support from them. In Jessica's case this led to a delay in getting help and support earlier which meant she was in a vicious cycle that spiralled downward until she could not get on with it any longer. Jessica suspected that she was depressed during this time. It was a whole year before she was able to get support, and then had to demand her family and GP's help and attention, before they realised what was going on. Jessica was mystified as to how they could not realise she was so stressed and unwell. She considered her role in this and whether she was presenting a "stoic" front and not letting them see how bad she was. Adelaide provided her view on this:

I feel like we're like little lone islands and it's like we sit here in our houses guilty one day, guilty the next and feeling stressed... We sit here in our houses and get depressed and cry all day and get angry at our children and then go out and pretend that everything's fine and happy thinking everyone's in the same boat... We just put on this funny little facade...

Here Adelaide thinks that working mothers pretend everything is fine when it is not because they think they need to be able to do it all. This prevents women from talking about their struggles, feelings of guilt or depression, and isolates them from each other, essentially making them "lone islands".

The expectations of others on participants to do it all, to do it right and just get on with it with little or no empathy or support, possibly influenced some participants to

carry the burden of increased stress, anxiety, depression, and general unwellness for longer than necessary. Participants who were struggling perhaps pretended that everything was fine and did not talk to their families, friends or health care workers because they thought everyone else was doing fine and they should just get on with it. It is suspected that this led to participants being isolated, not feeling understood or getting little support from their family or community when they really needed it. In addition, participants often had to deal with extra stressors described as *ongoing and/or multiple stressful events*.

Subtheme Four: The Struggle with Ongoing and/or Multiple Stressful Events

... for whatever reason in the last couple of years, I just feel like all my resilience has been stripped away.

The result of ongoing and/or multiple stressful events is resilience depletion, having no capacity to bounce back as quickly as before. The quote above is from Adelaide's, a 27-year-old, married, and mother of two children aged four and two who works part-time in retail. Adelaide experienced multiple and ongoing stressful events in a short period of time. She was reflecting on that time about one year ago. Adelaide's experience represented the significant impact that ongoing and/or multiple stressful events can have on someone. More than half the participants experienced an ongoing and/or multiple stressful event, preceding one to four years. These events were major illness, loss of job/income, loss of home, loss of integral social support, work competency issues, and court custody issues. These participants had to struggle with these stressful events at the same time or just following the increased stress, anxiety, and depression of *trying to get the right balance*. Participants described their experiences during this time as "*diabolical*" (Anastasia), "*it was just like a total cloud came over my life*" (Adelaide), "*It was just a nightmare*" (Rachel), "*It was extremely scary*" (Suzie) and it changed "*my whole life upside down*" (Sarah). It was clear by the

women's descriptions of their experiences that all these participants experienced significant increased stress during these times.

Suzie (32), has two children aged three and one. When she was eight months pregnant with her youngest child she contracted meningitis.

... it came out as meningitis. I was in hospital for a week where I was in isolation because they didn't want to expose me to my husband or the toddler. It was extremely stressful because not knowing what would happen with the baby and also some of the medication they haven't tested on pregnant women, so they wouldn't know what the side effects were ... A lot of sleepless nights that last month not knowing, what the baby would be like.

Suzie had to be hospitalised and was isolated from her child and husband during this time. This could not have been easy being separated from her child and her main support at a very vulnerable time in her life. It was extremely stressful for her because she did not know what would happen or the effect the medication would have on the baby. It caused her "a lot of sleepless nights that last month of not knowing" a lot of angst, which could not have been good for her physical or mental health. Suzie described this time as "it was extremely scary".

Rachel (39) is a single mother of one child aged four. Rachel suddenly became the sole custodian of her daughter eight months prior due to issues of unfit parenting with her ex-partner and the father of her child. This was her experience,

Yes, an added stress... I went from him having her every second weekend, which gave me a break for a start and a slight financial break because that's one weekend where I'm not having to do stuff in the weekend, which costs money or petrol or extra food or nappies, whatever. Going to six or seven months of having her full-time... I just had to pick up the extra.

"Pick up the extra" signalled the increased load/burden Rachel had to bear during this period in her life. Rachel went from sharing parenting responsibilities to being the sole parent with no financial or caregiver support from her ex-partner during a seven month period. This was a prolonged stressor which meant she had no breaks from being caregiver and the financial and emotional burden of caring for her daughter essentially doubled. Rachel did not have much family support during this time either. This must

have been a huge strain on her physically and emotionally. For Rachel this period was *“just a nightmare.”*

Anastasia experienced having two children and work competency issues in the space of four years. She had additional roles such as competitive sports woman and postgraduate student. The work competency situation happened when she was pregnant with her second child. She described:

For some reason I feel I cannot perform the same way, I cannot function and think the same way and also having the feedback from my colleague and my supervisor to say is there something going on? Why is it that you are behaving and working this way? It had got to the point that it was jeopardising my professional identity and my work as a therapist. I was actually probably depressed. I think it felt like nothing has light in it. It doesn't matter what I do I found no happiness, either going to Frisbee, going to work. I was anxious about going to work, I worried about going to work, and I worry all day when I'm at work.

It seemed for Anastasia the work competency issues, on top of the struggles of being a working mother, resulted in feeling depressed and anxious. There were too many stressors she had to deal with in a period. Competency issues are a major stressor and having to deal with it on its own would be significantly stressful for anyone, but having to deal with it on top of *juggling time, money and energy, juggling daily tasks* and being pregnant must have been really challenging and taxed her coping skills and resilience to its maximum.

Adelaide experienced multiple and ongoing stressful events in a short period of time. Two years ago, she experienced losing a fundamental support system and losing her home at the same time she was to give birth to her second baby. Then, later that year, their family business was not doing too well, and they had to reduce their income until she could no longer work for the company and was unemployed for a time. This led to having little or no money for a few months. Adelaide described what a crazy time it was for her, it was *“all just was really messy, walking through the mess, it was really full on... crazy stuff happened... ..it was just like a total cloud came over my life.”* This time for Adelaide was *“messy”* and *“crazy”*. It seemed Adelaide did not have time to fully recover from one event when another occurred. There seemed to be no break for

her from significant stressors, leaving her feeling as if a cloud had come over her life. Stressors overlapped in time and perhaps contributed to the messiness of unresolved prior stressors. She said:

For the last couple of years, I just feel like all my resilience has been stripped away, I feel like I've got no resources to even deal with period hormones. It's just kind of like every little thing becomes a big deal.

In Adelaide's case the multiple, ongoing stressors left her with no resilience to cope with *trying to get the right balance*. Adelaide reported having no resilience to cope with little things in everyday life, because of experiencing increased and ongoing stress in a short space of time. It was the number, time period, and intensity that influenced Adelaide's experience.

Sarah a mother of two boys aged five and two. Sarah was the only foster mother among the participants. She became mother to her two children within two weeks through a permanent foster programme. *"I had two weeks. I've gone from an adult friendly home to changing my whole life upside down to be a child friendly home. It's **that** (being a foster mother) [emphasised] **and** working."* Sarah was *struggling to get the right balance* in addition to making some major adjustments to her environment and lifestyle and this was extremely stressful for her. In addition, Sarah felt she was always trying to catch up to other parents, *"...it just feels like for us we're always one step behind other parents"*. Trying to catch up suggested that Sarah might have felt that she was not as good at being a parent compared to other parents, who have been doing this longer than her. This may have contributed to Sarah feeling *"depressed"*, *"not good enough"* or *"not doing a good enough job"* as a parent, which she expressed in her interview.

Conclusion

Anne's words are illustrative of the themes in this chapter,

I don't want to assume that every mum's got the same challenge that I have, which is really about juggling and it's about making it work and having more time for myself, but also for everything else that falls into place. (Anne)

The “*challenge*” in this context is the multiple, everyday struggles working mothers faced, encapsulated in the main theme as *the struggles of working mothers*.

Participants talked about trying very hard to achieve in their role as working mothers, but this was a battle for them – they had difficulty handling or coping with this role, making their way through with difficulty. Struggles were highly influenced by the women's self-perceived expectations; situated within their own experiences, close family and wider society. This was apparent in the self-expectations. The *struggle to get the right balance* was attributed to ‘*juggling, to try and make everything work and have time for themselves*’ in the form of *juggling time, money and energy* and *juggling daily tasks*. *Juggling time, money and energy* was about *the struggle to get the right balance* between these resources, to meet their unique and complex self-expectations and the impact that had on their stress, anxiety, and depression. Whereas *juggling daily tasks* was about *the struggle to get the right balance* between what should, and is, physically or actively done in a day, week, and month to meet their self-perceived expectations. These tasks included activities such as supervising the children, cooking, cleaning and showering, typical work tasks, going out. Trying to coordinate, plan, and execute these tasks required juggling daily which was stressful for working mothers.

Then there was the struggle to cope with “*everything else that falls into place*” that is the struggle *to be good enough, the vicious cycle, and ongoing stressful events*. *The struggle to be good enough* is about *the struggle to get the right balance* between doing enough and feeling good enough. Doing enough is the subjective evaluation of how well women juggled resources and daily tasks to successfully meet their self-expectations. The struggle with the vicious cycle was about *getting the right balance* between taking care of others and taking care of themselves. This struggle emerged

alongside the *juggling time, money and energy* and *juggling daily tasks and the struggle to be good enough* and as a direct result of the busyness experienced by juggling. The vicious cycle represents a cycle of keeping well or staying well. The struggle with *others' expectations* is about trying to get the right balance between what others expect them to do and what they want or need to do in their role as working mother. Included in others were family, like husband, mother, father, sister, friends or people from coffee group. Some more others were people on the street, in the mall, at school, at work or people they did not have a close relationship with but whom they interacted with during their day. Each participant had an example of one or more of the expectations these others placed on them that negatively impacted on their stress, anxiety, and depression. The struggle with multiple, ongoing stressful events were the ad hoc unpredictable stressful events. These events were major illness, loss of job/income, loss of home, loss of integral social support, work competency issues, and court custody issues. More than half the participants experienced ongoing and/or multiple stressful events, preceding one to four years. These participants had to struggle with these stressful events at the same time or just following the increased stress, anxiety, and depression of *trying to get the right balance*.

For working mothers in this study, there was constant or ambient daily stress, in the form of juggling. Alongside and in addition to this ambient stress were struggles such as the struggle *to be good enough* and *the vicious cycle*; as well as many more ongoing and/or multiple stressful events. This first findings chapter paints a multi-level, complex, transactional and dynamic interaction between women, their daily lives, broader society, and the influence this had on their experiences of increased stress.

Chapter Five: Solutions to Issues

Introduction

This chapter, *solutions to issues* will explore participants' descriptions of what helped or supported them to cope with the stressors in their everyday life. Data from both the individual interviews and participants' responses from the two focus groups were used to answer the second research question, '*What do these women identify as solutions to their issues?*' The aim was to identify the main coping mechanisms that participants found helpful in managing their stress. From the previous chapter it is noted that the stress women experienced was dynamic, complex and often unpredictable; this required women to have an array of personal strategies and environmental supports they could draw from at any one time to reduce or alleviate their stress. There were key helpful/useful characteristics of each coping strategy, as well as barriers and limitations of each. Some common strategies were identified but what was most helpful/supportive was unique to everyone; this highlighted both the collective solutions and idiosyncrasies of each woman's needs and specific contexts. It was noted that all participants did not have access to all the same strategies and supports. The main coping mechanisms and subthemes were *prioritising/re-prioritising*, *getting help/support* and *supportive activities*.

Subtheme One: Prioritising/Re-prioritising

Prioritise/Re-prioritise was explained by participants as a process of deliberate action to change or modify self-expectations and complex demands to reach a more meaningful, purposeful personal life and respond to stress on a daily basis. It was both a process and a life skill that supported them to take control over their life, their day to day activities, their time commitment, and life priorities. *Prioritising/re-prioritising* expectations and demands required the ability to judge what was meaningful or important to them in their unique context, helped them to manage frustration, decrease

pressure, limit internal conflict and adapt to ever-changing daily commitments. It allowed for pre-existing boundaries on expectations to be shifted and gave the women a sense of personal freedom to choose what they wanted or needed to do daily. Three subthemes were, *finding my own way*, *planning ahead* and *go with the flow*.

Finding my own way

Finding my own way relates to the process of solving some of the internal conflict, frustration, and pressure that created stress for working mothers in their daily life; with the aspiration to create a meaningful life that works for them and their family. The participants used the following terms “*congruent with who you are*”, “*doing what works for you and your family*” and “*the right fit*” between their expectations, what they do and how they perform everyday as working mothers. This process was explained as reflective and introspective learning, experimentation of solving strategies, self-evaluation of past experiences, and life changes as a woman’s personal journey. It recognised the importance of self-reflection, and reorganising a purposeful life and owning one’s sense of self-importance. It involved a continuous process of stock taking, negotiation of priorities within conflicting situations, and personal and social expectations (i.e. from children, partners, or families and friends) to sync with their ‘identity’ as a woman, a mother, a worker, and a wife. One of the fundamental steps in this process was to continuously adjust daily priorities to include themselves, to make “*my well-being*” a priority by “*putting me right at the top*”. Jessica aged 43, mother of two boys aged nine and four, working full-time in human resources, described her process.

It’s actually really hard [others’ expectations] when it is not congruent with who you are... I think that’s been a really important thing for me to realise over the last few years is actually... you don’t have to be busy for the sake of it... I just want the boys to be so happy and so [to be] a healthy mum.... I decided to put me right at the top... I kind of had to find my own way which was possibly quite different to the way they [her mother and mother-in-law] were. I did find that quite early on... now we’ve kind of overcome it and come to a happy equilibrium... it wasn’t until I came out the other side that I realised how actually hard it was. And how actually different it could have turned out if I hadn’t put some different things in place.

Along the line of that adjustment there included a continuum of self-reflection, self-analysis of one's life and own expectations, one's well-being, readiness and courage to try, experiment, make mistakes and overcome stumbling blocks, and one's skills of negotiating aspects in her life, family, work, and other social commitments. It was a challenging process, one that required courage, resilience, insight, creativity, and perseverance.

The trigger for engaging in the process of *finding my own way* was often a feeling of being really stressed, desperate, or helpless. For example, Sarah stated "*it is quite overwhelming and stressful... I struggle. I struggle being a mum... But I don't know where to go to ... you don't know where to go for help.*" Participants often mentioned that the beginning of *finding my own way* was generally triggered by a strong emotional reaction to their life, an awareness of the impact it was having on their role as mother, and seeking information or help with their issues.

From the data a continuum learning process evolved in terms of participants *finding their own way*, this consisting of three key stages. Participants were at varied stages in this learn, develop, and change process. '*Learn*' is the active exploration of new ways of doing, thinking, or seeking new information; exploring new ways of thinking, modifying expectations, questioning and developing new insights about self or context. '*Develop*' is the active experimenting of these new ways and modifications, a trial and error phase involving addressing limitations and barriers. Change occurred when the new/alternative/modified ways of doing and being were solidified and self-evaluated by women as working for them personally/individually and their family, and was continually being used. To follow are a few examples of participants at different stages in the continuum.

Anastasia realised that:

Actually, the solution is you change your perception. You try to improve your perception of what you have now and try to see the positive of it... I go back to, what is this that we want to do and setting expectations and working on them and constantly changing them, it's almost a solution on its own because you

end up focussing on that instead of the stresses outside because you know you can't change other people.

Anastasia, was in the process of experimenting, building a life upon the belief that she could not change others. Instead she needed to see the positives in her life. This self-reflection might have empowered her to experiment with strategies and reset her self-expectations. Her insights provided a distraction from feeling stressed, by having goals to achieve she felt more content and happy.

Anne explained her process of learning to work on priorities and self-reflection of her roles as a mother and wife:

I do enjoy being a mum, I enjoy being a wife... So, from that perspective that's where I weigh the priorities now... Work is becoming less of the focus and I'm actually okay with that. I don't look at my phone as much now at night. I don't have that need to do that anymore, so it's actually not as important to me.

Anne potentially managed to eliminate the internal conflict she had in navigating her roles as a mother and a worker by assessing her self-expectations versus her behaviour. Anne enjoyed her mothering role, being okay with work having less of a priority, and adopting positive behaviours like stopping checking her mobile at night and refusing to feel stressed or guilty by doing things her way.

For Jessica, *finding my own way* involved her self-identified 'indicators' of a successful working mother:

So, if I talk about my true north [her true purpose] and my indicators, I have lots of indicators along the way to, say we're not quite on the right track and we need to tweak something. If the boys were not happy, were unhealthy all the time, getting sick, having problems at school, that kind of thing, then those would be indicators that something needs to change. But given those indicators are all okay and we are a normal family that has ups and downs and the boys fight but often they're not, yes, we're on the right track at the moment... Yes, that is really helpful for reducing my stress.

Those indicators then became her pointers to navigate and juggle daily priorities and to perhaps give her the direction and confidence to make decisions on a day to day basis. Jessica seemed more grounded in herself and her values, and had developed relevant life skills to support her through any future changes. She would likely have her unique life philosophy and indicators as her compass to navigate her life and the life of her

family. These would be her priorities, formulated from *finding my own way* that would continue to guide her.

In conclusion, the process of *finding my own way* required learning from past experiences, developing strategies and changing one's own perspectives, habits, and behaviours. This process is key to successful coping for working mothers in navigating internal and external stressors in life. The process of *finding my own way* potentially developed self-confidence and resilience. Such process requires working mothers to be flexible, not afraid to unlearn, to challenge their own beliefs, and try new things. At the same time, they needed to be courageous and patient with ever changing worlds, people, tasks, and responsibilities around them

In addition to *finding my own way*, two other key personal strategies were identified under the subtheme *prioritising/reprioritising*. These were managing day to day tasks and activities through planning and organising as seen in the subthemes, *planning ahead* and responding to unpredictable daily changes, *go with the flow*.

Planning ahead

While trying to manage their daily demands, working mothers had to plan and organise themselves, their time, money and energy, and their work and family. This *planning ahead* coping mechanism involved a skill of prioritising daily tasks and then organising, planning, coordinating, daily, weekly, or monthly priorities.

Diana, aged 30, mother of one child aged two and pregnant at the time of the study, worked full time in customer services. Her husband worked as a consultant and could change his start and finish times to suit himself. She described how having established useful daily routines was the best way for her to keep up with her daily tasks.

10 o'clock is the perfect time because my husband leaves between 8.30 and 9 with our son and then that gives me 45 minutes to get ready and maybe put out some washing and then leave and get to work. Then I'll probably get home around 4.30 or just after 4.30 and that gives me time if I need to go to the supermarket or whatever and to get home and I'll start cooking, make dinner.

Diana planned and organised a well-established morning routine. This routine supports her to be where she should be [at home, get to work on time], get done what she should be doing [get dressed, put on some washing, go to the supermarket, cook dinner] in a day, week, or month in a fairly efficient manner. It seemed habitual or effortless; even though it requires complex organisation.

Another positive aspect of *planning ahead* was highlighted by Anne. She compared her experience of being disorganised to being organised.

There's nothing worse when you're exercising and in your brain, you're worrying about oh I've got to get back so that he can go and do that. That's happened to us before. So, now, everything goes on a calendar. It's making sure that when we've got activities taking place or if there are expectations of people's [her, her husband and/or family, friends and work] time that it goes on the calendar and we look at the calendar and just don't assume.... We actually function better when we have more organisation, so we actually have more fun...

Here, the *planning ahead* gives Anne peace of mind, certainty, and assurances that everything will get done and that expectations of who is doing what, when, and where in her family are clear. Anne's *planning ahead* encompassed such things as keeping to a routine, using a calendar, having a plan and a back-up plan, coordinating and negotiating supports such as husband, family, and work to best cope with *daily tasks*. As a result, Anne then would be able to spend relaxing and fun time with her family.

However, habitual routines or plans are largely influenced by constantly changing environments. Diana's daily plan required cooperation from her husband and her child; like the husband needs to take their son out of the house between 8:30-9am, to provide morning relief for Diana. Any disruption in this routine, such as a sick husband or child, will interrupt the routines and her plan.

In contrast to *planning ahead* Sarah, explained that "*you have good days, you have bad days and understanding that kids have good days and bad days and you've just got to go with the flow.*" For Sarah, being organised, planning ahead, and establishing a routine were important, but at the same time a working mother needs to

be flexible and resilient to unpredictable and unforeseen circumstances. This is where the coping strategy *go with the flow* was helpful.

Go with the flow

Unpredictable events in the life of a working mother might include illness, a moody child, the bus not running to schedule, or conflict and tension between role expectations and workplace demands. These unforeseen changes disrupted routines and consequently created frustration, angst, apprehension, and dissatisfaction. For some participants, the thinking of *go with the flow* was useful – some also used the terms “*never mind*” or “*having a realistic view*” – which concerned with an individual ability to accept a situation, rather than try to alter it. For example, Diana said:

I think for us not every day is a challenge, probably just when you have a like a tantrum and something like that or when you're sick... Well tomorrow I have to drop my son in the opposite direction of my work, go back home and then go to work because my husband is going to be away. So, I'm already pre-empting what will happen. Thinking I wonder what time he'll wake up, I hope he wakes up at 7 so I can just toddle him off to his grandparents, so I think it's the anticipation of what's coming up as well. And it doesn't necessarily turn to custard, it just what you thought. What you think could go wrong... you just want to have a realistic view of what it could be like. He'll just go in pyjamas and not eat breakfast.

