The Lived Experience of Postpartum Distress – An Integrated Approach to Social and Psychological Support in the Workplace and Community

THESIS PORTFOLIO SUBMITTED BY

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Signed:

"My story is not the worst of its kind, rather it is the familiar, all too recognisable experience of many women who become mothers today. And therein lies the problem."

Tiffany De Sousa Machado

Publications, Conferences & Awards

2021	Presenter	International Nurses Conference, Berlin, Germany *First time mothers' perceptions of social support: recommendations for best practice.*
2021	Publication	Current Research in Psychology and Behavioral Science *Behind perfect postpartum practices: An exploration into Parenting Support in Sweden.*
2020	Publication	Journal of Health Psychology Open *First time mothers 'perceptions of social support: recommendations for best practice.*
2020	Grant	Research and Commercialisation Grant Fund, The Village Foundation
2019	Presenter	Health Psychology Conference. *Postpartum Distress in Professional Working Mothers: Potential Implications of Policy on Structural and Functional Support for Psychological Wellbeing.*
2019	Poster	Health Psychology Conference - Winner of Best Poster *Connecting Experienced Mothers with New Mothers: An Exploration of the Role of Informal Support on Postpartum Wellbeing*
2019	Finalist	Winnovation Awards, Social Impact, The Village Foundation
2019	Presenter	Women's Lives Conference *Early Parenting Stress and Isolation in Professional Working Mothers: The Implications of Policy on Structural and Emotional Support for Psychological Wellbeing*
2019	Keynote	International Women's Day Address. *Balance for Better*
2018	Participant	Australian eChallenge, Social Change, The Village Foundation
2018	Finalist	Australian eChallenge, Medical, The Village Foundation
2017	Recipient	Westpac Future Leaders Scholarship
2017	Attendee	Nordic Marcè Conference
2017	Attendee	International Women's Congress for Mental Health, Ireland

Executive Summary

This thesis portfolio consists of chapters which contain two journal articles, and a third, applied section, which take the reader through a process from ideation, to formation and finally practical application. It begins with an account of personal experience with maternal postpartum depression, then explores postpartum depression and distress beyond the biomedical definitions, concluding with a number of models within which the lived experience of new mothers with postpartum distress make sense.

With absent social support at the crux of the lived experience, a review of social supports in Australia is presented in Paper 1. A narrative review of social support, including the recommendations in the literature and concluding with recommendations for best practice, are presented. The research identifies the common failing to distinguish qualitatively between social support elements and finds that despite the array of various social supports on offer in Australia, collectively they fail to address the overall functional support needs of new mothers. Paper 1 finds that current standards of social support for new mothers experiencing postpartum distress fail to be adequately addressed in terms of the 5 key areas of social support: information, appraisal, instrumental, emotional and social companionship support. Nor are adequate supports being providing for mothers experiencing postpartum distress (PPDS).

Paper 2 explores PPDS in Sweden, acknowledged as providing world's best practice in the areas of information, instruments and social supports postpartum. With PPD rates similar to those in Australia, and in a context of many political and economic

similarities, Sweden provides the perfect context in which to explore what is missing in terms of support. The researcher spent 3 months in Sweden conducting qualitative research, participant observation and semi-structured interviews, in order to provide a comprehensive analysis of the postpartum experience for new mothers in different national contexts and what, if anything may be missing in terms of social and other needed support. The research brings to light 4 themes, with resulting insights through the ethnographic process of cultural submersion. Notions of cultural embeddedness, equality and freedom are explored. It is found that despite the provision of substantial state provided social supports the needs of mothers with PPDS were not adequately addressed. Participants expressed the desire for trusted, informal relationships with women who had experienced similar emotions.

Section 3 takes a different approach. Drawing from the psychological research of papers 1 and 2, the third and final element of the portfolio, further explores the roots of PPDS, discussing biomedical, feminist and evolutionary perspectives. From this, a Biocultural Theory is offered as inclusive of these three approaches, establishing culture as the formidable arena for systemic change. Interviews are held with various high profile members of corporate Australia, exploring postpartum experiences from the personal lives, and professional roles of leaders in human resources, people and culture, equality, public sector employment and as heads of teams. Through categorisation and analysis of the responses, a model for Workplace Social Support is designed, and a business case is presented to address the recommendations found across diverse literature; much of which was confirmed by papers 1 and 2. The premise is simply, that 1) informal, individualised emotional and appraisal support are what women seek in the postpartum period, 2) women in

Australia and Sweden are likely to return to paid work within 2 years of the birth of their child, and as such, 3) the workplace is the most obvious place this support should be offered.

This research aims to do two things: address current postpartum social support needs based on existing cultural values and practices and explore the capacity for systemic change through the actions of individuals, corporations and policy makers. An innovative, first of its kind, business case is presented, established and was set to be piloted prior to COVID19. The business model includes consultancy, education and training to corporate Australia, and positions itself within a new social paradigm. An example of one the Village Foundation's offerings is the implementation of a face-to-face mentoring program between experienced employees, and new employees, in which parents are supported to smoothly transition, both practically and emotionally, into motherhood and back into paid work, before, during and after parental leave. The program is supported by facilitated training through a secure, company specific software application and communication materials. The case is made to benefit two distinct cohorts – the individual and related networks, and also Australian industry, which loses over 700 million dollars annually to perinatal mental health related loss of productivity and staff turnover.

This portfolio follows substantive investigation into the nature of postpartum depression and postpartum distress, and offers a practical approach, applying the recommendations and findings of the first two papers in an effective, practical and sustainable manner.

About the Author

My personal lived experience has influenced the development of this thesis. For this reason, I am declaring it here to the reader as a matter of transparency.

I have worked in many service and corporate businesses in Australia, predominantly in a managerial role, responsible for human resources, people management, training and development. I left corporate work to undertake a Bachelor of Psychology (Hons) in which I completed a double major in Psychology and Anthropology, obtaining first class honours.

In addition to corporate and academic work, I worked as a therapist and counsellor for eight years, during which time I designed and facilitated workshops and courses for cultural awareness in women's mental health wellbeing, parenting practices and the importance of cultural competence more widely.

In 2011 when I had my first daughter, Faith, I suffered in the postpartum period, and I turned my focus more acutely to postpartum wellbeing in women across various cultures. In 2017, I was awarded a prestigious Westpac Future Leader Scholarship to undertake a Ph.D., which was awarded on the grounds that it would contribute to meeting the requirements of creating a better Australia, in my case, through increasing mental wellbeing and productivity.

The scholarship allowed me to complete my research in Sweden, where I was able to connect with, and interview, key stakeholders in the space of mothers' wellbeing and mental health.

In 2018 I had my second daughter, Rumi, and experienced a completely different postpartum period, as a result of education, awareness and application of many of the aspects I present in this thesis. It is my belief that with knowledge and a wider lens through which to see and experience motherhood, many more women will have the opportunity for a happier, more balanced postpartum experience.

Acknowledgments

This thesis would not have been completed without the financial support of the University of Adelaide and the Commonwealth of Australia through the Australian Government and Research Training Program Scholarship.

The depth of research in this thesis would not have been possible without the financial support of the Westpac Scholars Trust, through the Future Leaders Scholarship which I was awarded in 2017. The scholarship enabled my overseas research and product development of The Village Foundation. Much more than money, the belief in me and the support and guidance that was offered by *Susan Bannigan, Amy Lyden, Lauren Hill, Felicity Duffy, Rachel Walters, Alissa Nightingale, Amy Blacker, Suzie Warrick, Dan Caprar and the extended team* at the Westpac Scholars Trust has been transformational.

I would like to express sincere gratitude to my supervisors *Dr Barry Elsey, and Dr Wendy Lindsay* for making the Ph.D. process one of exploration, creativity, camaraderie, fun and freedom. Thank you for making this journey one of the richest and most meaningful experiences of my life.

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I would like to thank *Professor Inger Sundstrom Poromaa* for inviting me to and hosting me in Sweden. Thank you to all the *professors, students, and midwives* I

interviewed in Sweden, to the *doctors and midwives* who took care of me while I was there. My sincere affection and gratitude to *Kerstin and Jerry Ståhlberg*, *Janet Cunningham and family*, *Malin*, *Jennifer*, *Dr Christopher Bean*, and all my friends in Sweden who took us into their homes, embraced my daughter and made us feel so welcome, providing the exact kind of social support I needed.

I would like to acknowledge *Professor Anna Chur-Hansen*, for 7 years of mentorship, and for widening my understanding of the depth of influence culture has on us as individuals and as a society. I would like to thank *Professor Helen Winefield, and Professor Pascale Quester* for inspiring leadership. *I acknowledge Dr Clemence Due* and *Dr Susan Hemer.*

I would like to thank my colleagues and friends, *Professor Nicholas Burns* and *Andi Tran*, for unconditional support and friendship. *Stephenie Pagoudis,* my dear friend for always standing by me and believing in me. My Westpac FL partner in crime and friend, *Daniel Conley* for sharing the Ph.D. journey with such integrity and positivity. *Fiona Rigney* for your generosity and spirit. *Dr Melanie Reddaway* for guidance, connection and a doorway to a better experience. My dearest *Narrah Zollo*, for being the constant, nurturing presence post-partum and beyond.

Dr Niki Vincent, Ben Owen, Keegan Sard and Justin Jamieson for being ambassadors of The Village Foundation. All the *executives* in corporate Australia, and the *officers of government* who I interviewed. *Emma Walsh* and team at Parents at Work for your important contribution to Australia, and for recognising and supporting the importance of The Village Foundation. *Krystyna Wielgosz* for your mentorship, your continued belief and investment in me and The Village Foundation vision.

I would like to thank *The Honorable John Gazzola* for your unconditional support, understanding, flexibility and mentorship. *Marion Wands* for opening your home and heart and *Dr Robyn Groves* for your contributions.

My family has played such an important part in the making of this thesis, and in the making of the mother that I am. I am eternally grateful to you all:
Craig Cowling, Sophie Renae and Gemma Cowling for the selfless gift of motherhood, for our beautiful Faith, and for being the living example of what family means.
Kaea, Cruz and Winter for your patience and your love. *Teati*, for your constant help and support with our beautiful Rumi. My brother, *Aaron Machado,* for coming to my rescue and filling very big shoes in the early days.

My dad, John Machado and Angie Ghinis, for providing me with the parenting experience I desperately missed the first time. For opening your home and your hearts and for providing the utmost in family care and support, all whilst believing in me. Thank you, dad, for showing me this side of you which has changed me and us forever.

James, for our amazing Rumi, for being the most hands on and connected dad to our tribe, for exceeding the highest post-Sweden fathering expectations, and for always having faith in us, with unconditional love and belief.
Faith and Rumi, for opening my heart to a dimension of love I never thought possible, and for challenging me to be the best version of myself. You are my everything, and each day I work, I work to show you a better way of being in the world.
My mum, Gilda Marie Hanna, for loving me, for being the voice inside my head when I feel out of my depth, and for leaving me to become who I am today.

Dedication

This portfolio is dedicated to my mum, Gilda Marie Hanna. In her presence she showed me what it meant to be a devoted, generous, hardworking mother. In her absence she showed me the depths to which I would fall without her guidance and love as I became a mother. Without her, I found purpose, meaning and truth in my life as I experienced and further explored the dark truth of motherhood; that which with her beaming devotion, she never unveiled to me. All that I have done, all that I hold dear, and all that I contribute is as a direct result of the void she left in my heart when she died before ever experiencing the delight and reward, she dreamed of in becoming a grandparent.

For Faith and Rumi

It's 3 o'clock in the morning. You are crying your eyes out; your gums are hurting and there is nothing I can do. I hold you in my arms and rock you – quite forcefully as this is what soothes you. Sue told me this and showed me one night and I couldn't believe it worked so quickly. Thank goodness she was there to help. I wonder if my mum would've known that. Would she have had a treasure chest full of tips? I miss her so much and I wish every day, but especially now in the dark, tired and lost, that she were here. What if Im not here for you one day? Will you too lay awake at night wondering what I would've said? How I would've helped? I pray to be with you always – to help you through the hard times and to hold you in my arms when you are older and need me when you have a baby of your own. But just in case…

It's sometimes hard my darling to know exactly what to do,
I often wished I had my mum, your nanna, to talk to.
I'd ask her all the things she knew to do the best I could,
To cope when days are hard, if I lose sight of all the good.

I held you in my arms last night and thought about your child
and even though you are just one, I thought of her and smiled.
I imagined you calling me on the phone, pulling out your hair,
Needing me to save you from a sleepless nights' despair.

Ironically, I thought of this while rocking you back to sleep
Your little mouth and aching gums, causing you to weep
My heart then sank as darkness quickly filled my heart
I wish I had my mum with me, her wisdom to impart.

So, my darling girl, just in case, as one never knows,
I compiled a list to share with you, as I gently held your toes
Advice and insights I have gained from our journey this past year
In case one day I'm not around to whisper them in your ear.

Bring your baby into the world, as peacefully as can be
Do this wherever you feel the safest – this, my love, is key
Trust yourself and your body to know what you need to do
Loving women to surround you, not many, just a few.

Hold your baby close to you, everything else can wait
Feel the bond and connection that spans all time and space
Gaze in wonder and drown in love for as long as your hearts desire
Skin to skin, soft noise, dim light and hearts ablaze with fire.

Wrap and wear your precious one close to your heart always
With baby secure and safe, into her eyes you will gaze
Sleep together naturally, warm and nestled in so tight
Feed and rest and doze together, your spirit will alight.

When your love is hungry, or sleepy, or awake
Throw all the clocks away, it's just their cues that you should take
Tired and worn and empty, you may feel like shattered glass
But my love, recite and remember, 'this time, it too, shall pass'.

When your baby cries my love, respond with love, stay near
It's the only way she can tell you; "mum I really need you here".
Fear and rules and strict regimes may suit the lives of some
but just a few years of all you can give will fill your little one.

A simple tip for quieting and soothing your screaming babe,
She isn't being naughty or trying to misbehave
Remind yourself of all the things she may be going through
Rock and sway and calm your mind, breathe my love and soothe.

Ask for help my precious girl, and trust in who you are
Surround yourself as I have done with women who you love
Be gentle on yourself, be kind, and follow your heart
You will never fail in anyway if from your soul, you never part.

Remember too that your little love has chosen her own way
Do all you can and then let go with loving detachment everyday
Whisper words of wisdom, inspiration, love and peace
Into baby's ear as she drifts gently off to sleep.

I share this with you sweetheart not as a list of rules,
But guidance from my heart to yours, just some helpful tools
You will find your own way through the maze, just as I have done
But angel I am with you now and always; I'm your mum.

Tiffany De Sousa Machado, 2012.

For all the daughters, should they become mothers

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Abbreviations

PPD	Postpartum Depression
PPDS	Postpartum Distress
Village	The Village Foundation
PL	Parental Leave
SS	Social Support
WPS	Workplace Parental Support
SPSS	State provided Social Support
ISS	Informal Social Support
PAW	Parents at Work
NSM	New Social Movement
CB	Collective Behaviour
RM	Resource Mobilisation
P	Particularist

1

Introduction

"Loneliness isn't a singular force. It lives inside an ecosystem. So, if we are to stymie the loneliness crisis, we will need systemic economic, political and societal change, whilst at the same time acknowledging our personal responsibility."

Noreena Hertz, 2020

Preface

This thesis comprises one publication and two manuscripts which have been prepared for publication. These are preceded by an introductory chapter and followed by a conclusion chapter.

This thesis begins where the exploration into the subject began – with lived experience of Postpartum Distress, its effects on my family and work. It is hoped

that by sharing this with the reader, a greater and more personal understanding of the nature of this work and of its importance to society will be revealed. Postpartum distress can have long and lasting effects on all members of a family. Indeed, family members make up workplaces which, together with communities, make up our society. Behind the statistics relating to Postpartum Depression, are the stories of real people, professional, capable, strong women, facing feelings of isolation, loneliness, a sense of incompetence and a potential loss of identity when transitioning to motherhood.

My story is not the worst of its kind, rather it is the familiar, all too recognisable experience of many women who become mothers today. And therein lies the problem.

1.1 My lived experience

My journey to becoming a mother was not a simple one. It was compounded by losing my own mother, health complications and various external factors which added to the stress of transitioning to parenthood. My perfectionist nature saw me carving out a plan which was always doomed to fail. Seeking perfection in the self is dangerous and so when my beautiful daughter was born and the picture in my mind so drastically misaligned with reality, I struggled. This is one piece of the puzzle. I was isolated following the death of my mother, estrangement from my father and the fact that my husband's parents lived interstate. None of my friends had children, so I felt very much alone. My husband struggled with becoming a new dad again and threw himself into his work which was largely located interstate. I felt quite desperate a lot of the time – desperate for connection and conversation. Desperate for help and for someone else to hold the baby. I was desperate for recognition of

what I had just been through and of this miracle in my arms. I could not understand the lack of significance the whole transition into motherhood was being given by so many, and I felt humiliated that I had anticipated more. I missed the life I had previously led, the sense of accomplishment and high achievement I had known throughout my career and found myself dreading each long day, devoid of acknowledgment. The guilt and shame over my feelings were always in the background. I never voiced any of this for fear that it would become real. I could not have adored my daughter more; she was perfection to me, and I just wanted to give her the best possible life and love I could. Increasingly I felt inadequate, and ill-equipped to be her mother, despite giving her all of me. I was tired, empty, lonely and constantly yearning for connection, missing my mum, and feeling sad. Despite feeling this so deeply and taking it on so personally I also somehow knew this was not a deficit in me – but life's circumstances closing in on an unrealistic dream.

Returning to work just saw my anger grow at the gross inequalities and assumptions made about me as a woman, my role and my ability and as well, my commitment to my career. I felt as though I was trapped in motherhood while my husband and everyone else around me were able to carry on fulfilling their needs, freedoms, choices and careers. I stood watching as it all sped past my tired eyes. My husband experienced his own grief and despair, his own mismatch between dreams and reality, his external and internal pressures to be the breadwinner, the 'hands on' dad and my emotional rock. Eventually it was the sheer depth of inequality around the roles in the home that broke us. I was desperate to work again and rediscover my sense of identity, and yet I had my role cut out for me, by everyone. When my husband and I separated after 14 years together, my daughter was 3. We both mourned and yet so much damage had been done. He missed me, my income, our life. He missed the fairy tale we had, while I dreamed of the fairy tale we could

make. The celebration of parenthood can end quickly and be replaced by loneliness, unmet expectations and grief. There is no ceremony, no celebration of motherhood, save one day a year, and little truth spoken of the degree to which the culturally embedded roles and the frequently unrealistic expectations of new mothers are inevitably unmet particularly for those who return to paid work.