Here, Diana described the angst she felt when the routine was interrupted due to her husband being away. By having a “*have a realistic view*”, Diana was able to *go with the flow* and felt less frustrated when things did go wrong.

Sarah, in the focus group, remarked “... *and if one child doesn't want to do something you know your timing's out and you're just like oh well or the bus is late or they're early. So yeah, it's ah well, never mind.*” Having a “*never mind*” or *go with the flow* attitude supported Sarah to be more realistic with her own expectations and to give her permission to feel okay about letting things go.

In summary, *go with the flow* was both an attitude and behaviour that followed the realisation that whatever is happening or has happened is beyond one's control. Attitudes of *go with the flow* involved the acceptance of being flexible, being okay with a change plan, and not feeling guilty about not getting all the things done as planned.

This attitude of *go with the flow* might potentially resolve internal conflict and decrease pressure in the life of a working mother.

Women also identified key environmental supports such as husband, family, and/or health professionals which is explored next to provide further solutions to issues.

Subtheme Two: Getting Help/Support from Others

Getting help/support from others was about being able to “share” the tasks and emotional “burden”, or “off load” the everyday burden with their husbands/partners, family members, work colleagues, and health professionals. Sharing the load included sharing tasks and resources (i.e. time, energy and money) to alleviate the emotional burden and vent frustration or worries. Helpful supports explained by participants needed to be practical and relevant (namely financial and/or emotional help). Next, I discuss: *getting help/support from husband/partner*, *getting help/support from family* and *getting help/support from health care professionals*. However, for each helpful support, participants had contrasting experiences. The findings emphasised the key characteristics of these supports rather than the named individuals. What these supports were, how they helped/did not help, and the influence upon a working mother to release women’s stress, anxiety, and depression, as well as the limitations of such supports, is presented in this section.

Getting help/support from husband/sharing with husband

In focus group one, three participants, Anastasia, Suzie, and Adelaide, who were all married, explained that integral to their everyday coping was the husband/partner or father of the child/ren. Anastasia identified this as a “*direct partnership*”, when she and her partner agreed to work together in a mutually beneficial way toward achieving their family goals. This is further explained by Sarah and Diana,

Sarah: If... I need to go for a run or I need to chill out and relax. My husband’s good in the fact that he says, I’ll take the boys off your hands.

Diana: *So, he [husband] does things like that, he can pick him up, he can get some groceries and do all that stuff that I don't really get a chance to do when I'm working.*

Here, Sarah and Diana highlighted what and how they shared the raising of their children with their husbands. They supported each other with work obligations, shared childcare duties such as pick up and drop offs, and supported family routines such as eating dinner together.

Getting help/support from the husband was needed every day. Some husbands were identified as giving emotional support too, although this was less common. Seven of the nine participants were married and living with the father of their children, one participant was not the biological parent but was raising their children in a married, committed partnership. Most participants spoke about their husbands as being supportive, understanding, and that they shared the burden of finances, childcare, and household chores between them.

Rachel, aged 39, mother of one child aged four, was a single mother and had a contrasting experience where she was not receiving any support from the father of her child and did not have a partner.

I don't know what it's like when you've got two people in a relationship. I guess they kind of share the stress of the finances but that's all on me. It's a big burden to carry... I do everything. I mow the lawns myself, I take out the rubbish myself, I clean the house myself, I do all the boy jobs and the girl jobs, there's no one to help with that.

It is clear from Rachel's contrasting experience that having a helpful and supportive partner could in her eyes reduce the pressures of having to be mother and main provider thus decreasing stress caused by conflict between the mother/worker roles.

The partnership nature of the relationship was explained by Adelaide, *"I am the lucky one, I have a fantastic husband and he is just onto it. He is just onto it and he's there and he's present and he's a communicator and has fun with the kids..."* Here Adelaide highlighted the direct partnership and the caring characteristics of the partner

that was helpful and supportive. *Getting help/support from family* was identified as another integral support and coping mechanism.

Getting help/support from family

Getting help/support from family was about close family (close in relationship and proximity) and included practical and emotional support. Practical support may involve childcare, babysitting, and household chores. All participants identified having close family like parents and/or parents-in-law who lived nearby or that could have been helpful if they were living closer.

More than half the participants had family living close by who helped most days or on occasion. Jessica reflected, *"I love it when my mother comes to stay. Well, the washing is done, dinner's cooked, boys are happy, clothes are put away, beds are made, and bathrooms are clean."* Jessica's mother lived about an hour's drive from her, so when her mother did come for a visit she would usually stay over. Her mother helped by tending to the household chores mainly washing, cooking, and general cleaning. This meant that for the time that her mother was there, Jessica could be relieved of the pressure of having to do those chores. She loved it when her mother came to stay because it gave her a break from the demands of doing those everyday chores.

While Jessica had this help and support only occasionally, Diana described how her parents and parents-in-law had a more integral part to play in the management and functioning of her daily life.

Yes, so they [parents-in-law] look after him, they look after my son, two days a week and then whenever we want really. If we said can you come over and look after him or can you look after him on the weekend, we'll just drop him off. So, they're pretty flexible and they can look after him at a drop of a hat... (Diana)

Diana's parents-in-law provide free child-care for their two-year-old son, two days per week. This has enabled both Diana and her husband to work on those days. In addition, they also helped with babysitting whenever it was needed. Her parents-in-law's support helped Diana and her husband to save on child-care costs, work, and

perhaps have a break, go out together or spend time with friends over a weekend.

Diana's parents-in-law only lived 30 minutes away. Diana was grateful that her parents-in-law were physically fit and able to help with their two-year-old son. They were quite flexible and willing to help when needed. Being the only grandson, both parents-in-law enjoyed spending time with Diana's son.

Other key characteristics of helpful, close family supports were, *"Because grandparents are free, so we don't pay them. That plays a huge part of it"* (Diana) and they are trustworthy. The element of trust was implied and confirmed by all participants as an essential requirement for anyone who took care of their children. Grandparents were often portrayed as the source of support that lifted some of the financial burden of child-care and babysitting costs by offering free, trustworthy babysitting.

However, for both Jessica and Diana, it is assumed that parents or parents-in-law could only be helpful and supportive if they had close, caring relationships with them. If either of these key characteristics of being able-bodied, available, willing, and mutual caring were not there, then the support might not be as helpful. For example, Anne, experienced conflict with her mother-in-law who lived about an hour's drive from her.

... I think that potentially some of the conflict that I have with my mother-in-law is because I don't agree with some of the cultural attitudes I guess to being a working mother. My mother-in-law lives in a retirement village, she's not mobile so typically they will actually go up, my husband and my daughter will go up and visit her. I'm not that close really.

Anne's mother-in-law lived far away, and may not have been able to physically look after her granddaughter even if she lived closer. Staying over for a visit was not possible due to her mother-in-law's physical limitations; even if this was not the case, it seemed the conflict they had would have been a barrier to overnight visits. It was certainly a barrier to normal visiting, where Anne would avoid going too frequently. The key message here was that both the relationship and along with being near where characteristics of helpful support from family.

So, while they disappear for three or four hours... it gives me some free time. I'm doing stuff around the house, I'm doing some yoga its great... It's just having a break because I won't be having a break if I go up and visit my mother-in-law I can tell you that I can tell you that. It will just be constant questions and the same questions and challenges really.

Despite the challenges she had with this relationship, Anne got some time and freedom to have a break, to do something she enjoyed, or an opportunity to catch up on some housework while her husband and her daughter visited her mother-in-law. Anne could not benefit from this relationship in the same way as some of the other participants found helpful.

Emotional support and encouragement from family was also important, as

Suzie described:

...advice and just comfort, saying it will be okay, just comforting me. You don't always want to have an answer because sometimes there's no answers, but just listening because one day I'll be the one crying and screaming on the phone and the next day she'll be the one crying and screaming on the phone. So we just listen and an hour later everything's back to normal and you're okay...

In this excerpt, Suzie retold 'sharing' the emotional burden with her sister. She revealed the importance of advice, comfort, and having someone to talk to, that knows you well enough, to allow some emotional release. Suzie's sister recently moved to Australia. She missed her sister and the support and comfort they gave each other. They are able to Skype, but the experience of the support is not the same anymore. For this emotional support to be helpful for Suzie, having her sister live close by, having a close relationship with her, and being able to have frequent access to her was key.

The key characteristics of helpful family supports were that they lived close by, were willing and able to help, provided practical day to day help, did not cost any money, did not cause any conflict, as was the case for some participants, and were people they could trust with the care of their children. These were the supports that were helpful and needed. In addition to close family, participants also sought and engaged with health professionals, specifically in times of high stress and low mood.

Getting help/support from health professionals

Some participants enlisted help from their family doctors, midwife, Plunket nurse, or counsellor. These supports were helpful in a range of ways. They provided information, medication, an opportunity to be listened to, counsel, feedback, and advice in a non-judgemental and empathetic way. Suzie was hospitalised for meningitis when she was eight months pregnant with her second child and her oldest child was one. She had this to say about the support her midwife gave her:

...but for me I was totally knocked down. I must say she was really lovely about it, the midwife, she was an excellent midwife, so she took really good care of me, emotionally as well. I had a lot of days just sitting there crying about nothing, being emotional and hormonal and she would just not say anything and would just sit there, just be supportive... I guess it did help, talking, talking helped or someone just listening... Afterwards my husband and I spoke about it a lot but whilst I was in that situation I couldn't really burden him with it. I didn't feel like I could but looking back at it I probably could have, but I didn't want to.

The significance of this relationship seemed to be about Suzie being able to talk to someone. This created an opportunity for her to unburden herself of overwhelming emotions and worry she had about the health and well-being of her unborn child because of having the meningitis. She was unable to share it with her husband at the time because she did not want to concern him. Perhaps it was the midwife's job to listen that made it easier or more acceptable for her to share her concerns. The relationship needed trust, empathy and non-judgement to enable Suzie to talk about her worries. However, this support stopped soon after the baby was born.

Nicola, aged 34, mother of one child aged 18 months and pregnant with a second child, had a similar experience with her midwife and highlighted the limitations of the Plunket services here in New Zealand, *"...if there can be some group opportunities provided through Plunket, not just a focus on child development but on parental well-being, that would be good"*. It seemed Plunket and the family doctor are the only agencies that have an ongoing role or interaction with mothers after the birth of their baby.

Like Suzie, working mothers in this study explained their engagement with health care professionals or the wider community when they felt really, “low”, when there was “no more getting on with it” or “I just had no resilience, so I had a chat with my doctor”. When things were not going well, they were unwell, they became desperate or scared, they then sought help outside of themselves and their families from health professionals.

Eight of the nine participants accessed health professional support at some point, all during a period of desperation and unwellness. All of them identified limitations and barriers of health care support given by family doctors, midwives, Plunket nurses, and counsellors. Adelaide said:

So, two months later I went back, and I had a scale for depression and anxiety and quality of life done. And he was really I guess impressed at how significantly I had dropped negatively on the scale. So, he prescribed me some stuff.

Later in the focus group she said, “If I could afford counselling I would have started counselling two years ago”. It became clear later that Adelaide would have liked to have had counselling but that the cost of counselling was too much for her. It seemed she wanted to engage in counselling two years prior when she was having to deal with major events in her life, like losing a main social system, losing her home and at the same time giving birth to her second child.

On the other hand, Sarah wanted her family doctor to give her something other than pills but there was no such option at the time. Sarah and her husband are different to the other participants in that they came to parent through a permanent foster programme 18 months ago. They managed with this major transition mainly by themselves with no extended supportive family or friend networks to rely on. However, it was starting to take its toll on Sarah and in desperation she reached out to her family doctor for help and support.

You get to the point where you do become quite low and you don't know what will work and by offering me pills it's not going to make it work... I'm not one for taking pills. So you take the easy option [the pills] or try to work it out yourself....

She asked her family doctor if there was anything else he/she could offer, other than “pills” but there was nothing at that time – she was disappointed at the limited options she was given. She had no choice but to “work it out” herself. Sarah was hoping that participating in this research would help her to work some things out. She said, “*But I don’t know where to go to for you know, you don’t know where to go for help, you know if you don’t have family*”. She was seeking supports external to the family unit, but it seemed there were no suitable options for her.

Jessica had a contrasting experience to Suzie, Adelaide, and Sarah with her family doctor:

She’s a lovely doctor I’ve known her for a long time, she was like nah, it’s just normal you know, get on with it. And I just go okay, I’m normal I just better get on with it. And it wasn’t until about 12 months later that I just said I can’t get on with it. There’s no more getting on with it. She said oh really? You should have told me earlier. I’m like I did tell you earlier!

In her time of desperation her family doctor failed to give her the needed space, time to talk, and support. Only with Jessica’s determination did she finally receive the doctor’s attention and support.

Some participants were able to access and pay for counselling services. When Anne’s husband lost his job this past year, they decided to go to counselling which they self-funded.

... maybe with my husband and we also did a little bit of work around where we caught up, we met with a counsellor just to talk through those changes that were happening and how we were both responding to it. So, he has actually given me some tools around being a bit more aware of other people’s stuff.
(Anne)

Major change like a job loss can be very stressful and create feelings of anxiety, guilt, or depression. Anne and her husband sought external professional help to support them through this major and difficult change in their lives. It gave them a space to talk about what was happening, get some advice and help with how to best manage this change as a couple. Anne was able to transfer the learning of being “aware of other people’s stuff” when managing a conflict with her line manager when her child was sick, and she needed to take off and reschedule.

I put it [being aware of other people's stuff] to the test, obviously I mean this week, but his issues, his prejudices or judgements around parent's full stop, that's his stuff. At the end of the day I'm entitled to a sick leave day, I don't have it often, I'm a great worker, and I have high outputs, get over it...

The strategy she learnt in counselling gave her the confidence and self-assurance to better cope with her line manager's unhelpful attitude about taking time off to care for a sick child.

Jessica was also able to access a self-help programme through work. She was advised to take a mindfulness session as well. Rachel was able to access limited counselling for her daughter aged four, through the courts during a time when they were experiencing custody issues with her ex-partner. Adelaide had accessed free counselling through a church, she commented, *"So there's a lady there who does free counselling. Nobody knows this... How do we know these things?"* Adelaide hinted that while there could be other helpful community based services, such as the church counselling support given by trained counsellors, for free or at discounted costs, she was not aware of them, suggesting they are either not well advertised or that she was isolated and had a limited social network. Alternative interventions such as counselling by private providers were expensive.

The element *getting help/support from health professionals* was related to characteristics of health care providers which are: being a generous listener, empathetic, and non-judgemental. Unfortunately, such characteristics varied across different health professionals. Findings highlighted the limitations of current primary health care services and the failure to meet the needs of working women, especially during the first five years of raising children, when the need for accessing health professionals was most prominent. Additionally, more affordable and potentially more comprehensive community support was not well-known by participants and therefore not easily accessed. It raised some critical questions regarding health services such as how vulnerable, stressed out working mothers seek help offered at primary health care

level and that they have no or very little idea of what else is available to them in their own communities.

Overall, the subtheme *getting help/support from others* with its elements *getting help/support from husband*, *getting help/support from family* and *getting help/support from health professionals*, uncovered the key environmental (external) supports participants employed to help them cope with everyday frustration, pressures, internal conflicts, and change. These external supports were multiple; no support was better or more needed, and each, despite its limitations, had a key role to play in supporting participants to cope. In addition to *prioritising/reprioritising* and *getting help/support from others*, participants also engaged in '*supportive activities*' that helped them cope with their stress.

Subtheme Three: Supportive Activities

Supportive activities may relate to those mundane as well as fun and enjoyable activities that helped women cope with everyday frustration, pressure, and internal conflict.

Work as a supportive activity

Work had multiple meanings when it came to supporting participants in their everyday life. There was '*work as flexible and supportive*', '*work to pay the bills*' and '*work as sanctuary*'. These subthemes highlighted the key characteristics of work that made it helpful or supportive.

Work as flexible and supportive

This subtheme was about the supportive and flexible nature of work that helped participants cope with pressure, internal conflict, or change. A flexible and supportive working environment or context may relate to flexible working hours, employer supports for working mothers, and special allowance such as working from home or childcare

subsidies. The outcome of this kind of work was key to supporting participants. Here is a clear example from Diana:

I got my hours negotiated, doing 10 to 4, so that means I miss the traffic coming here and I miss the traffic going home. We also get a day care allowance of a certain amount... If anything happened and I had to stay at home, if my son was sick, they're really understanding. If I have to leave early and if I have to make up my hours, I'll just make it up another day or just not take my lunch break one day. It's a really supportive workplace. Everyone's got children, so everyone understands... I don't have that guilt that if I have to call in and say my son's sick I can't come in they wouldn't be like oh no, so-and-so is going to be angry or anything. There's none of that... it makes it very easy having that.

Having flexibility of start and finish times, means Diana can have the 'perfect routine' that helped her to be organised and maintain routines that enabled her to be efficient and effective at home. With a flexible work arrangement, Diana did not feel guilty leaving work early to mind her sick child, knowing that her superiors and colleagues were fully supportive of her need to balance work and family. This supportive and flexible environment eliminated any potential distress that occurs when having to deal with the internal conflict of having to choose between work and family demands.

Having a supportive line manager or colleagues and flexible work hours, was identified by all participants as helpful. Flexible working hours may also include work from home options and variations of part-time and full-time employment. The choice and variety with flexible work hours was recognised by participants as the main factor that supported them to balance work and family. Suzie explained the reasons she went part-time:

I wanted to keep the family/work balance... I wouldn't want to work full-time. It is really difficult to find part-time work... if I can't make it to work if one of the kids is not well I can work from home. Yes, they are really, really flexible.

Two aspects that worked for Suzie was the part-time and the flexibility of working from home when and if needed. These were key to supporting her idea of work/family balance. This balance was also important for her well-being.

Participants experienced inconsistencies between employers when it came to offering or negotiating flexible work hours and having supportive colleagues and

employers. Two participants had decided to find new jobs with flexible work hours, as their previous employers would or could not offer that flexibility. Three participants had had traumatic experiences with unsupportive colleagues and line managers and changed jobs as a result. Another two participants were still trying to stay in their current jobs despite dealing with unsupportive managers and colleagues. All participants had, at some point, either changed jobs or requested a change in their work hours after they became mothers to better cope with the demands of work and home. At the time of the research, most of the participants were in a job that they were happy with and enjoyed due to the flexible work hours, but some still struggled with unsupportive line managers or colleagues. Another key function of work was meeting financial needs that will be discussed in subtheme *work to pay the bills*.

Work to pay the bills

Work to pay the bills refers to earning enough income to meet the basic needs of shelter and food. Participants identified the need to earn money and this was achieved through having paid work. It is the outcome of having money that was supportive for participants. “*We have to work to pay our bills, so purely from that perspective and to pay our mortgage. That’s the reality...*” (Anne). In addition, Sarah expressed, “*It’s the cost of having children – the financial cost.*” Therefore, participants needed to work to provide for their basic needs such as paying the bills, mortgage/rent, food, children’s activities or childcare. Having a stable, sustainable, and adequate source of income was essential to meeting those needs.

In contrast, and emphasising the significance of having income, Anne commented:

...not having money... it’s also stressful... If we both weren’t working I would be freaking out. Without doubt I would be freaking out. We would have to sell our home and really curb our lifestyle. I thought I don’t want to do that. I don’t want to quite do that yet if we don’t have to.

Anne highlighted how having an adequate source of income eliminates the increased pressure, frustration, internal conflict, or any significant change in lifestyle that may

occur because of not having any or enough money. As previously discussed, spouses were instrumental in sharing the burden of provider that gave them the freedom, choice and opportunity to meet their daily living needs. The third function of work was the personal meaning it provided for each participant that went beyond needing to work just to pay the bills, this is discussed under the subtheme '*work as sanctuary*'.

Work as sanctuary

Work as sanctuary was the often unobscured and vital function of work to create and preserve self-esteem, self-identity, relieve stress, provide relaxation and a good distraction from routine domestic demands and the chaos they experienced at home. Anastasia explained, "*I enjoy work more than I did before having children because work became my sanctuary. I can just sit there and do my work*". Here, work became her refuge from the disruptions she experienced at home. The work environment protected her from these disruptions as it is more structured and predictable than her home context.

In another example, Suzie explained how work preserved her sanity and made her feeling "*normal*" again:

I would say in all honesty for sanity. Some mornings it is nice to feel normal again... Yes, instead of being in sweat pants or pyjamas all day long and being burped and pooped on (laugh). It is nice to actually have a shower, put on some make-up.

Reengagement in work after the birth of her second child, gave Suzie a break from the monotonous schedule of being a sole carer to her children. Coming back to work brought back past familiarities and routines, which gave her a sense of normalcy. Work restored an aspect of her self-identity and sense of purpose and meaning to her morning routine, to include showering getting dressed [not staying in pyjamas], and putting on make-up in preparation for work, which had been overshadowed by the priorities of being mother. Suzie needed this reconnection to work to reclaim other aspects of her self-identity that may have been put on hold during the first year of becoming a mother. Work gave her the motivation and drive to change her routines

and allowed her to express other aspects of herself such as her skills, strengths, and personal aspirations.