As a new mother, I experienced the highs and lows that come with transitioning from one life to another. Without my own mother or any other significant supports, it became increasingly difficult to navigate life. The local libraries, playgroups and outings offered a place to go to be with others, yet they were not providing the support I was in search of; we were all alone, together. Many times, I felt that being alone in a large group felt lonelier to me than being by myself with the baby at home only added to the difficulties I was experiencing. – I.e. Other mums with children my daughter's age would talk about their mums being too involved or not involved enough; they would compare sleeping routines and discuss foods and crafts they were dabbling in. I became aware of the façade of many new mums as I donned my own and put my bravest face forward in what was a competitive and thinly veiled show of coping and happiness. Often, I would leave feeling worse than when I arrived, but I kept going because what was the alternative? I craved the closeness and honesty of parents who had walked in my shoes, and on the rare occasion when I would reach out and they would provide me with comfort, it was enough to keep me going for another day, and to alleviate some of the stress and guilt I was carrying.

As I delved into researching the postpartum experience from both an anthropological and a psychological perspective, I found that a distressing

postpartum experience was commonly experienced, that increased industrialisation and more individualistic cultures experienced a higher incidence of a prolonged suffering, and that social support was fundamental, all over the world, to a well-balanced and smooth transition to motherhood. The researching and writing of this thesis certainly brought up more questions than it provided answers. Questions around the very fabric of our society, its values, and the degree to which they determine our own values and needs. Questions remain about the basis upon which current structures are based; questions around motherhood and the cultural and psychological ties we have with it and how they manifest; what is real, what is conditioned and how could we tell them apart?

1.2 Research Background

Many women experience some form of emotional distress and significant change upon becoming mothers (Goldbort, 2006; Knudson-Martin & Silverstein, 2009). One in five women experiences postpartum depression and one in ten men (Perinatal Anxiety and Depression Australia, 2019), leading to both short- and long-term developmental implications for the infant and other family members. Up to 85% of women experience some kind of emotional distress after giving birth (Evagorou, Arvaniti, & Samakouri, 2016; Ussher, 2004). This thesis will address the postnatal experiences of both new professional working mothers, and experienced professional working mothers; in addition, it will explore the question of whether appropriate social support and validation increases new mothers' overall wellbeing and reduces loneliness and isolation. This study draws on what can be learned from Sweden in terms of appropriate social support to address the issues of isolation, role change, and postpartum and early parenting stress in Australian culture, from a position of prevention rather than by addressing symptomology alone.

There is extensive literature on the benefits of a 'community' raising children. In cultures where women have female support to transition to the role of motherhood there are reduced rates of PPD reported (Harkness, 1987; Negron, Martin, Almog, Balbierz, & Howell, 2013). Context plays a key role in a woman's mental wellbeing as she transitions from woman to mother; a lack of role-identity and validation may cause distress to women who have been used to levels of respect gained from working in paid employment; where once they may have been in an esteemed role, suddenly they are faced with a role which is not as revered in modern Australian culture, which may cause feelings of loss and insecurity (Lupton & Schmied, 2002). It is during these times that women may benefit from the support and guidance of women who have been in a similar situation and have come through with a sense of having succeeded.

This research focuses on the important roles of support and validation, culture, and mentorship as they influence mothers and the workforce, and the impact of these features on the mental and emotional wellbeing of new parents experiencing stress, a lack of role identity, and work-life balance conflict. The research highlights the dual benefits of bringing together both experienced mothers with new mothers in the workplace and the expected positive impact on participants individually, the workplace and wider society. Research by Punnett, (2006) and Stanford, (2006) suggests that older or experienced women, both working and retired, have much to offer in the way of insights and advice to new working mothers who are going through similar life events to those they may have already experienced and from which they learned.

How Does PPD Manifest?

Please note that shortly the word depression will be replaced by distress to convey a wider meaning of the postpartum condition and place it in a socio-cultural context as well as a bio-medical one. PPD manifests itself in women as a bio-medical – condition for women experiencing sadness after the birth of a child. It may be described simply as having the 'blues'. If they suffer extended or frequent periods of sadness or crying, feelings of emptiness, excessive worry, panic attacks, loss of appetite, reluctance to participate in usual activities, feelings of loneliness and despair, lethargy (from more than lack of sleep), thoughts of harm to themselves or their baby, feeling angry or irritated, then this is classed as postpartum depression and/or anxiety.

Postpartum depression is symptomatic in the way any depression is, but usually begins in the first few weeks after the birth of a child. Even that simple answer is far from perfect – onset can be during pregnancy, can include anxiety, can be hormonal in nature, or psychological, and of course of varying severity and length. PPD poses a major global health problem (Hahn-Holbrook, Cornwell-Hinrichs, & Anaya, 2018). Prevalence is 1 in 5 women, 1 in 10 men. Across the world PPD rates are between 13-35%; 85% of new parents experiencing some form of emotional distress (Evagorou, Arvaniti, & Samakouri, 2016; Ussher, 2004) and suicide is the leading cause of maternal death. However, this question is far more complex than first appears.

In our fragmented society and familial structures, women face many challenges as they embark on motherhood; depressive symptoms and striving to strike a work-life balance are two areas of interest for this study. Postpartum depression (PPD) in Australia affects approximately 15% of Australian women (BeyondBlue, 2016).

Maternal PPD affects all members of the family and can be long lasting in terms of mental health for the mother, her partner and the infants' siblings and developmentally, for the infant (Bilszta, Ericksen, Buist, & Milgrom, 2010). Many women fail to recognise or acknowledge PDDS symptoms and are often reluctant to accept a medical diagnosis of depression (Bilszta, Ericksen, Buist, & Milgrom, 2010).

1.3 Motherhood as a Rite of Passage

Becoming a mother is such an accepted and expected 'normal' part of being a woman in our society that its importance and the process as a Rite of Passage befitting of ritual, acknowledgement and reverence is downplayed (Budig, Misra, & Boeckmann, 2012; Turner, 1987; Yearley, 1997). The social process of becoming a mother is as defined, salient and visceral as the biological one, as women transition from one social status to another (Oakley, 2019; Turner, 1987). In our culture the social process of becoming a mother lacks deep ritual and presence before and particularly after the birth. As elegantly demonstrated in the works of Reed, Barnes and Rowe (2016) and Davis-Floyd, (2004), the birth process of transitioning from woman to mother aligns with the three main phases of a rite of passage: the *separation* from her external world, physically and emotionally as she turns inward during the early stages of birth, the *liminal* phase where a woman exists in-between her former social state and her future social state, moving into unfamiliar ways of being and expressing their experience, and *incorporation*, when she emerges from the birthing process and reengages with those around her, as a mother. In addition to the birth, these stages also fit the broader social shift and extended time frame of transitioning to motherhood; the *separation* from her existing social state and self-identity, the *liminal* phase where a woman exists in-between her former social state and her future social state, and *incorporation*, when she comes back into society, her

relationship and her work, with an altered social status. This process is rife with ambiguity and vulnerability, and one through which support is required. Rites of Passage are often met with formal recognition, ritual and acknowledgement all over the world, to the degree they reflect upon the state of affairs: the events deemed worthy of ritual and recognition within wider society. Ritual, reverence and role redefinition is a fundamental part of the social transition for women, particularly as they combine paid work with motherhood (Oakley, 2019; Yearley, 1997). The personal experience of becoming a mother is highly influenced by the underlying and overt political, social and economic cultural values of the society, thus making it a shared experience in terms of expectations and realities during the incorporation phase. Failure to acknowledge this Rite of Passage with appropriate recognition could be a significant factor in the prolonged distress women experience in the postpartum period.

1.4 Australian Culture and the Working Mother

Australia's culture is characterised as industrialised, individualistic, masculine, biomedical and technocentric (Anxo, Baird, & Erhel, 2017; Evagorou et al., 2016; Mauthner, 2010; Ussher, 2010). Motherhood is viewed as something undertaken alone, and in conjunction with other roles (Mauthner, 2010; Pinker, 2014; Reed, Barnes, & Rowe, 2016; Yearley, 1997). Looking at this understanding in the context of paid, professional, working women, the timeline and trajectory is relatively stable: work, baby shower, medical treatment, hospital birth, visit to work, home for 6-12 months, then back to work with the child in day care. Today women comprise almost half of the workforce. They are more highly educated than ever before and more women than men fill middle management positions (Cheung & Halpern, 2010). Women are, however, still responsible for the majority of household labour

and childcare and are expected to maintain dual roles (Emslie & Hunt, 2009). While approximately half of the most successful women in corporate positions have no children, there are many who are managing both successful corporate roles and motherhood (Cheung & Halpern, 2010). Combining these roles remains a struggle for women and the continual preoccupation with either role often negatively impacts their health (Emslie & Hunt, 2009).

Many women return to the workforce within the first year postpartum either due to necessity, cultural expectations or by choice. PPD can affect the woman's ability to effectively work and provide for her family, particularly if it is left unrecognised and untreated. Work-life balance is a cause of tension for many new mothers who return to professional work. Some experience the pressure of trying to successfully manage two roles and may feel guilty and inadequate when they feel out of control in one or both areas (Emslie & Hunt, 2009; Mauthner, 2010). The expectation of women with high socioeconomic status to be breadwinners, homemakers and mothers is the contemporary Australian cultural norm.