Work created the opportunity to develop and maintain self-esteem. Self-esteem is one's feeling of overall competency. A sense of competence at work contributed to job satisfaction. Jessica highlighted the opportunity work gave her some sense of achievement and self-worth.

...my desire to make a significant contribution [at work], not to be mediocre in what I do, to really take that and run with it and make it happen. The keynote one was very similar, it was me talking to a group of CEOs'. What other HR person gets to talk to 300 CEOs all in one go? It's a huge opportunity to change people's mind sets ...

Work gave Jessica the opportunity to act on a personal goal to make a “*contribution to the world*”, in her own unique way. It was who she wanted to be, it was part of her self-identity. Work gave her the opportunities, self-confidence, and inspiration to fulfil her personal goals. It both created and reinforced the development and showcasing of her competence and consequently boosted her self-esteem and self-efficacy. She valued and believed in herself and was valued by others for her contribution at work.

Besides working for income generation, it provided participants with a sanctuary from the disruptions at home; and work reinforced women's self-esteem and self-identity. The second supportive activity that emerged from the data, was ‘*doing something you enjoy or that's important to you*'.

Doing something you enjoy or that's important to you

Activities like healthy lifestyle - eating healthy, regular and plentiful sleep, going to the doctor; hobbies, walking, running, going to the gym, swimming; spending time with friends and families - dinner out or shopping with family and friends were opportunities for respite, and improvement and maintenance of general health and well-being. Some participants do these activities regularly. Often described as something “*It's my respite*”, “*I always quite enjoy*”, “*I need*”, “*I must*”, “*It's so good for me*” and “*It's so important.*” Most participants identified at least one of these activities they enjoyed and

felt good for their overall health and well-being. Most participants engaged in at least one of these types of activities in their regular daily life.

Anastasia expressed her enjoyment of having time to herself:

I remember hiding a lot. My husband was supportive but just going out to sit to have a meal on my own, it's a luxury that I never realised was a luxury until I had children. I think simple things like that, being the person, I am, I'm not sure if being an only child has anything to do with it but I always quite enjoy my quiet time...

Anastasia's struggle to find a time for herself, suggested a desire to have respite and a quiet time alone built in her daily routine. She explained her need to be 'left alone' as part of the essence of the person she is, connecting it back to her childhood. She was an only child and grew mostly in solitude. Such activity 'to have my time alone' would then revitalise her, 'feed her soul', so to speak. Anne explained her need to have her own time:

...importance of having our own time and having some space so that you can create some more mindfulness I guess. Things like exercise are quite important, even if you just walk down the road and sit on a park bench and don't think about anything that's actually okay. It's those sorts of things that give you kind of a bit more space and you don't get this over active imagination.

For Anne, having time alone or doing an activity like exercise was about clearing or calming her mind or becoming more mindful, focussing on the activity with calmness. This finding may suggest that working mothers need some physical and mental space away from the stress and busyness of everyday life, as a space to recharge, calm their minds and senses and rejuvenate themselves.

Jessica focused on reinstating healthy behaviours: "good diet, exercise, good sleep and happy health relationships pre-children were always there. Having children meant that I had to be very conscious about those things, I had to reintroduce those things." At a time when she was not feeling that great, Jessica decided to make a conscious effort to reintroduce things like good sleep, diets, and exercise to make her feel better. Women like Jessica are resourceful and determined in being able to strive for a better, healthier life – making conscious decisions and concerted efforts to achieve this goal. Yet the environment can be a hindrance to these aspirations.

For Diana, taking time to have dinners and watch movies with friends and family are important. She also liked late night shopping by herself when she had time on her own, free from carrying an extra bag full of nappies and baby's clothes.

It's mainly dinners and movies and then we [with her friends or family] go to the mall, late night shopping... it's time for myself, time on my own. I don't have to carry an extra bag full of nappies and clothes and I can just walk out of the house with my handbag.

Even though she said it was a time for herself, these activities were social. Having time alone for Diana perhaps meant engaging in an activity that was not for or with her son.

Most participants, however, found it difficult to prioritise and find the time to engage in those activities they enjoyed. They identified the prerequisites, limitations, and barriers to engagement in enjoyable activities. A prerequisite was embedded in the process of *finding my own way*. One of the key steps in this process was women's realisation of the importance of meeting their needs and fitting these needs within the day-to-day living. The realisation might require self-consciousness to find their way to doing activities which they enjoy, to take time for themselves, and still feel good about themselves. Yet, some working mothers might continue to struggle finding the balance between the demands of family and their personal needs, and would feel guilty about taking time for themselves.

Secondly, a barrier to having time alone was the availability of babysitters or carers. Many participants relied on their husbands or family. They needed to coordinate and organise their family and resources, which could be difficult.

Lastly, participants' busyness and tiredness were barriers to engagement in 'enjoyable' activities. They had no time or were too tired. It took participants quite a while to re-establish these activities as a regular part of their routine. No average time was determined, however for Jessica the changes began when she decided to "*put her right on top*." For Suzie the time came three years after her first child was born.

So, three years later I'm slowly but surely starting to look at doing things I used to do... The house is less chaotic. Hobbies - swimming for me. Doing a bit of

sport and going swimming, doing a bit of arts and crafts. I think we've got a well-established routine now. My work is settled way more. We have a second income; we can plan ahead a bit better.

Suzie needed everything else like, routine, children, income, and work to “settle” in order to consider taking some time for herself. Diana was able to settle a lot sooner than Suzie, her son was 18 months when she was taking regular time out. Compared to most other participants, Diana was also very well supported by her husband, parents, parents-in-law and extended family. This support played a significant role in enabling Diana to engage in something she enjoyed.

To have some respite, participants needed to prioritise themselves in their planning and organising the family schedule. The process of *finding my own way* supported participants to prioritise their needs and take time for themselves without feeling guilty or stressed or anxious. Jessica explained: “.... *you don't have to be busy for the sake of it... I just want the boys to be so happy and so a healthy mum... I decided to put me right at the top.*”

Conclusion

To this point, emphasis has been drawn to the internal processes, personal strategies, environmental supports and the nature of activities that helped participants cope with their everyday lives. Personal strategies were *prioritising/re-prioritising*, incorporating key aspects of *finding my own way*, *planning ahead* and *go with the flow* of things they had the most control over. Participants looked inward to change and adapt. Environmental supports, *getting help/support from others*, was about getting help and being able to share the burden or load with husbands, family, and health care professionals. The strategies shift from relying on their own personal strengths and resources to seeking external support. The women had less control over these environmental supports and there were limitations and barriers. Lastly was the strategy of using, *supportive activities* such as work and doing things for enjoyment or that was important to them. Such activities provided income, respite, supported and developed

self-esteem and self-identity, and evoked enjoyment. Despite the array of helpful supports implemented by participants, most supports had limitations or barriers. Consequently, participants did not feel they had sufficient supports to adequately address their multiple and complex needs. The third and final findings chapter focuses on participants' '*wishes for the future.*' These include suggestions, creative ideas, and desires for solutions which could better support or help participants, or other working mothers in similar situations.

Chapter Six: Wishes for the Future

Introduction

This chapter specifically focuses on participants' *wishes for the future*, and future aspirations, creative ideas and desires for solutions that could be relevant to other working mothers. In forming their collective ideas on *wishes for the future*, women often framed their discussion with questions regarding perceived barriers to accessing services and support. The immediate environment, including the places where they lived, worked and played were key to their health and wellbeing. Conceptually, they desired greater availability of support in different but interconnected environmental contexts including, but not limited to, health, community services, social support within the community and work environment. This is discussed in the following four themes: *Reorientation of health services*, in response to limited intervention offered by GPs and the cost of health services; *more community connection*, especially when they lack spousal or close family support; *centralised and accessible information* because they were not able to access information easily; and a *more supportive work environment*, creating consistency among employers with work flexibility policies. Interestingly, suggestions made were often within wider social, political and public spheres beyond the environment of women's closely-knit family or friends. In conjunction with the analysis of this theme, and as a starting place to explore possibilities for change within the current New Zealand context, I provide my own reflection on the possibilities and barriers of *wishes for the future*, based on my own personal and professional knowledge and experiences.

Subtheme One: Reorientation of Health Care Services

Women in this study had utilised various health services like the family doctor, midwife, Plunket nurse, sleep expert, and counsellor. However, those services were at times not meeting their needs and could be costly. The Plunket nurse was often mentioned

during the group discussion which may suggest women's familiarity and close association with such services. Plunket is a government funded primary health care service for children, family and whānau. It provides more general support for health and well-being but is not specifically tailored to the needs of working mothers. Women wished for Plunket services to include wider holistic care and referrals to link women with other services, for example counselling, regularly check on women's general well-being and provide screening for depression. Diana noted:

I suppose 'cause we have to have a smear every year don't you, every two years or something. You could have like a well-being mum check as well, as part of it, you know get all your bloods done. How are you coping with everything, what's happening all that kinda stuff? You can't always put off your smear, but if you had this compulsory... Plunket kind of mum check.

Participants also desired positive, comprehensive and non-judgmental services across all health, community and social sectors. As noted in Chapters Four and Five, the hustle and bustle of domestic life and finding balance between being a wife, a mother and a worker, left women with no means to look beyond their daily routine. I would assume regular access to women's wellbeing (i.e. regular depression screening) would mean one less thing for a woman to plan and organise. Further, such services, combined with regular reminders for check-ups, would enable an appropriate prevention strategy. Reflecting on my own experiences as illustrated in Chapter One, I would have hoped, at that time, for a home-visit or mobile services, depression screening and referral services to relevant community-based supports (i.e. working mothers group, mindfulness workshop). Women's desires challenge existing services to work together and toward creative solutions for services to be visible and feasible, and relevant to the life context and needs of the groups being served. Health services need to expand its mandate to support the needs of individuals for holistic well-being and open channels between health, community, social sectors and broader social, political, economic environments such as the community environment and connectedness.

Subtheme Two: More Community Connectedness

Participants highlighted the need to build stronger connections and relationships with their neighbours. They wished for good social connections and close acquaintance with members of their community as a possible means to access supports that are immediate and closer to home. Adelaide explained: *"We're all working mums and you're my people, you're my tribe, but how can I get more connected? It takes a village to raise a child."* A sense of belonging in one's own community, having mutual-helpful relationships with neighbours was important for many of the working mothers, Adelaide further explained: *"I wanna know my neighbour. If I need help I want to be able to go next door and say, oh my gosh, can I just have a cup of tea with you?"* Suzie picked up this idea and stated:

So, if you want to hop out for two minutes doing whatever you can actually go to your neighbour and say, my daughter is sleeping, just keep an eye on her. In a perfect world I think that would be an answer.

Women seemed to look creatively for potential support within their close community as they wished for their neighbours to be a significant source of support for emergency childcare or school pick up and drop offs and a friend with whom to chat and have a cup of tea. I wonder if women were aware of the potential of communities to enhance self-help and social support through more active public participation in promoting the health and well-being for working mothers and other groups. This challenges community based groups and leaders to work collaboratively within their own human and material resources to better enable self-help strategies and improve social supports within their own community actions. Key attributes to neighbourly supports included trustworthiness and reliability. Time constraints and lack of energy were identified as key barriers in forming connections and consequently developing trust. An additional consideration for building stronger community connectedness was whether neighbours were willing and had the space, time and shared similar interest to develop this social support.

Sarah: *"it's making the effort, taking that first step of the trust and building friendships."*

Diana: *"Everyone's so busy... I've probably spoken to one parent in the car park [at day care] for maybe like 5 minutes. And that's been the longest. So, it is a bit hard."*

Anastasia: *"You make a lot of effort, but it seems it just doesn't go anywhere. I love that every three months we had a 'do' [social event for parents] at our day care over the bridge... I tried to keep in touch with them after but it's impossible because we work different part-time days. Then on the weekend I have to study, so there were no long-term benefits for us... I think it really highlights how little time we have."*

These participants understood investing in time with neighbours or other parents, getting to know them, would be essential for establishing trust and reliability. However, the struggles of day-to-day chores made it hard for women to spare the time and energy to socialise. Within their hectic daily schedule, I was not surprised to hear Anastasia wish for an instant solution, which could be challenging in itself:

To me I just want people to have flags, like in the taxi if they're empty or they're not. A flag to know that people... so I don't have to spend time to get to know them... If you have a flag, I'm like oh you're in the same group... If I could just identify people who have the same... not same... if our parenting skills are really similar or expectations. Have a flag so I don't have time to waste to get to know them and realise that oh you're just going to judge me...

Social connection required an investment in time, energy and reciprocity, which is especially hard for working mothers. Anastasia's opt for an 'instant' solution may suggest lack of self-perceived ability, skills or experiences in working with diverse members in her community or previous adverse experiences. Anastasia's idea for a "flag" system, described earlier, was to avoid investing in social relationships; she was mainly interested in temporary and ad hoc practical support such as drop off and pickups and babysitting, which may include small cost.

Online platforms, such as community Facebook page as well as a community noticeboard, were mentioned as a potential way to connect people in their local community. Once again, this calls for more community ownership and control over their collective ability to enhance social support and collective self-help. The use of digital media or an online platform to enhance working women's well-being in a New Zealand

context would warrant further studies. Women also expressed the need to have more centralised and accessible information on topics relevant to working mothers' well-being and sources of support.

Subtheme Three: More Centralised and Accessible Information

Participants desired to have easily and readily available information on various topics relevant to the maintenance of their well-being, including balancing roles as a mother, wife and worker, and supports available for them, their children and family. Existing services were not visible and easily accessible for many of the participants.

Participants lacked knowledge and awareness of what supports, or services are available for them. Relevant services for example, free or subsidised counselling, home help or babysitting for new mothers were often haphazardly found with no obvious systematic organisation; for instance, being advertised in a church newsletter, on the citizen's advice bureau, at the GPs office, on the Plunket noticeboard and local coffee club newsletter. These sites and associated information are not visible unless women visit those centres or participate in those groups thereby limiting accessibility for working mothers in the community. Some of the participants, however, had utilised free community services, including Sarah and Anastasia.

Yeah and it's finding, we're trying to find the services you can hook into to help I guess. But then you, I don't know, I don't know where people are ... (Sarah)

She [a nurse] had all the right principles there, but she had no practical advice in terms of where I can find that help. Go and do something for myself - how am I going to find time to do something for myself when I'm a mum, I work part-time and I'm doing a thesis? (Anastasia)

Adelaide, had once attended a free counselling provided by a local church:

So, there's a lady there who does free counselling. Nobody knows this. How do we know these things? I would love some centralised or some person who liaises with the community, but is also linked into certain kindy's...

Adelaide thought that early childhood centres would be a good place to post information on support services for working mothers. Centralised information, specific to working mothers' diverse and complex issues, which is well-known and easily

accessible, both practically and economically, was desired. Online platform, web-based social media, digital technology, like mobile apps, were useful platforms to store and access relevant information on support, services and practical knowledge. Such knowledge could include, but is not limited to, pregnancy, childbirth, antenatal care, postpartum care and motherhood, depression and general mental well-being, general information on hygiene, nutrition and services, such as affordable childcare and babysitting services in the community, free counselling and working mothers' group.

Online apps are a potentially effective platform for centralised and easily accessed information for working mothers as it gives links to various topics and women could easily search for the information they needed. It would, however, need funding and a reliable authority to manage and make sure women were getting up to date information. A general practice or even a community organisation could possibly take this up, potentially a community organisation that is responsible for the compulsory mum well-being check or a community run Facebook page enabling more community connectedness.

Subtheme Four: More supportive work environment

Participants were aware of the preference of most employers not to offer part-time or flexible work options. It is not a legal requirement in New Zealand for employers to offer or accept flexible work options. Employees have a "right to request"; employers have "duty to consider" but employers can decline for certain reasons, although these reasons are not specified (Employment New Zealand, 2017). Participants, however, desired consistency for flexible work options, as well as a more empathetic and supportive work environment for working mothers with young children. Unfortunately changes in employment regulation may take years. For example, the Parental Leave and Employment Protection Act 1987, Section 1 A Purpose, made no provision for paid parental leave until 2001, initially 12 weeks, increasing to 14 weeks in 2006, 16 weeks in 2015 and most recently 18 weeks in 2016 (Forbes, 2009; New Zealand Legislation,

2016). So, the last 10 years has seen no significant improvement in paid parental entitlement since its appearance in 2001. This limitation of paid parental leave creates financial pressure for women at a time when they are susceptible to mental health issues such as depression (WHO, 2017). Any significant increase in paid parental leave would require law changes to improve and provide more equitable financial resources for working mothers. Another example is the Holidays Act 2003, Section 65 and Section 3 Purpose, which states that an employee is entitled to five days sick leave per year for themselves or to take care of a dependent, such as a sick child. This can create limitations and tension for working mothers when they must take sick leave for themselves and their children. Too many sick leave days could potentially label working mothers as problematic. While the Holidays Act 2003 makes provision for additional leave such as annual or bereavement, a law change would be required to include another leave category for care of dependents and nothing has changed regarding the Holidays Act in the last 14 years.

In, addition participants' desired employers to offer subsidised child-care in the form of child-care centres at or near to their place of work. Sarah argued for the capacity of many employers to support working mothers:

*There's so much more sometimes companies can do, to promote and even promote both women working and men... you know that flexibility of having child-care centres at your work or really close to your work, that are subsidised or encouraged so that you can, in your lunch break, how cool would it be in your lunch break, if you could spend half hour with your child to play. Which you don't have time at home... Where they really encourage family and that kind of stuff. Well-being type philosophies to promote if you're happy at work or if you're happy at home, because they keep talking work/life balance, you're doing more, the company can promote really go forward. Because finding the balance **is** difficult.*

Participants were unsure as to how they could influence changes within their current employment and company culture; changes often beyond their control. Yet they saw the inextricable links between the employee's well-being and productivity, and women realised the important role of a company in creating conditions that are satisfying, safe and enjoyable.

Anastasia offered a more specific argument referring to current sick leave policy as gender bias.

A simple thing like sure you're allocated sick leave, but being a parent or not you get the same amount of sick leave. So, it looks really bad when I had to take sick leave... you kind of almost have to have two separate rules (man vs woman) about sick leave because all of a sudden you have two children at home, you have four people to get sick, compared to someone who just comes in and out for work by themselves or has a husband at home.

Participants also expressed fears of being seen as 'a less capable employee' (Diana), if supposedly they were taking more sick leave or part time work than single or male employees. Suzie imagined for a safe, supportive and satisfying working employment to be integrated in the company culture, instead she was fearful that "... *all this marketing has been done about mums not coping or needing more assistance, I wouldn't hire you* [she speaks from an employer's perspective].

Suzie was aware of the stigma often faced by working mothers in current social and political contexts in New Zealand. She argued that advocating for more support and understanding could exacerbate existing stigma on working mothers as 'hard to manage' or 'less capable employees'. Anastasia echoed: "*You're struggling but you don't want to tell people you are so you're not giving them a reason to be a disadvantage for you, it's like there's no balance I guess... Yes. It's like a secret society (laughter).*"

Reflecting on my previous experience as a working mother with young children, I echo the dilemma faced by participants in this study – caught between fears of being judged as an incompetent worker and voicing their needs. I argue for conscious actions to identify obstacles to the adoption of policies promoting employees' well-being and ways to remove them.

Conclusion

This theme, *wishes for the future*, has emphasised the main and multiple changes participants wished for. *Reorientation to health care services* was in response to the limited supports women experienced from their current health care services.

Participants suggested a reorientation of health services to focus more on holistic well-being – an individual as a whole person.

More community connectedness was a mechanism to access wider practical and emotional support from within the women's own community. Women's needs and desires to get connected with their community have been hindered by time and opportunities.

More centralised and accessible information was about women having access to information they need using advances in telecommunication technology such as online platform and digital technology. An array of information was reflective of their holistic health and well-being needs as a whole person, a mother, a wife, a worker. An online platform was mentioned with caution, as it needs regular updates and quality assurance to ensure the delivery of relevant information and not to overload women with unnecessary hassle.

A more supportive work environment put employees' health on the agenda of the company's culture. A policy/law change would need to be driven by political, community or health sectors and would take considerable time, resource and energy. The suggestion here is largely about building health public policy that is equitable for working mothers and enables more choice and control in their daily lives.

The working mothers in this study suggested an array of solutions to barriers they faced in current social economic and political contexts of New Zealand. Women's wishes and desires for changing practice and regulation were often beyond their immediate control and touched on wider social or community or political discourse and challenged a need for the reorientation of health services. Integral to the change

needed is a wider gender inequality issue, where in general, women have less power which in turn directly influences the type and availability of resources for women (Waring, 2004). Women's wishes *for the future* require considerable intersectoral collaboration, conscious effort to identify barriers to working women's well-being and resilience and ways to remove those barriers.