It is well-established that new mothers and families may struggle to balance childcare needs with professional and financial responsibilities (Taneja, Pryor, & Oyler, 2012). Moreover, individualist societies are not structured for children being raised by a 'village', yet women's traditional domestic roles, including child rearing, require collectivist traits and behaviours. Women are expected to perform two roles and are forced to rely on expensive childcare or family members for assistance (Emslie & Hunt, 2009; Yearley, 1997). The woman as a new mother is largely responsible for the care and provisioning of the child, the majority of the household chores and bringing in an income (if not during the first 12 months, very soon

afterwards); research suggests that 40% of women return to work in the first year postpartum (Cooklin, Canterford, Strazdins, & Nicholson, 2011). In cases where childcare options are not available, where excessive childcare is relied upon, where women may choose to stay home to raise children, or where they are attempting to balance or integrate both career and home life, women in higher socioeconomic groups may suffer physically, emotionally and mentally through isolation, loneliness and from a perceived loss of role in society. Women report feelings of shame and failure at not being able to cope with the competing demands of motherhood (Liss, Schiffrin, & Rizzo, 2013; Mauthner, 2010). Additionally, within our individualist society which is heavily skewed towards independence and self-reliance, where families are widely dispersed and independence is highly valued, many women or couples, raise families alone (Winefield, O'dwyer, & Taylor, 2016). Stress and depression have reportedly significant effects on physical health such as reducing exercise and suppressing immune responses (Dhabhar, 2014; Stults-Kolehmainen & Sinha, 2014), and thus the initial stress can be further compounded.

On the other hand, older women in our society may struggle to find purpose or meaning in their lives when they retire, reach menopause or when their children are grown (Zhu, 2016). Social isolation has been reported as a major contributor to reduced wellbeing in ageing women and moreover, the role of social connection and positive emotions has direct impact on increased physical wellbeing (Kok et al., 2013). Volunteering in roles which are seen as important, where the time offered is used for prosocial reasons and where a moderate commitment is required, has been found to increase physical and mental health; moreover, the emotional support provided to others as an act of altruism reduces depressive symptoms and mortality rates (Anderson et al., 2014).

With women making up almost half the workforce, in part- or full-time paid employment in Australia. Our collective withdrawal from a village and community way of life in favour of an individualistic one, with fewer people attending social clubs and churches, and an increase in online 'community', the workplace provides the opportunity for a 'new age village', so defined at the very least, by the amount of time spent there (Hertz, 2020).

1.5 Postpartum Depression, Postpartum Distress, Work-Life Balance

In Australia women are often expected to be both professionals and mothers. Australian culture places importance on independence, education, employment and ultimately, doing and having it all (Emslie & Hunt, 2009; Hewlett, 2002). Thus, the role of early parenting can elicit a number of stressors; motherhood alone fails to meet the acceptable standards of social approval (Drury, 2017). Despite the enormous capabilities and expectations of women in high socio-economic groups to achieve academically, professionally and personally, motherhood still requires assistance. Women report difficulties in managing all areas of their lives (Emslie & Hunt, 2009). Parents are worried and anxious about returning to work, and perceive a lack of support from leaders in the workplace, and this is found to be more pertinent to women (Work, Karitane, & APLEN, 2019). Some women report negative effects to their physical health of recommencing professional work , whilst others say it helped them regain a sense of their former selves (Lupton & Schmied, 2002). The internal conflict of professional working mothers is salient, wanting to perform both roles well and often feeling inept at both (Emslie & Hunt, 2009). Various areas of life can be affected such as marital cohesion, maternal confidence or social

functioning and these differ from person to person, and vary in severity (Lee & Chung, 2007).

Leigh & Milgrom (2008) define parenting stress as all the difficulties a woman may face when adjusting to parenting. These include physical and emotional changes, adjustments made to the home and routines, changes in role and balancing work and career. Postpartum Depression (PPD) may be categorised as a more severe type of parental stress which some women experience. PPD is usually experienced within the first 12 months of having a baby, and is characterised by severe depressive symptoms such as loss of appetite, tearfulness, and feelings of anxiety, guilt and shame (Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015). It affects the mother, the child, any other siblings, and approximately 10% of female or male partners, as well as the relationship between parents, and the extended family (BeyondBlue, 2011; Bilszta et al., 2010; Evagorou et al., 2016). Furthermore, the mental health of the partner further impacts the mother resulting in a cycle of affect. As many as 40% of mothers return to work in the first year postpartum; as such, PPD has the potential to impact the working environment and the woman's experience, which are both important factors to continuing health. It is reported that PPD diminishes a woman's capacity to function efficiently and meaningfully in many areas of her life.

While PPD is defined as affecting mothers up to approximately 1 year postpartum, parenting distress may be experienced indefinitely, depending on the varying circumstances of each woman (Tu, Lupien, & Walker, 2005). The effects of PPD may be wider felt than expected, and last far longer than the immediate postpartum period. Many women experiencing stress do not meet diagnostic criteria for depression, and it is suggested that PPD is an inadequate label which fails to include

experiences of anxiety, PTSD, stress, fatigue, irritability and minor depression (Fisher, Wynter, & Rowe, 2010; Wilson, Wynter, Anderson, Rajaratnam, Fisher & Bei, 2019). Moreover, it is suggested that poor recognition of symptoms, which can include marital conflict, emotional highs and lows and fatigue can affect all members of the family mentally and physically (Bilszta et al., 2010). Postpartum Distress (PPDS) is far more inclusive of the myriad experiences of new mothers, and extends the timeframe in which these are validated. Unlike PPD, PPDS is multi-dimensional, and consists of a "constellation" of symptoms which the PPD definition simply does not address (Fisher et al., 2019, pg. 6). This research is based on the premise that parenting distress is common, and that lived experience falls on a continuum from 'baby blues' to severe postpartum depression (Lee & Chung, 2007; Ussher, 2004). The signs and symptoms include biological expressions of hormonal changes, emotional adjustment and behavioural changes including sleep, activities consistent with a change of role and balancing work and motherhood. For the purposes of this research, PPDS will be the term used to encapsulate the myriad experiences of new parents postpartum, and encompass the time from birth plus an additional 12-36 months exceeding far beyond the 12-month period (Figure 1), which would reflect the usual return to work period for mothers in a higher socio-economic group. As such, the researcher interviewed women who may have had a formal diagnosis of PPD, but also those who did not fulfil the formal diagnostic criteria.

Figure 1. Postpartum Distress Moving Beyond 12 Months Postpartum

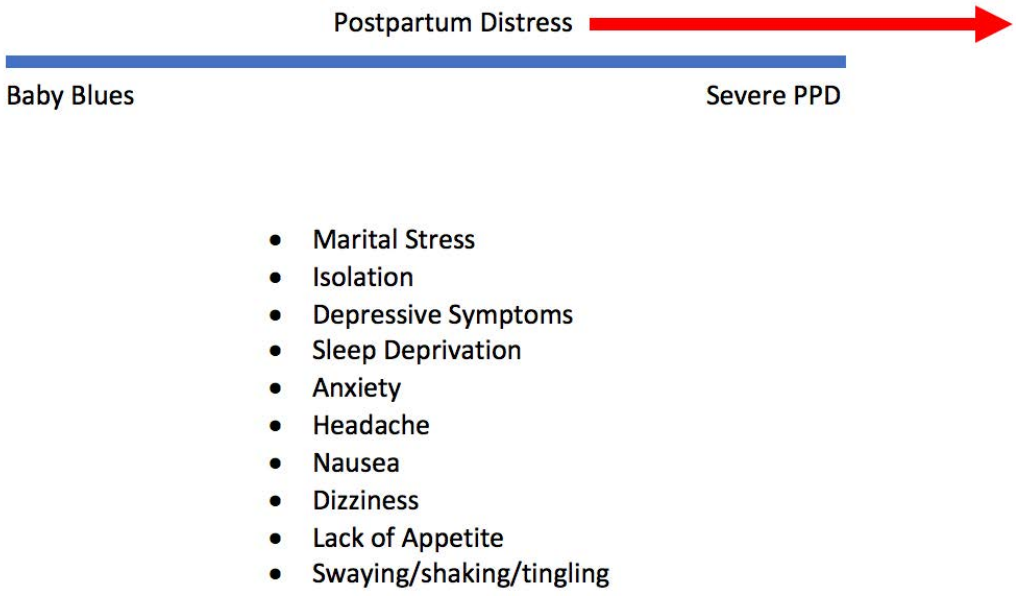

Figure 1. Postpartum Distress encapsulates a broader range of postpartum experiences and extends beyond 12 months.