Chapter Seven: Discussion

Introduction

This qualitative interpretive description study explored the subjective experiences of New Zealand working mothers' stress, anxiety, and depression, and their solutions to their issues. Highlighting women's common, as well as individual, experiences of stress, anxiety, and depression, in order to inform clinical practice in the future, required a research design that was open and explanatory – hence, selection of the interpretive description (ID) method (Thorne, (2016). ID seeks to go beyond simple description to in-depth interpretation, uncovering the relationship between phenomenon; or to see beyond what is merely observed (Hunt, 2009). The two research questions for this study were: *How does an occupational perspective explain working mothers' stress, anxiety, and depression?* and *What do these working mothers identify as solutions to their issues?* Data were collected through in-depth individual interviews and focus groups. Data were analysed using Braun and Clarke's (2006) six stage thematic analysis to interpret findings, through a process of inductive reasoning, constant comparison and recurrent analysis. Three themes were identified. The first, *struggles of working mothers*, explores the multiple, complex and dynamic challenges or issues working mothers faced daily. The second, *solutions to issues*, examined the current coping strategies women used to manage their stress. Lastly, *wishes for the future*, included the reflections on barriers and limitations of existing health, social services, the work environment, as well as community-based support to maintain working mothers' health and well-being.

This chapter begins with a summary of the key findings and then considers the findings in relation to existing literature. Later, the strengths and limitations of the study are articulated and recommendations for future practice, education and research are given.

Summary of Key Findings

The first set of findings, *the struggles of working mothers*, relates directly to research question one, and highlights the multiple, complex and dynamic interaction between working mothers, their social, physical and cultural environment and daily activities that impact on their mental health. It presents the chaotic and unpredictable nature of working mother's daily lives when they must constantly reprioritise and negotiate tasks. Working mothers are continually striving to get the right balance between self-expectations, family and work demands, and consequently they often neglect their own needs and well-being. Concurrently, they must cope with unpredictable or stressful events such as major illness and losses including job/income, home and social support, which were often beyond the woman's control. Yet, working mothers continue to strive towards positively adapting and coping with these enduring daily changes and pressures – this is *the struggle of working mothers*.

The second theme, *solutions to issues*, highlights the variety of personal strategies, perceived environmental supports and activities that women used to navigate their daily struggles. This theme answers research question two. Working mothers strive to achieve the best they can be as a mother, wife and worker. Participants in this study were resourceful and endeavoured to be resilient. Working women used skills and knowledge to problem-solve, improve time management or prioritise/reprioritise potentially unpredictable daily activities. Women might have learned some of the abovementioned skills from their own mothers, close friends, previous experiences or simply by trial and error. However, women were doing all they could or knew about to positively adapt and cope with struggling.

Working women also highlighted the importance of support from the environment. Environment is the external context wherein people live, work and play, and includes physical, social, cultural and institutional aspects (E. Townsend, A & Polatajko, 2013). Participants were appreciative of received support from others such as sharing childcare, household work and financial support. Health professional

support and advice relieved daily demands and helped mitigate stress and anxiety. Sources of support included close family members, husband/partner, and parents/parents-in-law, members of their community and health professionals. Types of support varied accordingly (see Chapter Five). The key characteristics of meaningful supports were identified as being reliable, easily accessible, based on trust and a good relationship, and free. Empathetic and non-judgemental health professionals were identified as most helpful.

Not all women, however, had supportive/husband's partners or family close by who were willing and able to help; nor had they met empathetic and responsive health professionals in time of need. Health professionals might have failed to understand and respond to a woman's concerns in a timely manner or refer the woman to the appropriate channel. Health and community supports for working mothers might be scarce or not relevant, limited or costly. For example, home visits by a Plunket nurse generally become less frequent as the baby gets older. Thus, those women who had access to helpful external supports had an advantage over those without.

The participants also identified supportive activities (leisure or enjoyable) that gave them a break from feeling stressed or as a stress outlet. For example, work (flexible arrangement) had multiple benefits for women's well-being, not only for financial needs but also as sanctuary from the tasks of day to day mothering. Enjoyable activities such as incorporating healthy eating habit, exercise, hobbies or socialising with friends and family offered respite from mothering and improved women's health and well-being. However, trying to incorporate these enjoyable, fun activities into an already busy schedule of a working mother is challenging and may take years to develop into a routine pattern.

The final findings, *wishes for the future*, observed the importance of societal support both for getting *more centralised and accessible information*, and the need for *reorienting* current health and social services and creating a more supportive working

environment. The crux of these findings, in Chapter Four, was that women were asking for creative solutions within their existing services, including primary health care services, workplace and community connection. These may require broader changes to health, social domains and employment, or policies related to work. On reflection, I became aware that my participants were a bit 'vague' in their responses which perhaps reflected their uncertainty or lack of knowledge of what could be done to change their circumstances. I am aware that perhaps it was the first time that someone had asked about their wishes for the future.

All their *wishes for the future* seemed to be around things women had little or no control over. What was clear to me was that women's *wishes for the future* brought with it, its own set of challenges that perhaps added to the complexity and challenges of working mothers' experiences of stress, anxiety, and depression. The findings suggest that it is perhaps the socio-cultural and political environment that is the least supportive and requires the most change to improve mental health outcomes for working mothers. For this reason, women would need considerable support and resource to enable these changes for themselves at political, social or health service level.

Evaluation of Findings in Relation to Existing Literature

Occupational perspective on working mothers' issues

This study contributes an occupational perspective on New Zealand working mothers and offers an in-depth interpretation of women's subjective experiences using a qualitative research design. It adds a different and new perspective on working mother's issues as no study was found that examined an occupational perspective of working mothers' stress, anxiety, and depression. Studies found in the literature used quantitative designs to identify, rate the satisfaction or importance of, or see the relationship between factors, using logical regression methods, of key influencing factors on working mothers' stress. To recap, the occupational perspective used in this research brings to the fore that occupational engagement is a basic need and a contributing factor to health, well-being and quality of life (Kirsh et al., 2009).

Therefore, an occupational perspective encompasses what individuals do every day or with others, how they live and seek identity, organise their lives, make choices to cope with their stress and how the environment supports or does not support their mental health (Whiteford & Townsend, 2011).

The findings in this study confirmed that working mothers find trying to balance work and motherhood a daily and ongoing stressful challenge, a fact widely supported by international literature (Cooklin et al., 2015; Kodagoda, 2010; Sumra & Schillaci, 2015; Vercruyssen & Van de Putte, 2013). In conjunction, it has been established that this stress from trying to balance work and family often negatively impacted on physical and mental health, while enduring stress led to fatigue, anxiety, distress and anger (T. D. Allen et al., 2000; Cooklin et al., 2015; Eby et al., 2005; Nomaguchi et al., 2005). This result confirmed that similar to working mothers' worldwide, New Zealand working mothers experienced increased stress and are therefore of increased risk of developing major depression. This supports a need for

this population to have access to comprehensive health promotion and prevention strategies to slow down or eradicate the progression of depression.

Well known factors, such as work (Brummelhuis & Lippe, 2010; Buehler et al., 2011; Chang et al., 2014; Cooklin et al., 2015; Gronlund, 2007; Kossek et al., 2011; Strazdins et al., 2010), family (Hill et al., 2004; Sumra & Schillaci, 2015; Voydanoff, 2005) and society (Hinnant, 2009; Roy, 2008; Sperlich et al., 2013; Sullivan, 2015; Sumra & Schillaci, 2015) were found to contribute to working mothers' stress. This study reiterated and reemphasised work, family and societal factors as significant contributors to working mothers' stress, as supported by several other international quantitative and qualitative studies. It seems imperative then, that these factors are analysed and addressed both singularly and interactively regarding working mother's mental health. However, very little is known about the transactional or contextual influences of family, work and society on working mother's mental health. An occupational perspective can explicitly uncover and contribute these transactional influences.

Hence this study adds and emphasises what is currently known about women's subjective experiences and contexts of work, family and society; highlighting the multiple, complex and dynamic interaction within and between these three elements. From an occupational perspective, further contextual and dynamic understandings of routines, choices and the subjective meaning and value work, the key characteristics of helpful family support and societal support, and how women managed these supports to influence their experience of stress were identified. This occupational perspective on working mothers' stress also supports the emerging concept of 'work-family system stress' or work-family interface stress', the stress of "trying to balance multiple roles" as identified by Vercruyssen and Van de Putte (2013, p. p.354). In doing so it opens up an opportunity for the notions of occupational balance discussed later in this chapter.

Women's mental health

The findings in this study showed that working mothers experienced acute, multiple, ongoing and accumulative stress in their daily lives. These types of stress have been identified as risk factors for depression (Heim & Nemeroff, 2001; Kendler & Karkowski, 1999; Kessler et al., 2003; Ministry of Health, 2012a; Mundt et al., 2000; Nanni et al., 2012; Schurer et al., 2016; Tennant, 2002; Vinkers et al., 2014; Weiten et al., 2014; Wiegner et al., 2015). Additionally, this study confirmed the types of physical and emotional stress found in working motherhood as created by negative life experience, multiple role pressure, gender discrimination and related socio-economic factors; factors that are well known to contribute to women's poor mental health (Belle, 1990; Beyond Blue, n.d.; Bifulco et al., 1991; Brown, 1998; Felitti et al., 1998; Macran et al., 1996; Mullen et al., 1993; Patel et al., 1999; Salsberry et al., 1999; World Health Organization, 2017c, n.d). The study supports the Mental Health Foundation (2014), the Mental Health and Addiction Service Development Plan 2012-2017 (Ministry of Health, 2012b) and the World Health Organization (2017b) position that working mothers' susceptibility to depression may be part of the reason contributing to women's overall increased risk depression both globally and in New Zealand. By virtue of being an at risk group for depression, the findings and literature provide a rationale for the implementation of more comprehensive mental health promotion interventions at primary health care level for working mothers as highlighted by Ekman et al. (2013), the Mental Health and Addiction Service Development Plan 2012-2017 (Ministry of Health, 2012b) and the World Health Organization (2017b), that could include occupational therapy.

Gender influences

The findings of this study identified the influence of gender role expectations in contributing to working mothers' stress. This is congruent with the knowledge that gender is a key determinant of women's mental health (Bracke, 2000; Kueher, 1999; Lipman et al., 1997; Macran et al., 1996; World Health Organization, n.d) and that gender stereotyping has implications for women's choices, their behaviour and

subsequently their experiences of everyday life (Sullivan, 2015). Despite the acknowledged importance of gender on women's mental health, there is a paucity of research in this area (Sullivan, 2015). Therefore, this study adds to the existing body of knowledge by explaining the relationship between gender, choice, behaviour and everyday experience in the theme *the struggles of working mothers*, particularly the subthemes *self-expectations*, where self-perceived gender role expectations underpin the subthemes of *juggling to get the right balance* and is reinforced by the subtheme of *struggle with others' expectations*. Conversely, stress is alleviated when women go through the process of *prioritising/reprioritising*, explained as theme one in Chapter Five, a process of deliberate action to change or modify self- expectations and complex demands to reach a more meaningful, purposeful personal life. Therefore, gender influences should never be overlooked in understanding and supporting working mothers' experiences of stress, anxiety, and depression in everyday life. Health care professionals, health sectors, stake holders, policy makers, community organisations, employers and working mothers' should have a sound understanding of the impact of gender roles on woman's mental health, in order to develop any sustainable supports or make any lasting impact or change for women's mental health.

Occupational perspective on working mother's solutions

An important finding in this study was the identification and analysis of the coping strategies women used to manage their stress. Although noted as a gap in the literature on working mothers' stress, it was clearly revealed through an occupational perspective. Women identified an array of personally implemented strategies/activities and environmental supports that were helpful in reducing their stress. The findings identified what, why and how the strategies were useful in supporting women to manage their stress, as well as the limitations and barriers of these strategies. The array of personal strategies and environmental supports aligned with Weiten et al. (2014) three constructive coping mechanisms. These are 1)

appraisal-focussed, applying rationale thinking such as in the subtheme *prioritising/reprioritising*; 2) problem-focussed involving active problem-solving such as time management and seeking help as noted in *planning ahead, getting help/support from others* and *wishes for the future*; and 3) emotion-focussed, strategies to relieve stress through relaxation, exercise or distraction, as apparent within the subtheme *doing something you enjoy or is important to you*. These constructive coping mechanisms are supported by Kleinke (2007) and Moos and Billings (1982).

Overall, women implemented a range of constructive coping mechanisms that indicated they were a resourceful and resilient group. However, not all women knew about or implemented all the strategies, limiting their resources and resilience, potentially making them more susceptible to not coping effectively. Enduring and accumulative stress, as identified by Vercruyssen and Van de Putte (2013) and Weiten et al. (2014), taxes constructive coping mechanisms and depletes resilience, making individuals more susceptible to developing major depression as supported in Chapter Four, subtheme four: *the struggle with ongoing and/or multiple stressful events*. Despite the range of constructive coping mechanisms that women implement, stress can undermine these strategies and increase women's susceptibility to mental health issues. Therefore, health professionals should assess and consider supporting working mothers to implement an array of helpful coping mechanisms, as a potential means to better support mental health and combat daily stress and anxiety.

Environment

The findings identified that environmental aspects such as *getting help/support from others* had barriers and limitations. The environment has been highlighted as an important determinant for individual's health, well-being and quality of life (Whiteford & Townsend, 2011; World Health Organization, 2017a). Hence, the barriers and limitations of the environment are of great significance to working mother's mental health and should not be overlooked by health professionals and working mothers.

Stressed, anxious and depressed working mothers with limited family, health, social and community support should be identified as at high risk for depression.

The analysis of working mothers' solutions highlighted the complexity of working mother's needs, while simultaneously illuminating the range of coping mechanisms woman used and needed, as well as the main barriers and limitations of environmental supports. Findings suggested that working mothers both collectively and individually were doing all they could or knew about to positively adapt and cope but that this was not enough to comprehensively support them, hence the need for future changes in the primary mental health care sector in New Zealand.

Woman's future aspirations/ changes and health promotion

Findings highlighted that it was the environment such as health, social, community and the context of work that was the least supportive and required the most change to improve mental health outcomes for working mothers. While the literature clearly identified work, home and societal environmental factors and their respective characteristics and limitations (Brummelhuis & Lippe, 2010; Buehler et al., 2011; Chang et al., 2014; Cooklin et al., 2015; Gronlund, 2007; Hill et al., 2004; Hinnant, 2009; Kossek et al., 2011; Roy, 2008; Sperlich et al., 2013; Strazdins et al., 2010; Sumra & Schillaci, 2015; Voydanoff, 2005), it did not clearly articulate how the health environment impacts on women's stress or what could be done to create more supportive environments from women's perspectives. This study contributes to understanding how the health environment impacts on women's stress and what could be done to create more supportive environments. Strategies that could be useful for health professionals, health sectors, policy makers, community organisations, employers and working mothers when trying to support woman's mental health.

Women identified the helpful characteristics and limitations and sought changes to how and what is delivered from health services. Women wanted stronger community connections, more centralised and relevant information and a more

supportive work environment. Besides work, where the literature acknowledged that there was an increased trend of work places establishing family-friendly policies (Brummelhuis & Lippe, 2010), the policies did not guarantee optimal work supports for working mothers, employers had to action these (N. J. Allen, 2001). The findings confirm that there is much inconsistency and variation between family-friendly policies, such as part-time options and flexibility policies amongst employers in New Zealand. There is a need for some mechanism to ensure consistent actioning of family-friendly policies across employment sectors. This consistency is likely to create more equitable resources and supports for working mothers, thereby contributing to achieving gender equality in New Zealand society; as well as better support working mothers to cope with the ongoing stress of trying to balance everyday life.

The literature did not specifically address stronger community connections and more centralised and relevant information, this is a significant gap. Therefore, this research offers some much needed preliminary ideas for health professionals, health promoters, policy makers, community organisations, employers and stakeholders of how to create supportive communities, reorient health services and build healthy policy to better support working mothers. These ideas align with the key cornerstones of health promotion (WHO, 1986) and supports a shift away from individual behaviour towards a wide range of social and environmental interventions for working mothers (WHO, 2015).

Another significant finding about future solutions were that the aspects of the environment women sought to change were considered externally controlled and beyond their influence; and that they were possibly too stressed, busy or tired to enable any change. From a health promotion perspective there is potential for broader interventions such as advocacy for more comprehensive mental health support, enabling equity and providing mediation between working mothers and sectors such as health and community in the pursuit of better mental health for working mothers (WHO, 1986).

Occupational balance/lifestyle balance

This study revealed that working mothers find trying to balance work and family stressful, and this puts them at risk of mental health issues such as depression. A concept from occupational science that is relevant to this population is occupational imbalance, doing too little or too much, always being rushed or tired, bored or dissatisfied with life (Wilcock & Hocking, 2015). An occupational perspective on working mothers' issues helped to identify those key aspects of everyday activities, routines and choices and environment that contribute to imbalance and increased stress. There is some support from these findings that an occupational balance approach could be useful as an additional intervention to support working mothers to cope; underpinned by multiple authors in varying disciplines (Greenhaus & Powell, 2006; Matuska & Christiansen, 2008; Wagman, Hakansson, & Bjorkelund, 2012; Westhorp, 2003). Wherein occupational/lifestyle balance is broadly considered the extent to which someone is involved and satisfied with their lives. An occupational perspective on balance would focus on integrating all aspects of the individual, environment and daily activities that both increased and alleviated stress, provide individual as well as group or population or systems assessment and intervention.

Further, the findings identified working mothers as an at risk group for major depression and that primary health care services are currently not comprehensive enough to address working mother's needs. This indicates a potential role for occupational therapy in providing occupation-focussed mental health promotion intervention in primary health care in New Zealand. This is supported by Wilcock and Hocking's (2015) second level of prevention, early recognition and stopping of illness, and Wilcock's (2006) second level of promotion, people at risk of experiencing illness to change behaviour or prevent further progression of the illness. In addition, this potential role is reinforced by both international, local and the occupational therapy profession's recommendations to provide more comprehensive mental health promotion (Ekman et al., 2013; Ministry of Health, 2012b, 2017b; New Zealand

Association of Occupational Therapy, 2009; Occupational Therapy Board of New Zealand, 2004; World Health Organization, 2008). Further to this potential role, this study's findings provide occupational understandings of working mothers' stress, anxiety and depression on which to develop the role and nature of occupation-focussed health promotion interventions. The findings also hint at a broader public health role focussed on creating supportive environments, healthy public policy and reorientation of health services to better support women's mental health from a health promotion and occupational perspective.

Implications of this Study

This next section draws attention to the implications for practice and education based on the analysis of the findings in this research.

Implications for practice

This research has shown how working mothers' experiences of stress, anxiety and depression are influenced by complex, multifaceted, interrelated and at times unpredictable factors, congruently highlighting the need for multiple, multi-sectoral support and change to more comprehensively and effectively support women's issues. This has three main implications for practice, namely developing occupation-focussed health promotion interventions for working mothers, considering a broader role in social determinants of health and improving comprehensive clinical services at primary health care.

The current research posits a health promoting role for occupational therapy focussed on promoting occupational balance for working mothers. This is congruent with the literature that highlighted manageability, personal meaningful occupations, and occupational balance as occupational pattern-related health indicators for women of working age (Hakansson et al., 2009). Occupational therapists are advised to focus on these indicators to support women to develop strategies that promote health and prevent increased stress (Hakansson et al., 2009) alongside developing "a satisfying pattern of daily activity that is healthful, meaningful, and sustainable

within the context of his or her current life circumstances” (Matuska & Christiansen, 2008, p.11). Lifestyle redesign interventions offer a way to increase participation in identified meaningful activities for life satisfaction and have a positive impact on physical and mental health (Horowitz & Chang, 2004).

However, much broader than this is the value of an occupational perspective in public health, addressing those social determinants of health and occupational imbalances that occur as a result. Women overwhelmingly identified their future needs as relating mainly to environmental changes. Their *wishes for the future* included stronger community connectedness, reorientation of health services, more centralised and accessible information and greater support at work. There is the possibility for an entity (health, social, or community) to provide individual support and/or group support, networking, access to comprehensive information and advocacy that is accessible, diverse, affordable, and useful to working mothers’ issues. For example, working mothers’ support groups, psycho-education on how to keep well, early depression online screening tools, an online forum or community noticeboard with relevant information and networking opportunities. Practitioners and representatives in social, health, and political sectors could more actively create supportive environments, address cultural change, equity, and the determinants of health in the prevention and promotion of women’s mental health.

Occupational therapists need to consider their broader role in public health and as agents of change at a population, societal and systems level (Hocking, 2013). This may include contributing towards gender mainstreaming, the process of evaluating and designing policies and programmes at political, economic and societal level to ensure women and men benefit equally and gender inequality is not maintained (World Health Organization, 2011). A gender perspective on working mothers’ issues and experiences helps with understanding the fundamental underlying and often uncontrollable historical, socio-economic and political factors influencing working mothers’ experiences; shifting the focus away from personal

responsibility to a wider social and political impetus, as emphasised by Sullivan (2015). Therefore, gender influences should never be overlooked in understanding and supporting working mothers' experiences of stress, anxiety, and depression in everyday life. Sick leave, flexible work policy and the gender pay gap require change as there is still much inconsistency and variation between policies amongst employers. Such changes require multi-sectoral collaboration, consultation and action that is far above the responsibility and capacity of working mothers alone. Occupational therapists could individually, collectively, or in collaboration with other professions (health promoter, social workers), community organisations and working mothers develop submissions, petitions, run awareness campaigns with political, social, community and work entities to achieve gender equality.

Current primary health care services are not comprehensive enough to adequately address the complexity of working mothers' experiences of stress, anxiety, and depression or their subsequent health and well-being needs. Most participants found the intervention strategies limited or inadequate for their needs, hence issues linger or do not get resolved and unwellness persists. This research concludes that working mothers could potentially benefit from occupation-focussed health promotion interventions that support them to increase control over and improve their health and well-being, thus adding to the diversity of care being offered at primary health care level. It will be the obligation of both the primary health care system and occupational therapy as a profession, in collaboration with working mothers, to drive this change in service delivery. A starting point for occupational therapy would be by investigating the effectiveness of occupation-focussed interventions for this population at primary health care level and to establish research evidence to underpin change recommendations.

Implications for education

I have included this section as I am an occupational therapy educator and wished to extend recommendations to include educating current and future practitioners. This research supports a push toward a population health focus and addressing the social

determinants of health. These are new areas of practice with limited practical examples. Education should provide students with opportunities to learn and more comprehensively understand public health related concepts, how they interrelate and the impact on client populations; and provide the opportunity to explore ideas for the role of occupational therapy in public health. This will support the enhancement of skills and knowledge needed to advance this area of practice such as becoming catalysts for political, social and health sector change to improve engagement in occupations for populations and the ability to work in a multisectoral and interprofessional way.

Health promotion education could consider adding skills and knowledge about an occupational perspective and ways to work interprofessionally with occupational therapy colleagues toward common goals such as influencing the social determinants of health, strengthening community action and building health policy. Similarly, doctors, nurses, Plunket nurses and midwives who provide primary health care or health promotion services could benefit from learning about working mothers' issues from an occupational perspective to enable them to more comprehensively assess and provide relevant supports to improve mental health outcomes for this population.

Strengths of the Research

To my knowledge, this is the first study (nationally and internationally) contributing an occupational perspective to working mothers' experiences of stress, anxiety, and depression. The findings add to the sparse qualitative research within the balancing work and family literature. There was much demographic variety of participants regarding age, ethnicity, number and ages of children, types and hours of work, partners' work situation and family support that justify and support the findings.

Limitations

This was a small scale study limited to one geographical location and therefore is not indicative of experiences of all working mothers across New Zealand. Thus, it is a snapshot into the experiences of working mothers' stress, anxiety, and depression and a starting point to further expand on research with this population. As with other qualitative studies it was never the intent to generalise the findings, rather to find commonalities and differences of experiences that could inform clinical practice. It was a homogenous group, all urban based, all in employment and all, except one, had a partner. Many voices were not represented, for example more single mothers' experiences, same sex parents, those from rural settings and a range of other cultures. Considering this was a study focussed toward a New Zealand context, the voice of Māori is not present and would add significantly to future research. Thus, further research is needed to address the comprehensive context of New Zealand.

Recommendations for Future Research

As a result of this research, further ideas and needs arose for future consideration. A larger study, with more participants and greater geographical area and demographic variety to compare and contrast the findings would be beneficial. Since environment plays a key role in determining individual health, well-being and quality of life (Whiteford & Townsend, 2011; World Health Organization, 2017a), further and more comprehensive consideration of environment on women's mental health is needed in the future. For example, an investigation into the significance of political, social and gender influences on working mothers' mental health; qualitative studies that gather subjective and collective experiences and draw out the transactional and contextual nature of women's experience; in conjunction with studies using an occupational perspective, will develop a more holistic picture of women's needs and contextual influences. This would include studies investigating the role of gender inequality on women's issues, as this is currently understudied.

Further research is needed to develop and evaluate occupational therapy or interprofessional strategies that create more supportive environments, build health public policy and re-orient health services to improve mental health outcomes for women. Conducting a comprehensive audit of existing health, social and community services to gain a more comprehensive picture of what is available to working mothers and comparing that to their experiences before implementing any new strategies would be a useful starting point. These investigations into potential environmental strategies would support the broader role of occupational therapy in public health and encourage intersectoral and interprofessional collaboration.

More research is needed into potential occupation-focussed interventions such as a lifestyle redesign programme for working mothers in New Zealand, to address the issue of occupation imbalance. Redesigning Daily Occupations (Eklund & Erlandsson, 2011), as analysed in chapter two, may be a viable option, but this would need to be evaluated further. Collectively research into environmental influences on working mothers' mental health, developing community supports, building health public policy, reorientation of health services and developing occupation-focussed health promotion intervention at primary health care will all lead to creating more comprehensive care for working mothers in the prevention and promotion of women's mental health.

Reflection

When I embarked on this research journey, I held a narrow view of what I wanted to do and the outcome I wished to achieve. This research was to be a neat, manageable piece of work and provide me with some key ideas for the role of occupational therapy in primary health care. I was trapped in this way of thinking for much of the time while conducting the research. However, I was challenged at every turn, how I did my data analysis, how I presented and critiqued the literature review, my depth of analysis of the findings, my understandings of key concepts like an occupational perspective, social determinants of health and gender inequality.

I was open to new understandings which gave me a sound understanding of an occupational perspective, a broader, more holistic approach that includes the importance of the social determinants of health. This realisation led me to reflect on and critique the formulation of my first research question, *How do occupational factors influence working mother stress, anxiety, and depression?* I then modified the question to more aptly reflect the inquiry of this research, *How does an occupational perspective explain working mother stress, anxiety, and depression?* This question still fitted with an ID methodology. The findings, as a result, grew to be multifaceted and interrelated. I was no longer able to fit the complexity of women's issues and needs into one role – the health promoting role of occupational therapy in primary health – and was compelled to put emphasis on the wider role and value of an occupational perspective in public health in addressing the social determinants of health and how well it complements a health promotion perspective. As women's experiences were uncovered to be complex, multifaceted and interrelated, I found my research experiences strikingly similar.

On a personal note, I found it reassuring that some of the findings mirrored my own experiences, such as not getting enough, or the right supports from primary health care services, and how an occupational perspective would have been helpful in supporting me to navigate my challenges. Although, more alarmingly, it seems nothing much has changed in the primary health care sector to more comprehensively address working mother's needs, since my experiences in 2004. I also gained further insight and appreciation for the challenges I face every day, even though I thought I had reconciled myself to this years ago. I have gained some new strategies to support my own mental health as I continue to struggle with juggling work, family and study. Because of this research process I am left more enlightened, curious, grateful, humbled and inspired in my pursuit of research with working mothers from an occupational perspective to make a real difference to their lives.

Conclusion

The findings highlight the daily and ongoing challenges working mothers face in trying to balance work and family. Exploring these challenges from an occupational perspective provides a broader picture of the complex and dynamic relationship between factors than what is currently portrayed in the literature. The findings suggest that women who become mothers and then start or return to work face many challenges, changes and pressures in their daily lives. The challenges are multiple, complex to manage and relentless due to the unpredictability and uncontrollability of life and people. These challenges impact on who they are, what they do, their families, work and their general and mental health and well-being. Yet working mothers continue to strive to positively adapt and cope.

Of equal significance, and largely due to the nature of working mothers' lives and complexity of their issues, women have had to implement a range of personal strategies, environmental supports and activities to support themselves. However, the inadequacy of environmental supports is a contributing factor to working mother's struggles. These participants' perception was that the environment was judgemental and not supportive. In addition, the availability of limited resources at a primary health care level does not meet the needs of working mothers; as well as the largely unappreciated and unsupported working mother role by wider society. These all played a part in exacerbating working mother's stress, anxiety, and depression. Working mothers need more supportive environments, changes in policy and service delivery to better support their mental health and well-being.

This was the first qualitative study to give a subjective and occupational perspective on working mothers' stress in New Zealand. The findings showed that the combined subjective and occupational perspective could offer new insights into working mother's issues and the resolution of those issues. The study confirmed working mothers as an at risk group for mental health issues, acknowledged the range of coping strategies they require, the barriers and limitations of their environments and the

lack of comprehensive support at primary health care level to adequately address their needs. Thus, there is a need for broader strategies that create supportive environments, build healthy public policy, re-orient health services, as well as more specific strategies such as developing occupation-focussed health promotion interventions at primary health care level.

There is a need for further research into occupation-focussed health promotion interventions for working mothers, alongside further evaluation of the impact of environment on working mothers' issues. Finally, development of knowledge and skills in health, social and political spheres is essential to enhance interprofessional and intersectoral collaboration to more comprehensively meet the mental health needs of working mothers.

References

- Abas, M. A., & Broadhead, J. C. (1997). Depression and anxiety among women in an urban setting in Zimbabwe. *Psychological Medicine*, 27(1), 59-71. Retrieved from <https://www.cambridge.org/core/journals/psychological-medicine>
- Allen, N. J. (2001). Family-supportive work environments: The role of organizational perceptions. *Journal of Vocational Behaviour*, 58(3), 414-435. doi:10.1006/jvbe.2000.1774
- Allen, T. D., Herst, D. E., Bruck, C. S., & Sutton, M. (2000). Consequences associated with work-to-family conflict: A review and agenda for future research. *Journal of Occupational Health Psychology*, 5(2), 278-308. doi:10.1037/1076-8998.5.2.278
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: Fifth edition*. Retrieved from <http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596>
- American Psychiatric Association. (n.d.). *What is resilience?* Retrieved November, 1, 2017, from <http://www.apa.org/helpcenter/road-resilience.aspx>
- Aryee, S. (1992). Antecedent and outcomes of work-family conflict among married professional women: Evidence from Singapore. *Human Relations*, 45(8), 813-837. doi:10.1177/001872679204500804
- Auckland University of Technology. (2016). *Social and cultural sensitivity including commitment to the principles of the Treaty of Waitangi (2.5)*. Retrieved November 6, 2017, from <http://www.aut.ac.nz/researchethics/guidelines-and-procedures/social-and-cultural-sensitivity-including-commitment-to-the-principles-of-the-treaty-of-waitangi-2.5>
- Avotri, J. Y., & Walters, V. (1999). 'You just look at our work and see if you have any freedom on earth': Ghanian women's accounts of their work and health. *Social Science & Medicine*, 48(9), 1123-1133. doi:10.1016/S0277-9536(98)00422-5

- Barnes, J., Bigari, K., Culler, T., Gregory, H., Krawczyk, S., & Earley, E. (2008). Health lifestyles through an Adaptive Living Program: A pilot study. *Occupational Therapy International*, 15(4), 269-283. doi:10.1002/oti.261
- Belle, D. (1990). Poverty and women's mental health. *American Psychologist*, 45(3), 385-389. doi:10.1037/0003-066X.45.3.385
- Beyond Blue. (n.d.). *Depression and anxiety: Factors affecting women*. Retrieved September 25, 2017, from <https://www.beyondblue.org.au/who-does-it-affect/women/factors-affecting-women>
- Bifulco, A., Brown, G. W., & Adler, Z. (1991). Early sexual abuse and clinical depression in adult life. *British Journal of Psychiatry*, 159(1), 115-122. doi:10.1192/bjp.159.1.115
- Bloom, D. E., Cafiero, E. T., Jane-Ilopis, E., Abrahams-Gessel, S., Bloom, L. R., Rathima, S., . . . Weinstein, C. (2011). *The global economic burden of non-communicable diseases*. Retrieved from <http://apps.who.int/medicinedocs/documents/s18806en/s18806en.pdf>
- Bracke, P. (2000). The three year persistence of depressive symptoms in men and women. *Social Science & Medicine*, 51(1), 51-64. doi:10.1016/S0277-9536(99)00432-3
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi:10.1191/1478088706qp063oa
- Broadhead, J. C., & Abas, M. A. (1998). Life events, difficulties and depression among women in an urban setting in Zimbabwe. *Psychological Medicine*, 28(1), 29-38. Retrieved from <https://www.cambridge.org/core/journals/psychological-medicine>
- Bromet, E., Andrade, L. H., Hwang, I., Sampson, N. A., Alonso, J., de Girolamo, G., . . . Kessler, R. C. (2011). Cross-national epidemiology of DSM-IV major depressive episode. *BMC Medicine*, 9(30), 1-16. doi:10.1186/1741-7015-9-90
- Brough, P., Hassan, Z., & O'Driscoll, M. (2004). Work-life enrichment. In M. F. Dollard, M. R. Tuckey, A. Shimazu, R. B. Nordin, & P. Brough (Eds.), *Psychosocial factors at work in the Asia Pacific* (pp. 323-336). Retrieved from <https://link->

springer-com.ezproxy.aut.ac.nz/chapter/10.1007/978-94-017-8975-2_17/fulltext.html

- Brown, G. W. (1998). Genetic population perspective on life events and depression. *Social Psychiatry and Psychiatric Epidemiology*, 33(8), 363-372.
doi:10.1007/s001270050067
- Brown, G. W., Harris, T. O., & Hepworth, C. (1995). Loss, humiliation and entrapment among women developing depression: A patient and non-patient comparison. *Psychological Medicine*, 25(1), 7-21. doi:10.1017/S003329170002804X
- Brummelhuis, L., & Lippe, T. (2010). Effective work-life balance support for various household structures. *Human Resource Management*, 49(2), 173-193.
doi:10.1002/hrm.20340
- Buehler, C., O'Brien, M., Buehler, C., & O'Brien, M. (2011). Mothers' part-time employment: Associations with mother and family well-being. *Journal of Family Psychology*, 25(6), 895-906. doi:10.1037/a0025993
- Byrne, C. A., Resnick, H. S., Kilpatrick, D. G., Best, C. L., & Saunders, B. E. (1999). The socioeconomic impact of interpersonal violence on women. *Journal of Consulting and Clinical Psychology*, 67(3), 362-366. doi:10.1037/0022-006X.67.3.362
- Chang, E., Chin, H., & Ye, J. (2014). Organizational work-family culture and working mothers' affective commitment: How career expectations matter. *Human Resource Management*, 53(5), 683-700. doi:10.1002/hrm.21581
- Cooklin, A. R., Westrupp, E., Strazdins, L., Giallo, R., Martin, A., & Nicholson, J. M. (2015). Mothers' work-family conflict and enrichment: Associations with parenting quality and couple relationship. *Child: Care, Health & Development*, 41(2), 266-277. doi:10.1111/cch.12137
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. New South Wales, Australia: Allen and Urwin.
- Davis, C. S. (2016). *Focus groups: Applying communication theory through design, facilitation and analysis*. New York, NY: Routledge.

- Dixey, R. (2013). *Health promotion: Global principles and practice*. Oxfordshire, England: CAB International.
- Drobnič, S., & Guillén Rodríguez, A. M. (2011). Tensions between work and home: Job quality and working conditions in the institutional contexts of Germany and Spain [Article]. *Social Politics*, 18(2), 232-268. doi:10.1093/sp/jxr008
- Eby, L. T., Casper, W. J., Lockwood, A., Bordeaux, C., & Brinley, A. (2005). Work and family research in IO/OB: Content analysis and review of the literature (1980-2002). *Journal of Vocational Behaviour*, 66(1), 124-197.
doi:10.1016/j.jvb.2003.11.003
- Edgelow, M., & Krupa, T. (2011). Randomized controlled pilot study of an occupational time-use intervention for people with serious mental illness. *American Journal of Occupational Therapy*, 65, 267-276. doi:10.5014/ajot.2011.001313
- Eklund, M., & Eriksson, M. K. (2013). Quality of life and client satisfaction as outcomes of the Redesigning Daily Occupations (ReDO) programme for women with stress-related disorders: A comparative study. *Work*, 46(1), 1-8.
doi:10.3233/WOR-121524
- Eklund, M., & Erlandsson, L.-K. (2011). Return to work outcomes ReDesigning Daily Occupations (ReDO) program for women with stress-related disorders: A comparative study. *Women & Health*, 51(7), 676-692.
doi:10.1080/03630242.2011.618215
- Ekman, M., Granstrom, O., Omerov, S., Jacob, J., & Landen, M. (2013). The societal cost of depression: Evidence from 10,000 Swedish patients in psychiatric care. *Journal of Affective Disorders*, 150(3), 790-797. doi:10.1016/j.jad.2013.03.003
- Employment New Zealand. (2017). *Benefits, rights and responsibilities*. Retrieved December 5, 2017, from <https://www.employment.govt.nz/workplace-policies/productive-workplaces/flexible-work/benefits-rights-and-responsibilities/>
- English Oxford Living Dictionaries. (n.d.). *Definition struggle*. Retrieved November 7, 2017, from <https://en.oxforddictionaries.com/definition/us/struggle>

- Erlandson, D. A., Edward, H. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods*. London, England: Sage Publications.
- Felitti, V. J., Anda, R. F., Nordenburg, N., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death. *American Journal of Preventative Medicine*, 14(4), 245-258. doi:10.1016/S0749-3797(98)00017-8
- Fisher, A. G. (2013). Occupation-centred, occupation-based, occupation-focused: Same, same or different. *Scandanavian Journal of Occupational Therapy*, 20(3), 162-173. doi:10.3109/11038128.2012.754492
- Forbes, K. (2009). Paid parental leave under (new) labour. *Social Policy Journal of New Zealand*(34), 12-24. Retrieved from <http://www.msd.govt.nz.ezproxy.aut.ac.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/index.html>
- Frenchman, K. (2014). The health promoting role of occupational therapy in primary health care: A reflection and emergent vision. *New Zealand Journal of Occupational Therapy*, 61(2), 64-69. Retrieved from <http://www.nzaot.com/publications/journal/>
- Frey, L., Botan, C., & Kreps, G. (1999). *Investigating communication: An introduction to research methods*. (2nd ed.). Boston, MA: Allyn & Bacon.
- Gilbert, P., & Allan, S. (1998). The role of defeat and entrapment. *Psychological Medicine*, 28(3), 585-598. Retrieved from <https://www.cambridge.org/core/journals/psychological-medicine>
- Gimenez-Nadal, J. I., & Sevilla-Sanz, A. (2011). The time-crunch paradox. *Social Indicators Research*, 102(2), 181-196. doi:10.1007/s11205-010-9689-1
- Gjerdingen, D., McGovern, P., Bekker, M., Lundberg, U., & Willemssen, T. (2000). Women's work roles and their impact on health, well-being and career: Comparisons between United States, Sweden and the Netherlands. *Women & Health*, 31(4), 1-20. doi:10.1300/J013v31n04_01

- Greenhaus, J. H., & Powell, C. (2006). When work and family are allies: A theory of work-family enrichment. *Academy of Management Review*, 31(1), 72-92.
doi:10.5465/AMR.2006.19379625
- Gregory, A., & Milner, S. (2009). Editorial: Work-life balance: A matter of choice? *Gender, Work and Organization*, 16(1), 2-13. doi:10.1111/j.1468-0432.2008.00429.x
- Grice, M. M., McGovern, P. M., Alexander, B. H., Ukestad, L., & Hellerstedt, W. (2011). Balancing work and family after childbirth: A longitudinal analysis. *Women's Health Issues*, 21(1), 19-27. doi:10.1016/j.whi.2010.08.003
- Gronlund, A. (2007). More control, less conflict? Job demand-control, gender and work-family conflict. *Gender, Work and Organization*, 14(5), 476-497.
doi:10.1111/j.1468-0432.2007.00361.x.
- Hakansson, C., Lissner, L., Bjorkelund, C., & Sonn, U. (2009). Engagement in patterns of daily occupations and perceived health among women of working age. *Scandinavian Journal of Occupational Therapy*, 16(2), 110-117.
- Hamlyn, D. W. (1995). History of Epistemology In T. Honderich (Ed.), *The Oxford companion to philosophy* (pp. 242-245). Oxford, England: Oxford University Press.
- Health, M. o. (2017). *Primary mental health*. Retrieved October 25, 2017, from <http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/primary-mental-health>
- Heim, C., & Nemeroff, C. B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: Preclinical and clinical studies. *Biological Psychiatry*, 49(12), 1023-1039. doi:10.1016/S0006-3223(01)01157-X
- Hellman, T., Westerberg, Y., & Jonsson, H. (2011). Experiences of women with stress-related ill health in a therapeutic gardening programme. *Canadian Journal of Occupational Therapy*, 78(5), 273-281. doi: 10.2182/cjot.2011.78.5.2

- Hill, E. J., Yang, C., Hawkins, A. J., & Ferris, M. (2004). A cross-cultural test of the work-family interface in 48 countries. *Journal of Marriage and Family*, 66(5), 1300-1316. doi:10.1111/j.0022-2445.2004.00094.x
- Hinnant, A. (2009). The cancer on your coffee table. *Feminist Media Studies*, 28(2), 33-49. doi:10.1080/00913367.1999.10673582
- Hochschild, A. R., & Machung, A. (1989). *The second shift*. New York, NY: Avon Books.
- Hocking, C. (2013). Occupation for public health. *New Zealand Journal of Occupational Therapy*, 60(1), 33-37. Retrieved from <http://www.nzaot.com/publications/journal>
- The Holidays Act 2003.
- Hooper, W., & Wood, W. (2014). The philosophy of occupational therapy: A framework for practice. In B. A. B. Schell, G. Gillen, & M. E. Scaffa (Eds.), *Willard and Spackman's occupational therapy* (pp. 35-46). Baltimore, MA: Lippincott Williams & Wilkins.
- Horowitz, B., & Chang, P. (2004). Promoting well-being and engagement through occupational therapy lifestyle redesign: A pilot study within adult day programs. *Adolescence*, 42(165), 103-114. doi:10.1097/00013614-200401000-00007
- Hunt, M. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professional in humanitarian work. *Qualitative Health Research*, 19(9), 1284-1292. doi:10.1177/1049732309344612
- Hunt, M. (2011). Book review: Sally Thorne, Interpretive Description. *Qualitative Health Research*, 21(292-294). doi:10.1177/1049732310374064
- Innstrand, S. T., Langballe, E. M., Falkum, E., Espnes, G. A., & Aasland, O. G. (2009). Gender-specific perceptions of four dimensions of work/family conflict interaction. *Journal of Career Assessment*, 17(4), 402-416. doi:10.1177/1069072709334238