1.6 The Cost to Australian Industry

Perinatal mental health costs Australia over $700 million dollars per annum in lost productivity, including increased workforce exit and absenteeism (PWC, 2019; Hertz, 2020). The average cost of recruitment per person in corporate Australia is $5070, the average cost of training per person, $1550, and there is a reported 15% decrease in productivity in the postpartum period; "Women and men experiencing depression and anxiety are likely to miss more days at work compared to their non-depressed counterparts" (COPE 2014). One in four parents reports that they had considered leaving their job due to difficulties combining work and family and those without a friend at work are as much as 7 times more likely to suffer mentally and emotionally (PAW Report; Hertz, 2020). As we face a "loneliness economy" implications such as these warrant serious attention (Hertz, 2020). The cost alone

requires dedicated attention. "If the prevalence of women affected by perinatal depression was reduced by just 5% (15,500 women) in 2013, total costs in the first two years could be reduced by $147M" (COPE 2014). Addressing the factors underlying this cost has the potential to address the widespread experience and cost of stress and reduced wellbeing in the workplace, the implications of which directly influence infant development, family wellbeing, costs to business and health. In short, it benefits the wellbeing of Australia.

1.7 Isolation and Loneliness

Paid professionals arguably spend the majority of their week in the workplace. This is where many find a sense of self-identity, gain their self-esteem and their need to belong, their sense of security, and personal self-worth. The promise of parenthood offers to deliver many of these same aspects to parents upon becoming a new mother. The reality is however, that motherhood can be one of the most isolating and lonely experiences, particularly in today's culture. Twenty eight percent of new mothers admit to feeling lonely, and given the stigma and negative perceptions of sad mothers, this number is likely to be understated (Lee, Vasileiou, & Barnett, 2019). Of course behind the numbers, are the myriad stories of distress and social exclusion from community, from work, and from society, as demonstrated by the findings of Mauthner (2010); Mitchell, Absler, and Humphreys (2015) and (Lee et al., 2019), to cite but a few.

Hertz, (2020, p. 34), re-defines loneliness:

> "I believe the contemporary manifestation of loneliness goes beyond our yearning for connection with those physically around us, our craving for love and being loved, and the sadness we feel when we consider ourselves to be

> bereft of friends. It also incorporates how disconnected we feel from politicians and politics, how cut off we feel from our work and workplace, how excluded many of us feel from society's gains, and how powerless, invisible and voiceless so many of us believe ourselves to be. It'as a loneliness that includes but is also greater than our desire to feel close to others because it is also a manifestation of our need to be heard, to be seen, to be cared for, to have agency, to be treated fairly, kindly and with respect."

From this definition it can be extrapolated that as a new parent, this experience is exacerbated by the physical loneliness of being away from peers, from family, from our sense of self, of competence and achievement, of what is seen to be of value in our culture and as mirrored on social media. While we do not see the exclusion of motherhood, it is there, and it is heightened more than ever (Hertz, 2020). Add to the new parenting experience an already increasingly disenfranchised ability to communicate with others face to face, with many of our interactions migrating online and becoming contactless, and we have a situation worthy of much needed attention and ironically, increased meaningful face to face interaction (Pinker, 2014). Kerr, Wiechula, Feo, Schultz, & Kitson (2019), explain that the emotional and positive immune related physiological response we get from direct eye contact and human touch cannot be replicated with technology or on screens. There is more to be gained, mentally and physically, from the sharing of experience and the face-to-face contact we are so fervently moving away from than we may realise (Kerr et al., 2019; Pinker, 2014).

1.8 Social Support

Biomedical culture places the onus of responsibility for postpartum disease largely on the woman (Mauthner, 2010; Ussher, 2004). Biology, psychology and personality factors are cited as key predicting factors. While the sociocultural factors are mentioned, little emphasis is placed on their importance in predicting stress or PPD and moreover, little is suggested to reduce them. In a study by Biggs, Shafiei, Forster, Small, & McLachlan (2015), 78% of women who called a peer support line for PPD did so seeking support. Women expressed a need to talk to others in order to reduce stress, even if they had family as a support. Feeling heard and being able to share their stories was key in addressing their emotional distress, and in increasing feelings of hope and self-acceptance in their parenting (Biggs et al., 2015). This supports findings by Bilszta et al., (2010); Leahy-Warren, McCarthy, & Corcoran, (2012); Mauthner, (2010); Negron, Martin, Almog, Balbierz, & Howell, (2013); Oates et al., (2004); Wisso & Plantin, (2015).

Social support is divided into Structural and Functional Support (Figure 2). Structural support refers to the existence and quantity of support through formal and informal social relationships (Leahy-Warren et al., 2012) and functional support refers to specific types of support (Taylor, 2011). Early work by Sherbourne & Stewart (1991), Bloom) 1990) and Uchino, Uno, & Holt-Lunstad (1999), defines social support as that which is perceived by the receiver of the support to be functional and which leads the receiver of the support to feel loved and cared for, of value and with a sense of belonging. They further define social support as comprising five main areas: 1) *emotional support* through understanding and the encouragement to express feelings, 2*) informational support* through advice and guidance, 3*) tangible or instrumental support* through material, monetary and behavioural aid, 4) *positive social*

interaction referring to having fun with and simply being with others and 5) *affectionate support*, through expressions of love and affection. In addition to these five, Sherbourne & Stewart (1991) refer to a sixth: *self-esteem* support as affirming comparison between self and others. Slomian et al. (2017) present social support in terms of the need for information, psychological support, a sharing of experiences and the need for practical support. In terms of state-provided support, the three aspects of relevant functional support are Informational (by way of government services and resources), Instrumental (by way of monetary and material aid and services, childcare, leave, and flexible work conditions) and to a degree, Social Companionship support (by way of hospital allocated mothers' groups).

Many aspects of these support items were indicative of having someone to whom the person felt close (p. 711), particularly in terms of emotional and informational support where sources could be either professional or personal. Whilst partners, families and friends were the main source of tangible support for most mothers, the emotional support of talking to others and receiving comfort and encouragement was sought from primary sources, as well as other mothers who could share their experiences (Negron et al., 2013). This could be particularly important when the new mother experiences frustration with her partner or family at the lack of or disappointment with other types of support which they expect from them, or when they feel that no one close to them understands exactly what they are going through (Negron et al., 2013). In turn, some women find it difficult to approach others for emotional support for fear of judgement, feeling like a burden and feeling embarrassed (Craig, 2007).

Social Support and Health

"Social support is good for health" claimed Oakley (2019, p. 2), which is certainly a biologically supported notion, with particular importance on face-to-face support (Bloom, 1990; Hertz, 2020; Kerr et al., 2019; Uchino, 2009). Social support has been found to protect or at the least buffer against illness and stress, and improve physical, and psychological health and wellbeing (Bloom, 1990; Sherbourne & Stewart, 1991). It is well established that social relationships and support directly, either as the primary source of relief, or indirectly, through altering the individual's coping mechanisms, affect health and mortality and is comparable to other well-known risk factors such as smoking (Bloom, 1990; Pinker, 2014; Uchino et al., 1999). People without social supports are likely to experience isolation and feel lonely (Bloom, 1990). Stressful events can be handled better or perceived to be less stressful in the company of social support which can influence psychological states such as mood and self-esteem, in turn affecting physiological and behavioural processes such as blood pressure, immune function, hormonal function, adherence to medication and activity. In the absence of stress, positive social support can affect the same psychological, behavioural and physiological processes, for increased self-esteem, elevated state of mind, activity and overall wellbeing (Bloom, 1990; Pinker, 2014; Uchino, 2009).

Bloom (1990), discusses the positive effects of social support on those suffering illnesses related distress and are thus lacking in energy, are remiss towards obligations and reluctant to make social commitments, choosing instead to stay at home, so increasing loneliness and disconnection. As a result of this withdrawal, social networks are diminished and opportunities to receive support diminish with them. Similarities exist between the Bloom (1990) example and new mothers who

find themselves at home and withdrawn from their usual social and paid working commitments, and, as such, similar results may occur. Overall, engaging in social relationships can promote good health outcomes, reduced levels of distress and depression and can enable physical recovery from illness, symptoms of stress and feelings of isolation, loneliness and disconnection from others. In particular, the relationship between emotional support and psychological wellbeing has been well established. It has been recognised to improve acclimatisation to motherhood and to reduce distress while increasing mental and physical health (Bloom, 1990; Hertz, 2020; Pinker, 2014; Reed, Barnes, & Rowe, 2016; Uchino et al., 1999; Yearley, 1997). Those health risks associated with loneliness pose further costs to Australia in terms of healthcare and medical resources.

The Need for Social Support

The need for and expectation of social support postpartum is not new (Negron et al., 2013; Small, Taft, & Brown, 2011). Research by Small, Brown, Lumley, & Astbury (1994), asked women specifically about their experiences and feelings during postpartum depression to which overall findings pointed to their need to have someone to talk to for emotional support, to relieve feelings of being unsupported and of isolation. Negron et al. (2013), found that a lack of, or dissatisfaction with social support increased the risk of postpartum depression. Many women expressed dissatisfaction with both their partners and professional services in dealing with their emotional needs. Women were also reluctant to attribute hormones as the reason for their distress. Women were three times as likely to suggest to other women that they seek someone to talk to about their experiences, rather than to seek professional help; moreover, the study found that over 75% of women expressed the need for interaction and talking to someone who could offer them time and

emotional support by contrast with other potential sources of relief (Small et al., 1994). Working mothers who attempt to balance paid work with motherhood may face particular feelings of guilt, and judgement, (both their own and others) at leaving children with non-parental care (Craig, 2007; Evans, Donelle, & Hume-Loveland, 2012).

More recently, the work of Gordon & Whelan-Berry (2004), has focused on women in paid employment and their perceived support from partners. Women, still responsible for the majority of work associated with home and family life, may find it particularly difficult balancing roles as a mother and a working professional, and rely heavily on partners for tangible support such as sharing home and parenting responsibilities, feeding, bathing and dressing the baby, cooking and shopping, laundry, in addition the scheduling of activities and financial contributions. The 'talking support' offered was more aligned with informational support than emotional, with a focus on providing career related advice (Gordon & Whelan-Berry, 2004). Such tangible and informational support does go towards reducing stress for mothers, however, there remains a significant need for emotional support, which may not be being fully addressed by partners (Gordon & Whelan-Berry, 2004; Negron et al., 2013). Mothers who work in paid employment and have children have been shown to surrender time needed for themselves in order to provide quality time for the child and to maintain work commitments. Quality time spent nurturing the mother would be of significant value (Craig, 2007).

Figure 2. The Structure of Social Support

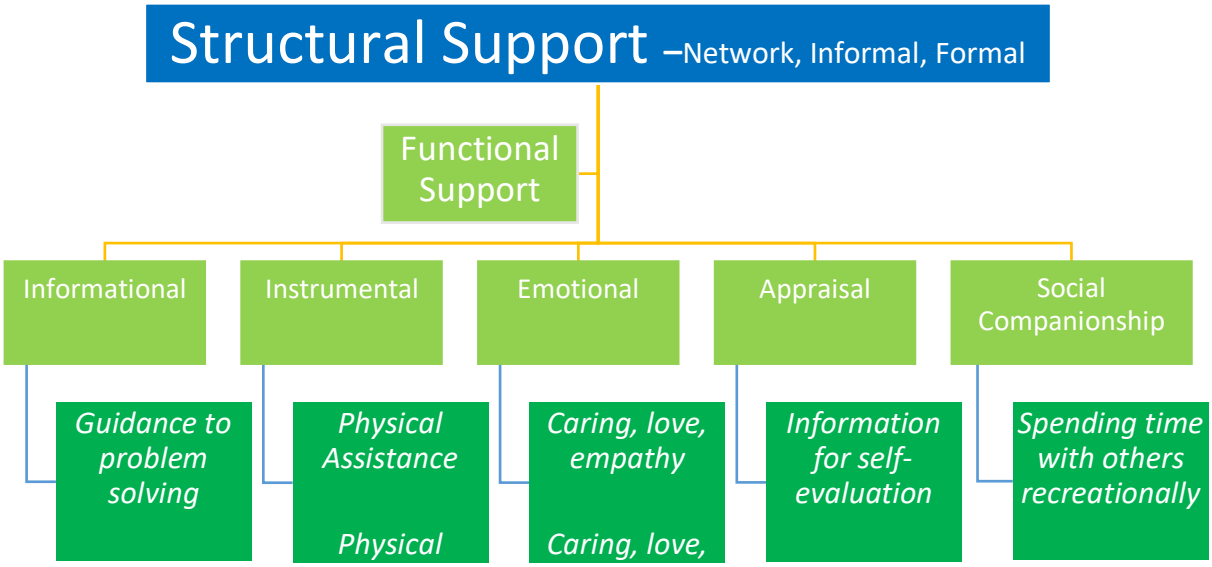

Figure 2. Social support is divided into Structural and Functional Support.

1.9 Supported, Professional Working Mothers

Working professional women who successfully manage work and family commitments have been shown to have high self-efficacy - high self-belief in their capabilities. Successful women report having strong social supports, in friends, colleagues, family and mentors. Furthermore, although mentors were preferred to be casual in nature, many women considered them to be a prerequisite for success. This supports the concept of networks to increase wellbeing and highlights the importance of relationships between women who can learn from each other (Punnett, 2006). Emotional support and validation has been shown to increase physical and psychological wellbeing (Burleson, Greene, & Burleson, 2003; Edlund, Carlsson, Linton, Fruzzetti, & Tillfors, 2015). Sharing and talking about experiences and difficult life events helps people to make sense of and to integrate their new realities more cohesively (Mallinger, Griggs, & Shields, 2006). A study by Small, Taft,

& Brown (2011), provides good evidence for the benefit of mentors to mothers who are potentially at-risk; finding empathetic support led to mothers feeling more confident, less isolated and better able to parent effectively.

This profile highlights the relatively privileged social and educational backgrounds of a segment of women in society, not representative necessary of all women. This means that further research could be more specific of women of less privileged backgrounds to see if their experiences are significantly different. It so happens that there is much research on women from these backgrounds, and the point of this research is to look at a relatively privileged group, who may appear to have all that they require, but in fact, still suffer postpartum.

1.10 Contributions to Knowledge

Two journal articles are presented in this thesis. These are reported below. Both manuscripts have been published. Both published publications have been peer reviewed. Chapters five and six are presented in a more traditional format. The thesis portfolio will take the following format:

Chapter 1

This chapter provides a basis to the research presented herein, beginning with background around motherhood in Australian culture, Social Support and the impact both have on working mothers.

Chapter 2

Paper 1 is presented within this Chapter.

De Sousa Machado T, Chur-Hansen A, Due C. First-time mothers' perceptions of social support: Recommendations for best practice. *Health Psychology Open*. January 2020. doi:10.1177/2055102919898611

Chapter 3

This chapter further explores state provided social support in Australia and delves into the Swedish structures and offerings around state-provided postpartum support.

Chapter 4

Paper 2 is presented within this Chapter.

Tiffany De Sousa Machado (2021) Behind Perfect Postpartum Practices: An Exploration into Parenting Support in Sweden. *Current Research and Psychology and Behavioral Science 2*: 1027

Chapter 5

This chapter presents new contributions to knowledge and describes an applied approach and recommendations for best practice for postpartum support within the workplace. It describes theoretical and practical recommendations for effective workplace parental support, as offered by The Village Foundation.

Chapter 6

This chapter summarises the thesis arguments and describes practical implications of the findings. Future research is suggested.

The Village Foundation Business Model has been validated through the successful South Australian state government RSCF grant funding.

Every publication is preceded by a statement of authorship indicating the work undertaken by the authors.

The following table provides a summary of key concepts, main arguments and knowledge contributions per chapter and publication.

Figure 3. Key concepts, central arguments and knowledge contributions per publication

Authors	Key Concepts	Central Argument	Knowledge Contribution	Fits Within Thesis
Chapter 2 a) De Sousa Machado, T., Chur-Hansen., & Due, C. 2020	Social support; emotional social support; lacking social support; lacking professional care; barriers to social support; recommendations	Social support is not sufficiently defined, broken down nor delivered effectively to mothers postpartum.	Clarification of types of support required and missing from current offerings.	Paper 1 establishes a need for increased social support. It breaks down support into necessary categories and then asks the question of what is still necessary; state or emotional support?
Chapter 4 b) De Sousa Machado, T. 2020	State provided social support in Sweden; emotional support; equality; parental leave; what is lacking; gaps in offerings	Functional social support is not sufficient to effectively buffer the transition to parenthood. Emotional support, recognition and increased choice is required.	The emotional experiences and perceptions of what is lacking from the postpartum period for new parents in a society with the highest social trust and state provided social support.	Paper 1 established a need for social support, without clarifying which type. Paper 2 explores needs for social support in a country where state provided support is seen as best practice, and demonstrated the need for increased emotional support as a distinct need from practical support.

Chapter 5 c) De Sousa Machado, T., Elsey, B., Lindsay, W. 2020	Cultural influence on PPDS; mothers in paid professional work; work life juggle; practical application; new social movement; business model	The workplace is a key space within which support can be provided postpartum. Almost 50% of mothers return in the first year with added pressures of work and family. A practical applied approach to supporting women within the workplace is necessary.	Five key knowledge contributions are made: - Reclassification of workplace support inclusive of all current and relevant terms - Biocultural Theory of PPDS The Village Foundation business model including: - Positing Village as part of a NSM - Tripe A Approach to WWPS - Flagship Mentorship Model	Paper 3 takes learnings from papers 1 and 2, and formulates a practical approach to addressing WWPS in Australia. It provides clarity around what is missing explaining how and why. Finally, it provides a theory which promotes change from the individual to political levels, and provides a solution to deliver that change.

1.11 Summary

This chapter has introduced the main concepts contained within this thesis portfolio and has provided an overview of the thought lines and contributions made. This was achieved first by, sharing the personal lived experience of the author and how the thought processes underlying the research were authentically and personally derived. Thereafter it examines existing Social Support (SS) and the way it has been defined and categorised in the literature, by explaining Postpartum Distress (PPDS) and the various levels at which this can be experienced, and by outlining the current cultural experience of mothers in paid employment and the costs-and benefits SS can produce in Australian Industry.

Applications and main contributions to knowledge were outlined, and through the publications and the chapters herein, constitute the thesis portfolio.

The main argument of this thesis is based on a documented understanding that the experience of transitioning to, and the experience of being a parent in an industrialised culture is one deeply devoid of recognition, acknowledgement, reverence and appropriate emotional support. This can often lead to prolonged experiences of PPDS, underproductive workplaces and a substantial cost to Australian industry. Therefore, a two-pronged approach is necessary: 1) more supportive individual/cultural shifts for systemic change, and more immediately, 2) application of continuous, standardised social support practices addressing both practical and emotional needs for parents in professional paid employment.