- Insel, T. (2011). *The global cost of mental illness*. Retrieved November, 3, 2017, from <https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2011/the-global-cost-of-mental-illness.shtml>
- Jansen, N. W. H., Kant, I. J., van Amelsvoort, L. G. P. M., Kristensen, T. S., & Swaen, G. M. H. (2006). Work-family conflicts a risk factor for sickness absence. *Occupational and Environmental Medicine*, 63(7), 488-494. doi:10.1136/oem.2005.024943
- Kawachi, I., Kennedy, B. P., & Glass, R. (1999). Social capital and self-related health: A contextual analysis. *American Journal of Public Health*, 89(8), 1187-1193. doi:10.2105/AJPH.89.8.1187
- Kendler, K., & Karkowski, L. M. (1999). Causal relationship between stressful life events and the onset of major depression. *The American Journal of Psychiatry*, 156(6), 837-841. doi:10.1176/ajp.156.6.837
- Kessler, R. C. (1997). The effects of stressful life events on depression. *Annual Review of Psychology*, 48(1), 191-214. Retrieved from <http://www.annualreviews.org.ezproxy.aut.ac.nz/loi/psych>
- Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., . . . Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives for General Psychiatry*, 60(2), 184-189. Retrieved from <https://www.ncbi.nlm.nih.gov/labs/journals/arch-gen-psychiatry/>
- Kessler, R. C., McGonagle, K. A., & Zhao, S. (1994). Lifetime and 12 month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*, 51(1), 8-19. doi:10.1001/archpsyc.1994.03950010008002
- Kielhofner, G. (2008). *Model of human occupation: Theory and application* (4th ed.). Baltimore, MD: Lippincott Williams & Wilkins.
- Kinnumen, U., & Mauno, S. (1998). Antecedents and outcomes of work-family conflict among employed women and men in Finland. *Human Relations*, 51(2), 157-177. doi:10.1177/001872679805100203

- Kirsh, B., Stergiou-Kita, M., Gewurtz, R., Dawson, D., Krupta, T., Lysaght, R., & Shaw, L. (2009). From margins to mainstream: What do we know about work integration for persons with brain injury, mental illness and intellectual disability? *Work*, 32(4), 391-405. doi:10.3233/WOR-2009-0851
- Kleine-Budde, K., Muller, R., Kawohl, W., Bramesfeld, A., Moock, J., & Rossler, W. (2013). The cost of depression - A cost analysis from a large database. *Journal of Affective Disorders*, 147(1-3), 137-143. doi:10.1016/j.jad.2012.10.024
- Kleinke, C. L. (2007). What does it mean to cope? In A. Monat, R. S. Lazarus, & G. Reevy (Eds.), *The Praeger handbook on stress and coping* (pp. 289-308). Westport, CT: Praeger Publishing.
- Kodagoda, T. (2010). Work-family stress of women managers: Experience from banking sector in Sri Lanka. *International Journal of Management and Enterprise Development*, 9(2), 201-211. doi:10.1504/IJMED.2010.036122
- Kossek, E. E., Pichler, S., Bodner, T., & Hammer, L. B. (2011). Workplace social support and work-family conflict: A meta-analysis clarifying the influence of general and work-family specific supervisor and organisational support. *Personnel Psychology*, 64(2), 289-313. doi:10.1111/j.1744-6570.2011.01211.x
- Kueher, C. (1999). Gender differences in the short term course of unipolar depression in a follow-up sample of depressed inpatients. *Journal of Affective Disorders*, 56(2-3), 127-139. doi:10.1016/S0165-0327(99)00035-X
- Lane, R. (1953). Businessmen and bureaucrats. *Social Forces*, 32(2), 145-152. doi:10.2307/2573712
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. California, CA: Sage Publications.
- Lipman, E. L., Offord, D. R., & Boyle, M. H. (1997). Single mothers in Ontario: Sociodemographic physical and mental health characteristics. *Canadian Medical Association Journal*, 156(5), 639-645. Retrieved from <http://www.cmaj.ca/>

- Macran, S., Clarke, L., & Joshi, H. (1996). Women's health: Dimensions and differentials. *Social Science & Medicine*, 42(9), 1203-1216. doi:10.1016/0277-9536(95)00432-7
- Marshall, N., & Barnett, R. (1993). Work-family strains and gains among two-earner couples. *Journal of Community Psychology*, 21(1), 64-78. doi:10.1002/1520-6629(199301)
- Matuska, K. M., & Christiansen, C. H. (2008). A proposed model of lifestyle balance. *Journal of Occupational Science*, 15(1), 9-19. doi:10.1080/14427591.2008.9686602
- Maume, D. J., Sebastian, R. A., & Bardo, A. R. (2010). Gender, work-family responsibilities, and sleep [Article]. *Gender and Society*, 24(6), 746-768. doi:10.1177/0891243210386949
- Mental Health Foundation. (2014). *Mental health foundation: Quick facts and stats*. Retrieved from <https://www.mentalhealth.org.nz/assets/Uploads/MHF-Quick-facts-and-stats-FINAL.pdf>
- Ministry of Health. (2001). *Primary Health Care Strategy*. Retrieved from <http://www.health.govt.nz/publication/primary-health-care-strategy>
- Ministry of Health. (2014). *Primary health care providers*. Retrieved October, 27, 2017 Retrieved from <http://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/primary-health-care-providers>
- Ministry of Health. (2015). Retrieved 4 November, 2015, from <http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/public-health-units>
- Ministry of Health. (2001). *The primary health care strategy*. Retrieved from <http://www.health.govt.nz/system/files/documents/publications/phcstrat.pdf>
- Ministry of Health. (2012a). *The health of New Zealand adults 2011/2012: Key findings of the New Zealand health survey*. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/health-of-new-zealand-adults-2011-12-section4.pdf>

- Ministry of Health. (2012b). *The Mental Health and Addiction Service Development Plan 2012-2017*. Retrieved May, 5, 2017, from <https://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017>
- Ministry of Health. (2014). *Treaty of Waitangi principles*. Retrieved November 6, 2017, from <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles>
- Ministry of Health. (2016a). *Health loss in New Zealand 1990 - 2013: A report from the New Zealand burden of diseases, injuries and risk factors study*. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/health-loss-in-new-zealand-1990-2013-aug16.pdf>
- Ministry of Health. (2016b). *The New Zealand Health Strategy*. Retrieved from <http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-future-direction-2016-apr16.pdf>
- Ministry of Health. (2017a). *District health boards*. Retrieved from <http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards>
- Ministry of Health. (2017b). *Primary health care*. Retrieved October 24, 2017, from <http://www.health.govt.nz/our-work/primary-health-care>
- Ministry of Health. (2017c). *Primary health organisations*. Retrieved October 24, 2017, from <http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/primary-health-organisations>
- Ministry of Women. (2017). *Gender pay gap*. Retrieved May 14, 2017, from <http://women.govt.nz/work-skills/income/gender-pay-gap>
- Moos, R. H., & Billings, A. G. (1982). Conceptualising and measuring coping resources and processes. In L. Goldberger & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects*. New York, NY: Free Press.

- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *The British Journal of Psychiatry*, 163(6), 721-732. doi:10.1192/bjp.163.6.721
- Mundt, C., Reck, C., Backenstrass, M., Kronmüller, K., & Feidler, P. (2000). Reconfirming the role of life event for the timing of depressive episodes: A two-year prospective follow-up study. *Journal of Affective Disorders*, 59(1), 23-30. doi:10.1016/S0165-0327(99)00127-5
- Nanni, V., Uher, R., & Danese, A. (2012). Childhood maltreatment predicts unfavourable course of illness and treatment outcome in depression: A meta-analysis. *American Journal of Psychiatry*, 169(2), 141-151. doi:10.1176/appi.ajp.2011.11020335
- New Zealand Association of Occupational Therapy. (2009). *Primary health care position statement*. Retrieved May 5, 2017, from <http://www.nzaot.com/publications/position.statements.php>
- New Zealand Legislation. (2016). *Parental leave and employment protection Act 1987*. Retrieved December 5, 2017, from http://www.legislation.govt.nz/act/public/1987/0129/latest/versions.aspx?search=sw_096be8ed815c7654_paid+parental+leave_25_se&p=1&av=True
- The New Zealand Public Health and Disability Act 2000.
- Njelesani, J., Tang, A., Jonsson, H., & Poltajko, H. (2014). Articulating an occupational perspective. *Journal of Occupational Science*, 21(2), 226-235. doi:10.1080/14427591.2012.717500
- Nomaguchi, K. M., Milkie, M. A., & Bianchi, S. (2005). Time strains and psychological well-being. Do dual-earner mothers and fathers differ? *Journal of Family Issues*, 26(6), 756-792. doi:10.1177/0192513X05277524
- Occupational Therapy Board of New Zealand. (2004). *Scope of practice for occupational therapists*. Retrieved May 5, 2017, from <https://www.otboard.org.nz/Registration/CurrentlyRegisteredOccupationalTherapists/OTScopeofPractice.aspx>

- Organization, W. H. (2015). *Health Promotion*. Retrieved November 17, 2015, from http://www.who.int/topics/health_promotion/en/
- Oxford Dictionary. (n.d.). Retrieved October, 31, 2017, from <https://en.oxforddictionaries.com/definition/resilience>
- Pacheco, G., Li, C., & Cochrane, B. (2017). *Empirical evidence of the gender pay gap in New Zealand*. Retrieved from http://women.govt.nz/sites/public_files/Empirical%20evidence%20of%20GPG%20in%20NZ%20-%20Mar2017_0.pdf
- Parental Leave and Employment Protection Act 1987.
- Parker, G., Roy, K., Mitchell, P., Wilhelm, K., & Eyers, K. (2000). Costing depression and it's management: An Australian study. *Australian and New Zealand Journal of Psychiatry*, 34(2), 290-299. doi:10.1080/j.1440-1614.2000.00714.x
- Patel, V., Araya, R., de Lima, M., Ludermir, A., & Todd, C. (1999). Women, poverty and common mental disorders in four restructuring societies. *Social Science & Medicine*, 49(11), 1461-1471. doi:10.1016/S0277-9536(99)00208-7
- Pierce, D. (2014). Occupational science: A powerful disciplinary knowlegde base for occupational therapy. In D. Pierce (Ed.), *Occupational science for occupational therapy* (pp. 1-10). Thorofare, NJ: Slack Incorporated.
- Regier, D., Rae, D., Narrow, W., Kaelber, C., & Schatzberg, A. (1998). Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. *The British Journal of Psychiatry*, 173(34), 24-28. Retrieved from bjp.rcpsych.org/
- Repo, K. (2004). Combining work and family in two welfare states: A discourse analytical perspective. *Social Policy and Administration*, 38(6), 622-639. doi:10.1111/j.1467-9515.2004.00410.x
- Roy, S. C. (2008). Taking charge of your health: Discourses of responsibility in English-Canadian women's magazines. *Sociology Of Health & Illness*, 30(3), 463-477. doi:10.1111/j.1467-9566.2007.01066.x

- Ryan, A., & Kossek, E. (2008). Work-life policy implementation : Breaking down or creating barriers to inclusiveness? *Human Resource Management*, 47(2), 295-310. doi:10.1002/hrm.20213
- Salsberry, P. J., Nickel, J. T., Polivka, B. J., Kuthy, R. A., Slack, C., & Shapiro, N. (1999). Self reported health status of low income mothers *Journal of Nursing Scholarship*, 31(4), 537-543. doi:10.1111/j.1547-5069.1999.tb00523.x
- Sareen, J., Jacobi, F., Cox, B., Belik, S., CLara, I., & Stein, M. (2006). Disability and poor quality of life associated with comorbid anxiety disorders and physical conditions. *Archive of Internal Medicine*, 166(19), 2109-2116. doi:10.1001/archinte.166.19.2109
- Saxena, S., Thornicraft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health, Scarcity, inequity and efficiency. *Lancet*, 370(9590), 878-889. doi:10.1016/S0140-6736(07)61239-2
- Schurer, S., Alspach, M., Macrae, J., & Martin, G. (2016). The medical care costs of mood disorder: A coursened exact matching approach. *Economic Record*, 92(296), 81-93. doi:10.1111/1475-4932.12218
- Sieber, S. (1974). Toward a theory of role accumulation. *American Sociological Review*, 39(4), 567-578. Retrieved from <http://www.asanet.org/research-and-publications/journals/american-sociological-review>
- Sobocki, P., Lekander, I., Borgstrom, F., Strom, O., & Runeson, B. (2007). The economic burden of depression in Sweden from 1997 to 2005. *European Psychiatry*, 22(3), 146-152. doi:10.1016/j.eurpsy.2006.10.006
- Sperlich, S., Arnhold-Kerri, S., Siegrist, J., & Geyer, S. (2013). The mismatch between high effort and low reward in household and family work predicts impaired health among mothers. *European Journal of Public Health*, 23(5), 893-898. doi:10.1093/eurpub/cks134
- Stark, E., & Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health*. Thousand Oaks, CA: Sage Publications.

- State Services Commission. (2015). *Public service gender pay gap*. Retrieved from <https://www.ssc.govt.nz/sites/all/files/GenderPayGap2015.pdf>
- Statistics New Zealand. (2013). *Census 2013*. Retrieved May 30, 2017, from http://www.stats.govt.nz/tools_and_services/tools/nzdotstat.aspx
- Statistics New Zealand. (2016). *Measuring the gender pay gap*. Retrieved from http://m.stats.govt.nz/browse_for_stats/income-and-work/Income/gender-pay-gap.aspx
- Statistics New Zealand. (2017). *Effect of motherhood on pay*. Retrieved November 4, 2017, from http://www.stats.govt.nz/browse_for_stats/income-and-work/Income/motherhood-penalty-summary.aspx
- Strazdins, L., Shipley, M., Clements, M., O'Brien, L., & Broom, D. (2010). Job quality and inequality: Parents' jobs and children's emotional and behavioural difficulties. *Social Science & Medicine*, 70(12), 2052-2060. doi:10.1016/j.socscimed.2010.02.041
- Sullivan, C. (2015). 'Bad mum guilt': The representation of 'work-life balance' in UK women's magazines. *Community, Work and Family*, 18(3), 284-298. doi:10.1080/13668803.2014.970128
- Sullivan, C., & Smithson, J. (2007). Perspectives of homemakers and their partners on working flexibility. *International Journal of Human Resource Management*, 18(3), 448-461. doi:10.1080/09585190601167797
- Sumra, M. K., & Schillaci, M. A. (2015). Stress and the multiple-role woman: Taking a closer look at the "superwoman". *PLoS ONE*, 10(3), e0120952-e0120952. doi:10.1371/journal.pone.0120952
- Tennant, C. (2002). Life event, stress and depression: A review of the recent findings. *Australian & New Zealand Journal of Psychiatry*, 36(2), 173-182. Retrieved from <https://www.ranzcp.org/Publications/RANZCP-journals-public.aspx>
- The Office of Research Integrity. (2017). *Data collection*. Retrieved May 25, 2017, from https://ori.hhs.gov/education/products/n_illinois_u/datamanagement/dctopic.htm

- Thompson, C. S., Beauvais, L. L., & Lyness, K. S. (1999). When work-family benefits are not enough: The influence of work-family culture on benefit utilization, organizational attachment, and work-family conflict. *Journal of Vocational Behaviour*, 54(3), 392-415. doi:10.1006/jvbe.1998.1681
- Thorne, S. (1991). Methodological orthodoxy in qualitative nursing research: Analysis of the issues. *Qualitative Health Research*, 1(2), 178-199.
doi:10.1177/104973239100100203
- Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.
- Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). New York, NY: Routledge.
- Thorne, S., Kirkham, S., R., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, 20, 169-177. doi:10.1002/(SICI)1098-240X(199704)20:23.3.CO
- Thorne, S., Kirkham, S., R., & O'Flynn-Magee, K. (2004). The analytical challenge in interpretive description. *International Journal of Qualitative Methods*, 3(1), 1-11.
Retrieved from <https://ejournals.library.ualberta.ca/index.php/IJQM/>
- Tomonaga, Y., Haettenschwiler, J., Hatzinger, M., Holsboer-Trachsler, E., Rufer, M., Hepp, U., & Szucs, T. D. (2013). The economic burden of depression in Switzerland. *PharmacoEconomics*, 31(3), 237-250. doi:10.1007/s40273-013-0026-9
- Townsend, E. (1997). Occupation: Potential for personal and social transformation. *Journal of Occupational Science*, 4(1), 18-26.
doi:10.1080/14427591.1997.9686417
- Townsend, E., A., & Polatajko, H., J (Eds.). (2013). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (2nd ed.). Ottawa, Canada: CAOT Publications ACE.
- Vercruyssen, A., & Van de Putte, B. (2013). Work-family conflict and stress: indications of the distinctiveness of role combination stress for Belgian working mothers.

Community, Work and Family, 16(4), 351-371.

doi:10.1080/13668803.2013.776515

Vinkers, C., Joels, M., Milaneschi, Y., Kahn, R., Pennix, B., & Boks, M. (2014). Stress exposure across the lifespan cumulatively increases depression risk and is moderated by neuroticism. *Depression and Anxiety*, 31(9), 1-9.

doi:10.1002/da.22262

Voydanoff, P. (2005). The differential salience of family and community demands and resources for family-to-work conflict and facilitation. *Journal of Family and Economic Issues*, 26(3), 395-417. doi:10.1007/s10834-005-5904-7

Wagman, P., & Hakansson, C. (2014). Exploring occupational balance in adults in Sweden. *Scandinavian Journal of Occupational Therapy*, 21(6), 415-420.

doi:10.3109/11038128.2014.934917 .

Wagman, P., Hakansson, C., & Bjorkelund, C. (2012). Occupational balance as used in occupational therapy: A concept analysis. *Scandinavian Journal of Occupational Therapy*, 19(4), 322-327. doi:10.3109/11038128.2011.596219

Wagman, P., Hakansson, C., Jacobsson, C., Falkmer, T., & Bjorkelund, C. (2012). What is considered important for life balance? Similarities and differences among some working adults. *Scandinavian Journal of Occupational Therapy*, 19(4), 377-384. doi:10.3109/11038128.2011.645552 .

Wagman, P., Hakansson, C., & Jonsson, H. (2015). Occupational balance: A scoping review of current research and identified knowledge gaps. *Journal of Occupational Science*, 22(2), 160-169. doi:10.1080/14427591.2014.986512

Waring, M. (2004). *Counting for nothing: What men value and women are worth* (2nd ed.). Toronto, Canada: University of Toronto Press.

Weiten, W., Hammer, E., & Dunn, D. (2014). *Adjust: Applying psychology to life*. Belmont, CA: Wadworth, Cengage Learning.