2

Emotional Social Support

"What is important is not only the individual's social situation,
but the meaning she attaches to it."
Ann Oakley, 2019

Preface

This research explores existing social support structures for new mothers experiencing postpartum distress in order to better understand the needs of such new mothers and whether the support they are currently offered is sufficient. I conducted a narrative review of postpartum social support to provide a clearer understanding of appropriate social support and to serve as a base from which further exploration, differentiation and subsequent action would stem.

Statement of Authorship

Title of Paper	First - time mothers' perceptions of social support: recommendations for best practice
Publication Status	[Y] Published ☐ Accepted for Publication ☐ Submitted for Publication ☐ Unpublished and Unsubmitted w ork w ritten in manuscript style
Publication Details	Health Psychology Open January - June 2020 DOI: 10.1177/2055102919898611

Principal Author

Name of Principal Author (Candidate)	Tiffany De Sousa Machado		
Contribution to the Paper	Research, analysis, summarisation of findings, writing, and editing		
Overall percentage (%)	80		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	20.1.21

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Professor Anna Chur-Hansen		
Contribution to the Paper	Supervised development of the manuscript. Reviewed and assisted with manuscript drafting and editing. 10% contribution		
Signature		Date	25.1.21

Name of Co-Author	Dr Clemence Due		
Contribution to the Paper	Supervised development of the manuscript. Reviewed and assisted with manuscript drafting and editing. 10% contribution		
Signature		Date	25.1.21

Please cut and paste additional co-author panels here as required.

HEALTH PSYCHOLOGY OPEN

Theoretical Contribution / Commentary

First-time mothers' perceptions of social support: Recommendations for best practice

Tiffany De Sousa Machado, Anna Chur-Hansen and Clemence Due

Abstract

Research indicates social support is imperative for postpartum well-being. The types of social support and access to preferred supports are less understood. This article considers first-time mothers' perceptions of the effectiveness of social supports and perceived barriers to accessing support and provides recommendations for best practice. A search of the literature for terms related to postpartum social support was conducted. Major themes were identified and synthesised. A critique and analysis of the literature is presented with recommendations for best practice. Much of the research around postnatal support fails to distinguish the specific type of support, meaning creating support solutions for the postpartum period may not be effectively targeted. Recommendations for individualised support are made.

Keywords

mothers, postpartum depression, postpartum distress, social support

Introduction

Some groups of first-time mothers are at known risk for potential mental illness or psychological distress in the postpartum period. Thus, research concerning best practice options for support is vital to ensuring positive outcomes for women after they have had a baby. Previous research has shown that social support is instrumental in promoting well-being in the postnatal period (Razurel et al., 2012), with this literature considering issues such as levels of social support and impact on distress, types of support and access to those supports for women after childbirth. Similarly, low social support can equate with a lower quality of life (Webster et al., 2011). While much of the research is focussed on the benefits of social support, some literature outlines issues with the utilisation of the social support available to women, as well as issues accessing those sup- ports (Leahy-Warren et al., 2018; Prevatt and Desmarais, 2018) – a particularly salient issue for particular groups, including women with migrant, refugee or asylum seeking backgrounds (Benza and Liamputtong, 2014; Tobin et al., 2014). This overview draws together the existing literature concerning social support for women in the postpartum period. There are two key areas which are addressed: (1) the perceptions first-time mothers have of social supports, and (2) the barriers women face in accessing social support. The overarching questions are as follows: what are first- time mothers' perceptions of social support, and what barriers do they face in accessing support?

Distress, depression and anxiety

Research suggests between 7 and 80per cent of women experience some form of postpartum distress from the more common 'blues' to depression (Slomian et al., 2017; Ussher, 2004), although it may not be labelled as such outside of biomedical settings (Goldbort, 2006). This distress is not specific to particular groups of women, with Chavis (2016) reporting in their research with women up to 24months postpartum that postpartum distress may be experienced 'regardless of income,

education, race, perceived social support, or the sense of competence' (p. 474). Increased distress is typically found earlier in the postpartum period and dissipates as the woman becomes more familiar with her new role (Leahy-Warren et al., 2011).

Postpartum distress (PPDS) is any psychological problem which impairs daily functioning, encompassing a range of experiences such as anxiety and stress, but not including the 'baby blues', which presents in the days immediately following childbirth and is likely attributed to hormonal and birth-related factors (Coates et al., 2014; Miller et al., 2006; Ussher, 2004). More commonly, researchers have focussed on postpartum depression (PPD) which begins from between 2weeks and 4months postpartum and is experienced as more severe depressive symptoms similar to classic depressive symptoms (Austin et al., 2017). Austin et al. (2017) stipulate that Perinatal Depression and Anxiety (PNDA) includes depressive and anxiety disorders such as mild to severe depression, generalised anxiety disorder, obsessive compulsive disorder, panic disorder, social pho- bias and posttraumatic stress disorder, which occur during the perinatal period, the more severe of which can affect approximately 20per cent of women. While the perinatal period is considered from conception to the first year post- partum, one in seven women in Australia report persistent depressive symptoms up to 7years postpartum (Austin et al., 2017).

Data sourced from the Australian Bureau of Statistics found women contribute more to family and home life when they return to employment postpartum than men (Craig et al., 2012). Mothers who work in paid employment and have children have been shown to surrender time for themselves in order to provide quality time for the child and maintain working commitments, particularly mothers who attempt to balance paid work with mother- hood and who may face feelings of guilt and judgement (both their own and others) at leaving children with non- parental care (Craig et al., 2012; Evans et al., 2012). These factors have been found to contribute to postpartum dis- tress and may account for some of the extended period aforementioned.

Women with migrant, refugee or asylum seeking back- grounds undergo a 'double transition' as they face mother- hood with geographical and emotional displacement from what is familiar (Migliorini et al., 2016: 139; Tobin et al., 2014). Many have also experienced significant levels of trauma, and motherhood may exacerbate feelings of power- lessness or lead to re-traumatisation. For example, Studies by Tobin et al. (2014) and Benza and Liamputtong (2014) highlight the specific challenges women with asylumseeking and migrant backgrounds face which exacerbate issues in the perinatal period. These include low local cultural knowledge, little to no connections, language barriers, isolation, social and racial oppression, fear, distrust, birthing in a mainstream medicalised system which may be very different to that in their countries of origin, and personal disempowerment. Language and communication barriers alone have a direct impact on the health and well-being of women in minority groups, while the lack of culturally relevant rituals which are known to maintain and bolster well-being during the perinatal period may also negatively influence the health of mothers. The needs of this cohort are complex, multifaceted and deserving of significant attention in terms of perinatal care (Migliorini et al., 2016; Tobin et al., 2014: 837).

For many women, the myriad of fears relating to child- birth are universal and can add to perinatal distress. These include but are not limited to concerns about the pain of delivery, fear of complications, interventions and emergency caesarean section, and overall safety during and after delivery of mother and infant, and motherhood, in general (Rania, 2019). These factors, together with the fact that a medicalised birth may be incongruent with the idealised birth of some women, can lead to birth trauma. Birth trauma – an experience where women may feel powerless, dehumanised and disrespected – can severely impact postnatal well-being (Beck, 2018; Rania, 2019). The emotions and beliefs surrounding childbirth and trauma can be powerful for not only the mother but also for health care professionals as they bear witness to and are involved in the process of childbirth and the myriad experiences which accompany it. This too can in turn impact the mother's experience (Leinweber et al., 2017; Morano et al., 2018).

Social support

Early works by Sherbourne and Stewart (1991), Bloom (1990) and Uchino et al. (1999) define social support as support which is considered functional, and which leads the receiver of the support to feel cared for, valued and with a sense of belonging to a larger network. Taylor (2011) states that the mere perception of support improves health and well-being by reducing stress levels. Social support may be provided by partners, family, peers, col- leagues and others from within the community (Sherbourne and Stewart, 1991). Social support has been categorised into two main areas: structural support and functional sup- port. Structural support refers to the existence and quantity of support through formal and informal

social relation- ships (Leahy-Warren et al., 2012), whereas functional sup- port is the specific type of perceived support (Taylor, 2011). Sherbourne and Stewart (1991) report a model of five functional elements; (1) *emotional support* through understanding and the encouragement to express feelings, warmth, nurturance and reassurance; (2) *informational support* through providing advice and guidance, helping another to understand, sourcing resources and/or coping strategies, information, advice and management strategies; (3) *instrumental support* through material, monetary and behavioural aid, tangible assistance, services, specific aid or goods; (4) *appraisal or comparison support* refers to encouragement and advice by those who have been in similar situations and (5) *social companionship* by spending leisure time with others (Ni and Lin, 2011). Leahy-Warren et al. (2012) limit functional support to four key proponents: *emotional, informational, appraisal* and *instrumental*. Regardless of how social support is categorised, the effectiveness of social support depends on the perceived need and effectiveness and also on the relationship between the giver and receiver of the support (Leahy-Warren et al., 2012; Ni and Lin, 2011). Slomian et al. (2017) discuss social support in terms of needs: the need for information, psychological support, a sharing of experiences and the need for practical support. Many aspects of support are indicative of having someone the person feels close to, particularly in terms of emotional and informational support where sources could be either professional or personal.

The main role of social support is protecting the physical, mental and emotional well-being of those exposed to stress. More specifically, social support has been found to buffer against stressors, reducing psychological distress, depression and anxiety in turn impacting physical health (Thoits, 2011).