Westhorp, P. (2003). Exploring balance as a concept in occupational science. *Journal of Occupational Science*, 10(2), 99-106. doi:10.1080/14427591.2003.9686516

- Whiteford, G., & Townsend, E. (2011). Participatory occupational justice framework (POJF 2011): Enabling occupational participation and inclusion. In F. Kronenberg, N. Pollard, & D. Sakellariou (Eds.), *Occupational therapy without borders: Learning from the spirit of survivors*. (pp. 65-84). London, England: Churchill Livingstone.
- Wiegner, L., Hange, D., Björkelund, C., & Ahlborg, G. (2015). Prevalence of perceived stress and associations to symptoms of exhaustion, depression and anxiety in a working age population seeking primary care: An observational study. *BMC Family Practice*, 16(1), 1-8. doi:10.1186/s12875-015-0252-7
- Wilcock, A. (2006). *An occupational perspective of health* (2nd ed.). Thorofare, NJ: Slack Incorporated.
- Wilcock, A., & Hocking, C. (2015). *An occupational perspective on health* (3rd ed.). Thorofare, NJ: Slack Incorporated.
- Wilson Scott, K. (2004). Relating categories in grounded theory analysis: Using a conditional relationship guide and reflective coding matrix. *The Qualitative Report*, 9(1), 112-126. Retrieved from <http://tqr.nova.edu/>
- World Federation of Occupational Therapy. (2012). *Definition of occupational therapy*. Retrieved October 31, 2017, from <http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx>
- World Health Organisation. (2017). *World health statistics: Monitoring health for the sustainable development goals*. Retrieved November 2, 2017, from <http://apps.who.int/iris/bitstream/10665/255336/1/9789241565486-eng.pdf?ua=1>
- World Health Organization. (1986). *The Ottawa charter for health promotion*. Retrieved November 5, 2017, from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>
- World Health Organization. (2008). *Global burden of disease: 2004 update*. Retrieved from

http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf?ua=1

World Health Organization. (2011). *Gender mainstreaming for health managers: A practical approach*. Retrieved from

http://apps.who.int/iris/bitstream/10665/44516/1/9789241501071_eng.pdf

World Health Organization. (2017a). *Depression*. Retrieved November 2, 2017, from <http://www.who.int/mediacentre/factsheets/fs369/en/>

World Health Organization. (2017b). *Depression and other common mental disorders*. Retrieved from <http://apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf?ua=1>

World Health Organization. (2017c). *Gender and woman's health*. Retrieved October 30, 2017, from http://www.who.int/mental_health/prevention/genderwomen/en/

World Health Organization. (2017d). *TO BE FILLED IN*. Retrieved

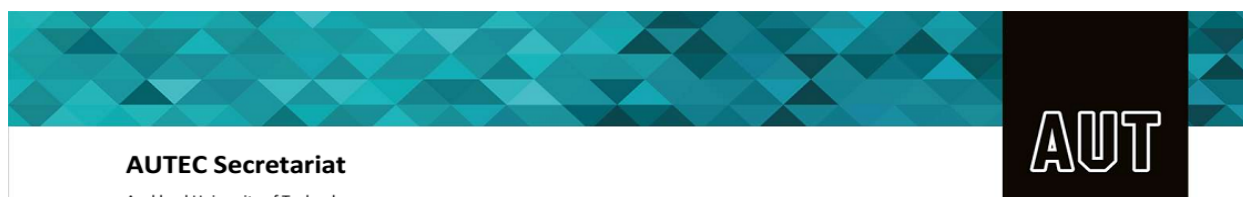
World Health Organization. (n.d). *Gender disparities in mental health*. Retrieved from http://www.who.int/mental_health/media/en/242.pdf?ua=1

World Health Organization. (2017). *Maternal mental health*. Retrieved December 5, 2017, from http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

Worthington, N. (2005). Women's work on the world wide web: How a new medium represents an old problem. *Popular Communication*, 3(1), 43-60.
doi:10.1207/s15405710pc0301_3

Appendices

Appendix A: AUTECH Approval



AUTECH Secretariat

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E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

28 July 2015

Kirk Reed
Faculty of Health and Environmental Sciences

Dear Kirk

Re Ethics Application: **15/162 Working mothers' experiences of stress, anxiety and depression.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 27 July 2018.

As part of the ethics approval process, you are required to submit the following to AUTECH:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 July 2018;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 27 July 2018 or on completion of the project.

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

A handwritten signature in black ink, appearing to read 'K O'Connor', is placed above the typed name of the signatory.

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Kim Frenchman kfrenchm@aut.ac.nz, Sari Andajani

Appendix B: Research Information Pamphlet

Working mothers' experiences of stress, anxiety and depression

RESEARCH PROJECT

Are you?

- ✓ Feeling a bit stressed, anxious or depressed lately?
- ✓ A woman aged 18-55 years?
- ✓ Currently living in the North Shore community?
- ✓ Working in full, part-time or casual employment?
- ✓ A mother of a child under 5 years?

Would you like to?

- ✓ Share your unique experiences of everyday life
- ✓ Have a say in the development of health promotion interventions for women in your community?

For more information please [*contact the student researcher: Kim Frenchman](#)

E-mail: kfrenchm@aut.ac.nz

Ph: 9219999 ext. 7517

Contacting the student researcher does not mean you consent to participating in the research

Ethics approval was gained by AUT Ethics Committee for this research on 28 July 2015. Application number15/162.

Appendix C: Participant Information Sheet

Participant Information Sheet



Date Information Sheet Produced:

23 March 2015

Project Title

Working mothers' experiences of stress, anxiety and depression.

An Invitation

Hello, my name is Kim Frenchman, I am an occupational therapy lecturer completing a research project. I am also a mother of two boys aged 8 and 12.

You are invited to participate in a research project to explore the factors influencing your experience of stress, anxiety or depression in your everyday life. Your participation in this project is entirely voluntary. You can withdraw from this project within 2 weeks of the interview or focus group. Your participation or non-participation in this project will neither advantage nor disadvantage you.

What is the purpose of this research?

This research will contribute to the completion of a Master of Health Science thesis. The research aims to uncover working mothers' perspectives of their mental health. This knowledge will be used to inform the development of health promotion interventions for working mothers in the future.

How was I identified and why am I being invited to participate in this research?

You are being invited because you have contacted me after reading a pamphlet advertising the project or information was given to you by another mother, friend, family, health care professional or staff at an early childcare centre.

You have identified yourself as a woman who has been feeling stressed, anxious or depressed lately; you are in paid full-time, part-time or casual employment; aged between 18-55 years, can speak and read English and have at least one child aged 5 or younger living at home with you.

You have not already been diagnosed with a mental health disorder nor currently receiving mental health services from a hospital, have a cognitive impairment; or any other health issues that may interfere with your ability to communicate effectively.

What will happen in this research?

I will negotiate a convenient time and place for an interview with you and also invite you to attend a focus group at AUT University on the North Shore. In total this project involves the completion of two activities:

1. Individual interview (1 hour).
2. Focus group with other research participants (1 hour).

What are the discomforts and risks?

No serious discomforts or risks are expected to result from participating in this research. Some minor discomforts may occur. These are; you may feel upset during or after the interview or focus group and you may need to travel to and from AUT University for the interview or focus group.

How will these discomforts and risks be alleviated?

Should you become upset or feel upset after the interview or focus group, please tell the researcher. You can stop the interview or leave the focus group without fear of consequence. Someone will be available to listen and support you at this time. The researcher can refer you to your GP for further support. You also have access to three free counselling sessions at AUT. Please contact 09 921 9998 to make an appointment. The researcher could arrange a place of convenience for you for the individual interview, however, this may not be possible for the focus group.

What are the benefits?

This research project will uncover working mothers' perspectives of their mental health. This knowledge will be used to inform the development of health promotion interventions for working mothers in the future and contribute your shared experience and factors and strategies that influence women's stress.

How will my privacy be protected?

Your information will be securely stored and kept confidential for 6 years by the researcher and her supervisors. Transcribers will be required to sign a confidentiality form to ensure the secure and confidential storage of your information. When reporting on the research, pseudonyms will be used and only the broad location of North Shore community will be specified.

What are the costs of participating in this research?

A total of up to 3 hours of your time will be needed. The individual interview and focus group session is expected to take one hour each on two separate occasions - please take into account travelling to and from the venues. There may be additional parking or transport costs associated with travelling to and from the venue. You will be asked to review your interview transcripts for accuracy – this may take up to 45min to read, review and send back to the researcher.

What opportunity do I have to consider this invitation?

You have one week to consider the invitation

How do I agree to participate in this research?

At the time of your interview and focus group the researcher will give you a consent form to complete and sign before progressing. You will also be asked to sign a confidentiality form before the start of the focus group. The researcher will give this to you at the time of the focus group.

Will I receive feedback on the results of this research?

You may make a written request to the researcher to receive feedback on the results of this research. This will be sent to you in the form of a research report once the project is complete.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Kirk Reed, kreed@aut.ac.nz, 921 9156.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext. 6038.

Whom do I contact for further information about this research?***Researcher Contact Details:***

Kim Frenchman, kfrenchm@aut.ac.nz, 9219999 ext. 7517.

Project Supervisor Contact Details:

Dr Kirk Reed, kreed@aut.ac.nz, 921 9156.

Approved by the Auckland University of Technology Ethics Committee on 28 July 2015, AUTC Reference number 15/162.

Appendix D: Participant Consent Form

Consent Form



*Project title: **Working mothers' experiences of stress, anxiety and depression.***

*Project Supervisor: **Kirk Reed***

*Researcher: **Kim Frenchman***

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 23 March 2015
- ☐ I have had an opportunity to ask questions and have them answered.
- ☐ I understand that notes will be taken during the interview and focus group and that they will be audio-taped and transcribed.
- ☐ I understand that the identity of my fellow participants and our discussions in the focus group is confidential and I agree to keep this information confidential.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project up to 2 weeks after the interview or focus group, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was a part of, the relevant information about myself, including tapes and transcripts, or parts thereof, will not be used.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature :.....

Participant's name:

Participant's Contact Details (if appropriate):

.....
.....
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 28 July 2015
AUTEC Reference number 15/162**

Note: The Participant should retain a copy of this form.

Appendix E: AUTECH Amendment



AUTECH Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

30 November 2015

Kirk Reed
Faculty of Health and Environmental Sciences

Dear Kirk

Re: Ethics Application: **15/162 Working mothers' experiences of stress, anxiety and depression.**

Thank you for your request for approval of an amendment to your ethics application.

I have approved the minor amendment to the recruitment advertisement to include the advice that the project is student research.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTECH):

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 July 2018;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 27 July 2018 or on completion of the project.

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Kim Frenchman kfrenchm@aut.ac.nz, Sari Andajani

Appendix F: Confidentiality Form – Support Person and Co-Facilitators

Confidentiality Agreement



For an intermediary or research assistant.

Project title: Working mothers' experiences of stress, anxiety and depression.

Project Supervisor: Kirk Reed

Researcher: Kim Frenchman

-
- ☐ I understand that all the material I will be asked to record is confidential.
 - ☐ I understand that the contents of the Consent Forms, tapes, or interview notes can only be discussed with the researchers.
 - ☐ I will not keep any copies of the information nor allow third parties access to them.

Intermediary's signature:

Intermediary's name:

Intermediary's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Project Supervisor's Contact Details (if appropriate):

Dr. Kirk Reed

E-mail: kirk.reed@aut.ac.nz

Ph: 921 9156

***Approved by the Auckland University of Technology Ethics Committee on 28 July 2015
AUTEC Reference number 15/162.***

Note: The Intermediary should retain a copy of this form.

Appendix G: Confidentiality Form - Transcriber

Confidentiality Agreement



For someone transcribing data, e.g. audio-tapes of interviews.

Project title: *Working mothers' experiences of stress, anxiety and depression.*

Project Supervisor: **Kirk Reed**

Researcher: **Kim Frenchman**

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Project Supervisor's Contact Details (if appropriate):

Dr. Kirk Reed

E-mail: kirk.reed@aut.ac.nz

Ph: 921 9156

***Approved by the Auckland University of Technology Ethics Committee on 28 July 2015
AUTEK Reference number 15/162.***

Note: The Transcriber should retain a copy of this form.

Appendix H: Chart Initial Codes

Braun and Clarke (2006)

Step 1: Read and familiarise self with data, generate initial list of ideas about what is in the data and interesting

List of Ideas from the data:

Life before and after children – very different more stressful, everyday stress seems to be much more and with children stress is a permanent part of everyday life – have to live and manage with this

Accumulative stress – stories start a year ago, two years ago some as long as five years

Personal or close family member experience of mental health issues relating to stress, anxiety, depression or trauma as adolescent

Role conflict – choosing between responsibilities to children and work

Nothing for self or difficulty accessing things for self-due to child-care – wants/needs time for self, enjoys doing things without children or with other adults that don't have children

Feeling of guilt at letting people down, don't want to let people down (husband, children, family, work colleagues and managers)

Wanting to be or striving to be a 'good' mother, 'good' wife, good worker'

Changes in work demands or work demands contributing to stress

Changes in work from full-time to part-time

Guilt over financial pressure due to reduced work hours

Have to work a matter of income for survival

Work and income from work seen as part of mother role – take care of the children's needs – essential to child's well-being.

Can't afford to stay at home

Don't want to be stay at home mum - work is my sanctuary – I want to work it keeps me sane, I feel good about myself, I can talk to adults and do things that isn't related to childcare, household or care of children, I am valued for me

Children's needs always prioritised over work

Would like better work/life balance – what is this, not sure of this is possible, what can be done – not sure anything can be done

Some employees supportive of carer role others not – cause of stress and for working mother

Wants to work – wanting a career vs needing to work to provide for children now

Not having enough financial resources – married couple better off than single mum in regards to finances

Changes in relationship with spouse

Need and benefits from having a supportive spouse –share childcare, financial and home management responsibilities – opposite creates stress and anxiety – having a co-parent really important factor in stress

Support of family is comforting for babysitting or childcare duties, not having family support is stressful, even more so for a single mum who has not family living close by - organising and paying for a babysitter not always feasible and don't have access to reliable, trustworthy babysitting service, so limited options. Single mum feels anxious and stressful without spousal or family support – feels the weight/burden of doing it all by myself –is envious of married mothers with supportive spouses.

Feeling disconnected from self and feeling when stressed or depressed – unable to plan or organise life – see into the future. Crying lots of crying, withdrawing from going out or doing things I enjoy.

Being a mother challenging by a joy – different type of joy, despite challenges. A young life dependent on me for its survival – I want to my absolute best.

Children's well-being linked to mother's well-being- if the children are well and thriving I know I am doing a good job. We check the children my husband and I.

Change in values – focus shifts from work to children, even spouse shifts down – loss of wife role

Insight

Worried about not being there for kids, wanting to do what's best for the children

Leisure sanctuary

Study sanctuary

Having children stress permanent - you're in a constant state of adaptation

Others noticed I was struggling before I did or others did not notice I was struggling

I need to talk – being listened to by non-judgemental person/people really good

Despite good supports days can still be stressful

Reflective and insightful mothers??

Counselling helps – can't always afford it – helpful when employers have employee assistance programmes

Woman shouldn't have to take sick leave to take care of their sick children, they should have different leave entitlements – this is not fair and lots of sick leave is interpreted by HR as concerning – what do I do if my child is sick of course look after them

Sleep – lack of sleep unable to sleep, sleep disruptive when children are sick

Good stress, ongoing stress, increased stress

Trust and respect of employer

Coping strategies – lots of coping strategies especially intellectual ones

Powerless and frustrated positions as employee

Judging vs non-judging employers and wider society

Children are people I am responsible for

Loss of control after children born

Change in expectations – never going to be good enough

You can only experience it (stressful situation/breakdown/trauma) to understand it

Loss of confidence after children

Struggling with breastfeeding, couldn't believe my mind could go so dark

No-one was listening – they weren't listening – I told them

Non-one acknowledged my ability to assess my own baby

Health-care professional who noticed, listened and supported and those that didn't

Angry with system for not supporting me

Being separated from parents when the first baby came

Pressure and constant judgement I came back to at work

Becoming a mother at 50 for the first time – bam within two weeks to a 4year old and 2 year old – this is hard

Change houses and change jobs

Having a stressful time with breastfeeding

I know that this is good for me and I need it (exercise and time alone) – needs husbands support to be able to this

Everything was happening all at once and so fast

It all happened one after the other (describing stressful events)

Oh my husband is great like that (looking after the children, so she can have time alone or do things she enjoys)

When the children are sick, need to take time off work. Receive negative looks and attitudes from boss and/or colleagues sometimes makes things difficult

I avoid this one manager when I have to take time off or go and fetch my daughter from school because she is sick –what am I supposed to do – I need to fetch her there is no-one else –just makes thing uncomfortable.

Being in a contract means that when she takes off because her child is sick she doesn't get paid – but what else can she do

Husband has full-time job or flexible job so they can share parenting responsibilities

Loss of home, job, severe financial stress and had a new baby in a space of one year

Doctor, midwife, family, and friends became concerned – they didn't notice. One participant wanted her family to notice but they didn't - she thought she was being clear

Appendix I: Example of Participant's Narrative

1. Demographics:

- Age: 33
- Children: 2 (3 & 4 years old)
- Married (husband works full-time as a builder)
- Ethnicity – Chinese
- Part-time work (three days per week)
- Part-time student: completed postgrad Diploma 2013 – started Master's thesis (two days per week)
- Competitive Ultimate Frisbee player
- Ultimate Frisbee club committee member
- Type of work/profession: Health Care Professional

2. Comments:

- Anastasia's story starts in 2005 (10 years ago)

3. Terms she uses to describe stress, anxiety or depression:

- *I definitely stress*
- *I actually had a conversation with someone maybe who did not have children or someone, I can't remember, just one of my groups of friend when they asked me, are you a bit stressed? Maybe they could see it on my face or something, I'm like I think stress has just become a normal thing for me. I think I'm swimming in it and at times when I feel I'm drowning in it then I'll move into I'm feeling anxious. If I feel like I can't come up to the surface, then it feels like I'm in, you know, probably more depressed.*
- *It came to a point that I was feeling very anxious about going to work all based on the anxious state as relating to my performance as a professional, my performance as a mother and also my performance as a student.*
- *I was actually probably depressed. I think it felt nothing has light in it. It doesn't matter what I do I found no happiness, either going to Frisbee, going to work. I was anxious about going to work, I worried about going to work, I worry all day when I'm at work.*
- *I felt incompetent in all my life roles, unless I'm really protected in that particular area of practice that I feel I can do my job. But that almost served as a horrible contrast as to what I can't do in the other job. I was crying a lot. Basically every single day involved crying. I questioned myself and I think that comes from interaction with people, how they question my judgement, how I make decisions. I become fearful of making decisions at work. I become fearful making decisions on the field when I'm playing. Everyone's comments became a criticism that I cannot reason out of. I cannot reason*

myself to be able to perform my job. It started affecting how I feel about the really one good day I have during the week, I feel terrible at home all the time. The children are crying; you feel like you can't do anything in a way.

- *It was so, so, so stressful that I would burst into tears with something someone said, something I hear on the radio. I'd be driving and I'd be crying. I'm surprised that I can talk about this without crying but back then there was no way I could be describing this for that long without crying.*
- *Yet those times are quite dark, I remember them vividly*
- *Having children makes the stress permanent*

Considerations that increase stress, anxiety and depression	Considerations that relieve stress, anxiety and depression
<p>Internal</p> <ul style="list-style-type: none"> • Multiple roles • Multiple role demands • High role expectations of herself • Being a good mother and worker important to her • Unable to cope with pregnancy, working full – time and part-time study (not enough physical or mental capacity) • Husband does not meet her expectations of being a diligent father • Lack of confidence in work capacity • Unable to think, and perform, feeling useless in work after having her second child and now having two children • Not getting rest – too busy • Feeling guilty for taking sick leave to look after children or because she has been sick • Being attached to the job she had for a long time and finding it difficult to leave • Guilty feelings about spending time with children and work and not enough time on study • Fatigue • Lack of sleep or poor sleep • Getting sick • Must see progress – of no progress in tasks feels stressed. • Difficulties managing negative self-talk • She worries more since becoming a mother • Children are most important in her life – feels responsible, needs to be a good role model • Feeling “not good enough” as a mother • Losing control once pregnant of body and then after the baby is born losing sleep, sense, body, eating, managing work (sleep deprivation and breastfeeding) 	<p>Internal</p> <ul style="list-style-type: none"> • Enjoys sport and playing Ultimate Frisbee competitively (social outlet and fulfils her love for exercise) – “Don't think I can live without it” • Decreased role demands of Ultimate Frisbee committee (used to be president, now just a committee member – less responsibility) • Gaining insight into experience • Seeking professional help and using counselling strategies • Accepting that the one job is not suitable and making the decision to leave • Reflecting and gaining perspective about what is important in life • Being courageous and making change • Having some time alone and/or enough time to socialise • Ability to reduce and manage her stress better now • Loves being a health care professional. • Feeling valued as a competent team member • Getting to sleep, strategies • Courageous • Positive self-talk • Values the importance of being acknowledged and supported • She doesn't give up – she perseveres • Setting alarms to eat and take medication • Being grateful eve when times are really bad • Having hope, being hopeful • Self- acceptance and forgiveness • Gained back ability to control things in my life • Having confidence in self again • Coping strategies

<ul style="list-style-type: none"> • Traumatic experience as a first time mum • Being isolated from mother when she had her first child • Feeling disempowered by health professionals as a competent mother • Feeling guilty and responsible for oldest son's "lack of thriving" because she didn't put him on formula sooner • Needing to be in control – children give you not control • Constant experience of anxiety • Doubts about own performance as a mother • Body changes post pregnancy – feeling like a failure when not performing in sports 	
<p>External</p> <ul style="list-style-type: none"> • Life stage – adulthood, forming stable relationship, starting a family, working • Relationship with husband • Cultural expectations of motherhood from own mother • No physical help from her parents as they live in Hong Kong • Several time periods of increased stress between 2007-2015 • Lack of support and understanding from manager about being a parent • Lack of confidence from her manager in her abilities to practice competently • Time – lots of toing and froing between working full-time and part-time work role, being a mother to one and then two children within 19 months and starting and stopping post grad study during 2010 - 2015. • National level competition expectations and committee and team member expectation from Ultimate Frisbee club • Children and husband getting sick • Working in an environment with sick children • Poor sleep since first child was born (5 Years ago) • Being judged as a parent by people in the community • No support or training for new job expectations • Strained relationship with in-laws • Family and cultural expectations of being a mother – being judged as a result of how your children behave • Mothers criticism of her mother role • Not being supported and respected by healthcare system as a mother and health professional • Judgement from health professionals when she chose not to breastfeed 	<p>External</p> <ul style="list-style-type: none"> • Children in day-care three days per week • Having a supportive husband to assist with household, income and household tasks • Husband has flexible job and works locally • Telephone support from mother • Good professional supervisor • Help from work union • Supportive and understanding manager and colleagues • Managers having faith in her abilities as a health care professional. • Time: Life is just settling now 2015 • Been playing ultimate Frisbee since 2003 – had a break between 2010 and 2015. • Coffee group friends – provides support for her as a whole (children, work, study, socialising and babysitting) • Engaging in counselling service for a period of time • Having surplus leave available • 10 hours sleep when she visited her mum in Hong Kong • Being valued and respected a competent team member by manger and colleagues • Respect as a mother from her mother • Practical help from mother when she visits • Able to make better decisions when at home in China with her mother • Counselling available through work • Babysitting support from coffee group • Supportive professional supervisor and supervision • Someone to help you identify help and areas you need to work on, an

<ul style="list-style-type: none"> Stress period began when first child was born in 2010 	<p>objective, no-judgemental person</p>
<p>Occupations/Activities (type, what, when, who, where, how and why (meaning):</p> <ul style="list-style-type: none"> Engaging in multiple role tasks (not enough time and energy to do it all) Engages in competitive ultimate Frisbee Engaging in Post-graduate study activities two days per week Recently gone back to playing Ultimate Frisbee (in summer plays four times per week, up to three hours of time outside home, work and study) Working for two different managers in two different work locations and areas of practice at the same time. Not having time alone and/or enough time to socialise Not completing study tasks for supervisors Doing the research is stressful – trying to find answers Major changes to job expectations When her mother comes for a visit from overseas – lead up to The day before and day of taking the children to swimming Trying to balance being a good mum, achieve in study, playing good Frisbee 	<p>Occupations/Activities:</p> <ul style="list-style-type: none"> Deferred post grad study in 2010 - took it up again in 2012. Changed from full-time to part-time work Changed jobs Recently gone back to playing Ultimate Frisbee Taking a few weeks annual leave from the stressful job Meets with coffee group regularly Working for two different managers in two different work locations and areas of practice at the same time. Having a meal on her own without her kids or husband Doing research related to her work Work, study and Frisbee is a sanctuary
<p>Main contributors:</p> <p>Multiple role demands and high expectations of herself</p> <p>Lack of confidence in her own abilities in all roles. Traumatic experience becoming a first time mum</p> <p>Lack of support and confidence in her abilities as a health care professional from her manager and colleagues in one work environment</p> <p>Time: all seems to happening at the same time and for a length of time</p> <p>Multiple role tasks, significant professional and competence issues within one of two working environments, having time without the husband and kids. Occupation of work had a significant influence on her stress, anxiety and depression (changes to the nature and expectations of the her role, lack of support and training)</p> <p>Main alleviators:</p> <p>Insight and strategies learnt from counselling in the past</p> <p>Supportive and flexible work environment</p> <p>Working in a practice area she loves and feels competent in</p> <p>Supportive husband</p> <p>Supportive manager and colleagues <i>“I felt that I never have to shoulder everything ever again.”</i></p> <p>Ultimate Frisbee player</p>	

4. **Other :**

- Unclear whether these factors contributed or alleviated her stress, anxiety and depression:
 - Time away from Ultimate Frisbee when she had her two children
 - Did not want to burden her parents or husband with her issues

Clearly identified a significant period of stress as September 2014 – *“That would be the most diabolical stress that I have ever experienced in my whole life.”*

5. Children affected her ability to do the one job in paediatrics (she doesn't explain how though) – this impacted on her relationship with her children
6. She seemed to be unaware of how significantly stressed and depressed she was in her life – although she was feeling it. *“...and I remember being in a lecture, it was a stats paper, completely unrelated to anything about depression or about mental health or anything like that. We were analysing some data from a Beck's depression scale and I looked and thought maybe I should do this just for fun. I wonder what my score is. The score frightened me. I can't function like this is how I felt”*
7. Wanting to hide when she was stressed and depressed.
8. She says she is in a constant state of stress now and at times she can reduce that for herself
9. It looks as if Anastasia experienced increased stress and anxiety over a long period of time and it eventually developed into depression with the last significant stressor in September 2014 - *“I couldn't really enjoy anything in my life for that period of time. I think it built up as well, I didn't just start like that, it became worse and worse. The snowball became bigger and bigger” ...“So if my study is stagnant for a while then it gets larger of if my sleep deprivation builds up it gets larger. If I'm physically tired from Frisbee then I can't get the motivation to go and do study because I'm exhausted”*
10. Sleep – *“I now have to sleep... actually since my second baby, I have to sleep with grade 5 industrial earmuffs. Literally the one my husband uses for digging and construction work. I have to put that on, not every night, but if I'm falling asleep and I'm feeling that my head is swimming I have to do my own breathing exercises to fall asleep. I used to have big trouble falling asleep in that really stressful time and then I'd wake at night.”*
11. Occupations as Sanctuaries – *“Work became my sanctuary. The postgrad room is my sanctuary”....“Going to Frisbee is my sanctuary*
12. Being Chinese influences her values and ideas of being a mother and parent – she doesn't say how though – she expects her husband to follow through with these values – he is New Zealand European
13. Anastasi on being a parent: *“Having children makes the stress permanent”*
14. *“Thank you for listening”*

Appendix J: Memo

Expectations (realistic and unrealistic - learnt from other enforce by society internalised by women The role of worker and mothers holds meaning and significance for working mothers' these are roles they cherish and want to do well in – give their best but it's hard it's a struggle. There a good days and bad days, sometime multiple or prolonged bad days. It is this constant daily struggle that is stressful for working and can lead to anxiety and depression. The more resources and support the better the women cope.

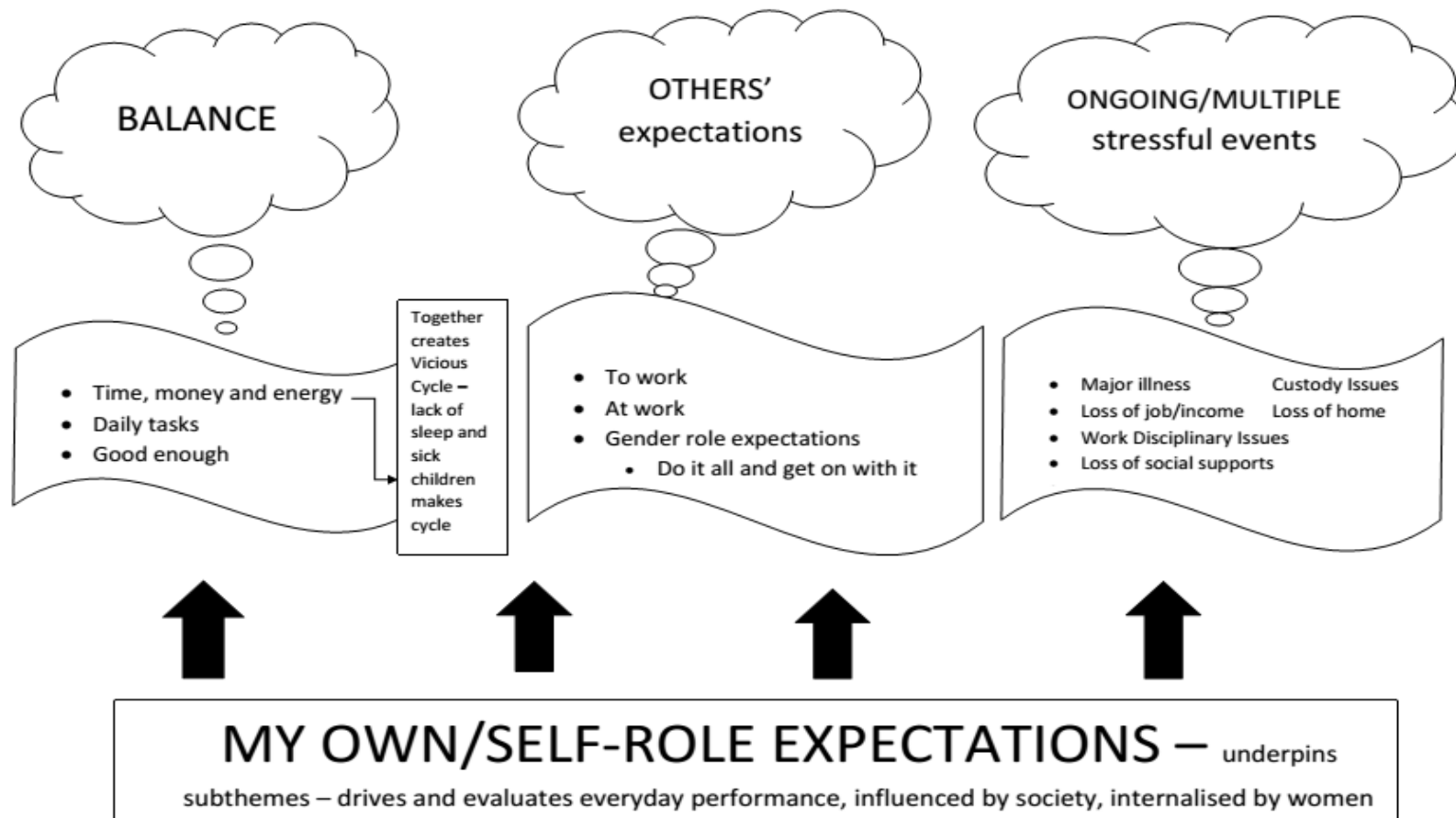
Being a mother and living in society and being worker, expectations can lead to women seeking help late - in response to these expectations there is more to do in a day, juggling emerges, balancing time, energy and money (expectations rule the juggling – when expectations are unrealistic or don't fit with what the woman can cope this is stressful and leads to feeling of not being good enough –makes it hard for working mothers' to feel good about themselves) and more to do this is stressful, expectations lead to low prioritisation of women's needs leading to cycle of unwellness,

In addition to these daily struggles women have to struggle to cope with unplanned events that range from minor to major life events, Suzie, Adelaide and Anastasia gave good examples of these.

Prolonged or multiple unplanned events over a period of time can lead to depression for example win the case of Anastasia, Adelaide and Sarah.

Appendix K: Theme 1 Diagram

Theme One – Struggles that cause stress



Appendix L: Conditional Relationship Guide

Solutions: Helping with the balance

Things the women did that relieved, eliminated, easier to balance

Shaping and reorganising your unique life

Evolution

A fierce commitment to getting it right and making it happen, for them, their families and society in general.

Role Identity

Responding to stressors – eliminate or prevent stress, mostly on their own – need better support

Creating a life that works for you – process

1. Establishing priorities/meaningful /Prioritising/Creating a new self
2. Sharing the burden/load/Sharing
3. Activities
4. Wish list/Aspirations

Prioritisation/Reprioritisation

All kicks in when they are experiencing stress – coping strategies

Uniqueness/Complexity

Conditional Relationship Guide						
Category	What	When	Where	Why	How	Consequence
Prioritising me-putting me first Bringing me back to the front	Putting me right at the top Each participants – different stages of process Becoming congruent with who you are, doing what works for you and your family, putting me right at the top is the process of Prioritising and Reprioritisation personal expectations and daily activities that best fits with the unique person and their context Reflecting, analysing, negotiating, adjusting and creating over a period of varied time.	Transition or Trauma	Insight and experience.	Desperate and hopeful	Reflected and analysed themselves and their context, made decisions about what was important to them, what they wanted out of life, what they wanted to achieve, how they wanted to feel, experimented with doing things differently, allowed themselves to do things in a different way, defending and upholding those changes and choices to others Changing perceptions Let go of preconceived expectations of themselves and others Try new things Be more flexible and adjust/cope more easily Decrease daily	Freedom and choice balance juggling expectations
		Varied between participants, after or during a period of transition	They engaged with the process during or after period or periods of significant stress, anxiety and depression	Because they were desperate for change, they were tired and frustrated of feeling stressed, anxious or depressed, they wanted to get better, and to do better. Hit rock bottom – no more getting on with it. They were afraid they were going to crash They wanted to be successful, believed there was a way to be satisfied and minimise their stress, anxiety and depression		Builds resilience
		After one year of having the first baby	When they felt they could not continue to do the same things every day and that somethings got to change			Builds self-confidence
		After one year of having the second baby				Rewrite priorities
		After self-help courses				
		After a period short or long of trying and failing to meet their and others' preconceived expectations of being the ideal mother and worker				
		After a role change and addition – going back to work, changing to full-time work, going				

		back to work, changing work expectations			demands Able to feel satisfied, connected and happy about their life despite challenges Make time for themselves – do things they enjoy and good for their health and well-being Learn, develop and grow Creating their own unique way of life that works for them	
Prioritising daily activities	Staying two steps ahead to keep ahead Being Organised, Planning Ahead, Not as carefree as I used to be Is the skill of organising, planning, coordinating, negotiating, renegotiating, reorganisation and routining of daily activities – managing themselves and their environment in order to meet their daily demands efficiently. Being prepared being ready, having a plan	Everyday – maintenance, constant Integral periods During or after periods of stress - returned to work or had a change in work hours – where there is role conflict Everytime a new role is added-When a new role is added Some immediately after the children were born or received. Some after a period of when things didn't go so smoothly, where there was no plan and this was stressful	Constant - always working to a schedule At work and at home, constantly on the participants mind – what's next It's both a fixed and dynamic happening Anytime really in the morning, in the afternoon , at night, anytime, all the time	Determined and Enthusiastic Because they want to and need to meet be a working mother and therefore have to meet the daily demands Doing a good job important to them Take pride in being mothers and doing what is best for children It is necessity there is no choice – must find a way to do it all Putting me right at the top sets the foundation and framework for staying two steps ahead. It will influence the daily priorities as valued by the working mother and subsequent daily allocation of time and resources – this will	Doing what best fits with me and my family. Keep to a routine, Use a calendar, Have a plan and a backup plan for the day Coordinating and negotiating with husband, family and work (flexible work hours) Re-adjust easily to unpredictable environment Quotes about all the positive things about	Helps to balance daily tasks and expectations Self- esteem, self- efficacy, Control, Ease and predictability, od daily life that eliminates or decreases stress Being prepared being ready, having a plan

				unique for each participant and their context. When a working mother is unsure about what is important to her, it makes the process of staying two steps ahead challenging		
Go with the flow	What: Attitude that you have good days and bad days – you can't control everything. So on those days just go with the flow – adjust easily to unpredictable change –throw the plan out the window	When: Days when things don't go according to plan, child is grumpy, Bus is late/early, children are sick....	Where: Anytime really in the morning, in the afternoon , at night,	Why: Because there is nothing else they can do, can't change what's happened, can't unsick or reverse time Only response to unpredictable events To try to control is to increase stress	How: Doing what best fits with me and my family at the time. Be flexible Reprioritise Do something different and be okay with it Letting go of the plan Not feeling guilty about not getting things done Laugh	Counterbalancing unpredictable life events
Sharing	Partner is essential So good , never be able to cope Family Work, attitudes makes it easy GP – really helpful, counsellor Array of supports that were useful – practical and emotional help –stories of those that did have this Having useful supports	During periods of depression, stress During Unpredictable events such as sickness	Everyday Every week Occasionally	Making it possible Practical and emotional support Can't do everything by themselves Need a break Can't afford paid help Co-parent – role sharing - expectation – financial sharing Single mother – limited resources for sharing – feeling of it's all on me Less conflict at work	Doing what best fits with me and my family. Good spousal relationship Division of chores and child-care Comprise on work hours Share paying of bills and mortgage – maintain lifestyle etc. Childcare, financial and accommodation support Talking and non-judgemental and empathetic listening Professional Advice And Treatment like medication In order to work, close by, supportive and relevant – those that experienced the opposite	Helps to balance workload Balancing tasks and emotions Share the load or burden – Relief that she doesn't have to do it all on her own. Peace of mind – more relaxed – more freedom more choice Offloading of worry Relief of stress, anxiety and depression symptoms

					Supportive colleagues, understand flexible work hours and responds - easy (Diana)	
Work	Creating a symbiotic relationship with work					
Having enough money	What: Pay bills, afford stuff, work, maintain lifestyle	When: Everyday	Where: All the time	Meet living an lifestyle needs of self and family Living in Auckland expensive	Have work – more stressful not having money. Flexible work hours Spouse working (need two income families) Balancing money and needs and wants Sacrificing time with children to work Juggling work and family life Choosing between part-time and full-time - living consequences of part-time vs full-time work. Earning enough to maintaining a lifestyle Not so for Rachel	Opportunities and basic living and achieve lifestyle needs of self and family
Taking some respite guilt-free time for myself	Hobbies, walks, health, sleep Doing things I enjoy	Once things settle, money, work, and children. Recognise that something needs to be done Confidence and lack of guilt to do it	Some daily, others weekly and others seldom.	Need to feel better, poor health and sleep – do something differently Feeling like not coping Miss doing those activities. Have done those activities before having children and enjoyed it. Sometime having the time to do it and enjoying it – want to do more of it.	Bringing me back – Putting me right on top - rid of the guilt Scheduling and coordinating and negotiating time for self. Allocating resources such as money and supports to have the time for self. Doing what's good and right for me without feeling guilty Doing the things I enjoy Having time out/Time alone Having hobbies Taking care of my health, like sleep, physical exercise, going to the doctor Take the time when the opportunity is there Rachel – not much supports	Good health and well-being Respite Emotional experience opposite to stress Connecting to self Balancing self

					or resources for this	
The Wishlist	Wish, solutions, what else or more can be done?	During periods of dissatisfaction with service, work Feeling lonely, isolate from community, not feeling like they have enough support or right kind of support Negative and unsupportive attitudes from others During the focus groups	In focus groups In discussion with others During reflection periods In times of stress, loneliness, isolation or after that Not coping	Belief that things can get better Given the opportunity to think about wish list Desire for change See the benefits to them Experienced the challenges Experienced stressful events in regarding these aspects and then had a wish Have had glimpses of what helps Experienced both supportive and non-supportive aspects Experienced the barriers and lack of support	Community connectedness Changing people's attitudes – unsure how? More information, more centralised and accessible information More Financial support Gender role expectations Changes to work Changes to health-care services. Flexible employment, fairer sick leave	Increase support, choice and opportunities – balancingrelieve stress Minimising stressors

Balance – nothing supporting multiple change – what happens during change?

All contributes to the juggling - Helps them cope with the struggling challenges or helps to eliminate some conflict, guilt and frustration

Appendix M: Memo Cultural Consultation

Key points from Dr Huhana Forsythe and Dr Gary Leaf's consultation

1. Open and clear communication to participants re: expectations
2. Inquire and negotiate each participant's individual cultural needs which may or may not include the following:
 - Invitation to have a support person
 - Invitation to karakia
 - One to one support/meeting opportunities
 - Presentation of a koha
 - Meeting protocols
3. Give participants an opportunity to check the transcripts and clarify their viewpoint
4. Work within ethical principles outlined by AUTEC

Appendix N: Researcher Safety Protocol Individual Interviews

Researcher Safety Protocol



Project title: Working mothers' experiences of stress, anxiety and depression.

Project Supervisor: Kirk Reed

Researcher: Kim Frenchman

Researcher Safety Protocol for conducting the individual interviews at participant's homes or community centres:

- The researcher will advise the project supervisor in writing in advance of the dates, times and addresses of the interview.
- The researcher will phone or send a text message to the project supervisor prior to the commencement of an interview indicating the expected time of completion.
- As soon as is practicable after the interview the researcher will phone the project supervisor to advise the interview is successfully completed.
- Each interview will last up to 1.5 hours. If the project supervisor does not receive a call from the researcher after 2.5 hours they will firstly call the researcher's mobile. If no response, the project supervisor will phone the researchers nominated contact who is authorised to phone the police to report the concern.
- Should the researcher feel any concerns about safety at any stage during any session, they will terminate the session, leave the venue and phone the primary supervisor.

Approved by the Auckland University of Technology Ethics Committee on 28 July 2015, AUTEK Reference number 15/162.

Appendix O: Researcher Safety Protocol Interview and Focus Groups

Safety protocol interview and focus groups

In the event a participant becomes upset:

- a) In the interview – after taking a few moments for the participant to recover, the researcher will check if the participant is able to proceed with the interview with or without a support person, if so the interview will continue on that day or be rescheduled.
- b) In the focus group - there will be two facilitators in the focus group – should any of the participants become upset during the focus group – one facilitator will lead the participant out of the group to a private area to support the participant, or the participant could be supported by their support person, if one has come along. Should the participant need a short time (5min) to recover and wished to return to the focus group, they may do so. Alternatively they may choose not to return to the focus group.

The co-facilitator or researcher will:

- Take reasonable steps to ensure the participant gets home safely and/or has support at home.
- Advise the participant of the free counselling service available at AUT and supports available from their GP.
- Call the participant within 48 hours to check if they wished to withdraw or continue to participate in the research.

Focus Group Co-Facilitating

1. Co-facilitators are third year OT students who have completed both the mental health and group's paper in second year.
2. The researcher will meet with the co-facilitators one week before the group to prepare them for their role.

Role of co-facilitator:

- Help set-up and clear room and resources
- Time keeper
- Note taker
- Support any upset participants (see protocol above)