It has been argued that in order for social support to be effective, the support needs to be personalised, and needs must match the support provided (Leahy-Warren et al., 2018; Taylor, 2011). Women are likely to need and seek support from a variety of sources, including from other women (Ni and Lin, 2011) and in times of stress, women are more likely than men to give, access and benefit from social support (Taylor, 2011). Social support by way of rituals is vital to well-being. For migrant women, social sup- port can enhance health and well-being for all mothers, including those in minority groups (Migliorini, et al., 2016). In Dennis and Chung-Lee's (2006: 327) review, which included cross-cultural data of women up to 1 year postpartum, they reported specifically, women wanted: (a) to be given permission to talk in-depth about their feelings, including ambivalent and difficult feelings; (b) to talk with a nonjudgmental person who would spend time listening to them, take them seriously, and understand and accept them for who they are; and (c) recognition that there was a problem and reassurance that other mothers experience similar feelings and that they would get better. There is a risk of psychological distress and possible isolation for those who fear stigmatisation, are unable to effectively communicate the type of support they need, are unable to access culturally familiar and relevant social sup- ports or have limited social networks.

Need for informal support

Many studies have found that women report 'less than adequate social support' (Darvill et al., 2010; Lee et al., 2017; Negron et al., 2013; Prevatt and Desmarais, 2018: 127; Rowe et al., 2013; Slomian et al., 2017) and often experience insufficient supports emotionally and psychologically in the postpartum period (Darvill et al., 2010; Leahy-Warren et al., 2011; Prevatt and Desmarais, 2018). Negron et al. (2013) and Slomian et al. (2017) found this lack of, or dissatisfaction with, social support increased the risk of postpartum distress. A qualitative systematic review of the literature by Dennis and Chung-Lee (2006) conducted across 11 countries found women were three times as likely to suggest speaking to a lay person who may understand what they are going through over seeking professional help. They found that a key theme in terms of preferences for social support was simply having the opportunity to talk to someone who would empathise. However, the mothers demonstrated a preference for support from other women with children, which they felt came from experience and a place of genuine understanding. This kind of reassuring support was most effective, as it provided the women with a sense of confidence (Dennis and Chung-Lee, 2006). Similarly, a Canadian multisite descriptive qualitative study by Letourneau et al. (2007) reported that women expressed the need for interaction and talking with someone who could offer them one-on-one time and emotional support.

The supportive role family, friends and peer counsellors play in enhancing the well-being of mothers postpartum has been considered in a number of qualitative and quantitative studies (Barkin et al., 2014; Darvill et al., 2010; Leahy-Warren et al. 2012; Letourneau et al., 2007; Negron et al., 2013; Ni and Lin, 2011; Prevatt and Desmarais, 2018; Razurel and Kaiser, 2015; Reid and Taylor, 2015). Participants in these studies varied, including mothers prenatally, 6weeks postpartum, up to 1 and 2years postpartum.

Mothers of first-time mothers in particular have been identified as a main source of emotional, practical, appraisal and informational support (Leahy-Warren et al., 2012). Qualitative research in the United States by Chavis (2016) and research on South American women in Italy by Migliorini et al. (2016) found the support offered by mothers was more desired and efficacious than that provided by their partners. In some cases, depression was found to be related to low partner support. Despite this, partners and mothers were shown to be key support people, and for some migrant women, the change in culture which allowed for increased father support and involvement was found to be highly valued (Benza and Liamputtong, 2014).

While social support from friends and family has been identified as highly valued and contributing to improve postpartum outcomes (Ni and Lin, 2011; Taylor, 2011), there is conflicting research regarding the effectiveness and accessibility of friends and family as support. Research suggests family, friends and partners are the most important factor in addressing the needs of mothers (Reid and Taylor, 2015). Yet, despite many women reporting family and friends as key in providing them with emotional support, Dennis and Chung-Lee (2006) found many women felt family and friends were unable to be supportive due to a lack of understanding about PPD. Letourneau et al. (2007) similarly found that while the support of close friends and family was essential, it was not always sufficient, with women reporting feeling burdensome and sometimes judged for their distress. Other mothers may also be important sources of support (Negron et al., 2013); however, Letourneau et al. (2007) report the potential for competitiveness. Nevertheless, other mothers may be particularly important sources of support for first-time mothers who experience frustration with their partner or other family members (Hong Law et al., 2018; Negron et al., 2013).

Importantly, not all women have access to or draw upon social networks for support. For example, Barkin et al. (2014) and Darvill et al. (2010) found women experience difficulties seeking help if family were not living close by, and women may not be sure where to find support in such instances (Dennis and Chung-Lee, 2006; Letourneau et al., 2007). In these instances, one potential source of support may be community mothers' groups and playgroups, which have been shown to provide support and connections for many women, including first-time mothers (Strange et al., 2014). Dennis and Chung-Lee (2006) found for some mothers these groups provide companionship and a sense of normality, and yet for some they can be the source of greater isolation through feeling a sense of competition with other mothers in the group and the pressure to attain or portray the idealisation of motherhood or pressure to conform to expectations about particular styles of parenting (Dennis, 2010; Dennis and Chung-Lee, 2006). For women with migrant, refugee or asylum seeking backgrounds, accessing culturally familiar community supports may be challenging. Transport, language, unfamiliarity with the neighbourhood and available services are all barriers to connecting with social support (Benza and Liamputtong, 2014; Tobin et al., 2014).

Inadequate professional care

There are various challenges for health professionals providing emotional support to mothers. Screening for depression may be insufficient (Corrigan et al., 2015; Prevatt and Desmarais, 2018), and women from various countries, including Iceland and the United Kingdom, have reported that medical health centres were 'inappropriate' to deal with emotional needs of women postpartum and lack of culturally responsive care (Dennis and Chung-Lee, 2006: 324; Tobin et al., 2014). Razurel et al.'s (2011) study involving high socioeconomic, low-risk first-time mothers in Western Europe also found women to be stressed when dealing with health care professionals for postpartum emotional support. Some research has found issues with trust and disclosure, such as participants choosing not to disclose symptoms of postpartum mood disorder to their primary health care provider (Prevatt and Desmarais, 2018) and being fearful of having concerns minimised and dis- missed (Letourneau et al., 2007). Issues such as Female Genital Mutilation are also relevant to some women, who may find their experiences difficult to discuss in a foreign setting (Benza and Liamputtong, 2014). A US study by Prevatt and Desmarais (2018) found while some women were least likely to report concerns to their midwives, they were most likely to disclose to their obstetrician/gynaecologist or paediatrician as more time was spent with them giving more opportunity to establish a relationship. This finding may not reflect the direct role of the health care professional, but rather the increased time spent with these health care providers and which may differ in circum- stances where the midwife or nurse is the primary caregiver. Darvill et al.'s (2010) qualitative study in the United Kingdom, of women 6 to 15weeks postpartum, found that if bonds with health professionals had been formed prior to the birth, it was useful postpartum for a continuation of the support role.

A need for more informational support to be provided by professionals has been identified in

previous research (Manuel et al., 2012; Shaw et al., 2006; Slomian et al., 2017), with a corresponding lack of overall professional postpartum care, a lack of continuity of care, a lack of culturally responsive care, and thus low preparedness for the postpartum period (Benza and Liamputtong, 2014; Darvill et al., 2010; Leahy-Warren et al., 2011; Rowe et al., 2013; Tobin et al., 2014). Antenatal classes have been found to provide a good foundation for informational support and knowledge leading up to and including the birth, but in some studies have been found as inadequate for postpartum information and support (Corrigan et al., 2015; Darvill et al., 2010; Razurel et al., 2011). One explanation for this offered by Razurel et al. (2011) is that women may be more focussed on the birth and that the postpartum period is too far removed to be of immediate concern.

Hong Law et al. (2018) and Rowe et al. (2013) discuss a lack of available resources to handle postpartum care in terms of education for new mothers and their networks, and how they perceived familial support. Research by Razurel and Kaiser (2015) found information, advice, sup- port and appraisal provided by professionals postpartum showed a decrease in anxiety in women in France. They recommended it is important for health care professionals to provide other types of support, emotional and appraisal, given their exposure to women postpartum. Letourneau et al. (2007: 447) found 'most mothers' prefer to have face-to-face support in their homes, as some women reported leaving their homes with a small child to gain support could be an onerous task.

Barriers to accessing social support

Research shows that various barriers to accessing social support exist for many first-time mothers, making it extremely difficult to seek social support (Prevatt and Desmarais, 2018). Barriers identified across this literature can be considered under two main areas: *Self* and *Societal* (Hong Law et al., 2018; Negron et al., 2013).

In terms of self, the literature indicates that feelings of guilt, shame and embarrassment often prevent women from sharing how they feel in the postpartum period (Letourneau et al., 2007). Some researchers have argued that denial of levels of distress may lead some women to be hesitant to admit they are not coping or disclose how they feel (Dennis and Chung-Lee, 2006; Letourneau et al., 2007; Liss et al., 2013; Negron et al., 2013). Feelings of worthlessness, a lack of motivation or energy and issues of pride and independence also all became barriers for some women (Letourneau et al., 2007; Negron et al., 2013; Prevatt and Desmarais, 2018). The systematic review by Dennis and Chung-Lee (2006) aimed to identify help-seeking barriers and treatment preferences for PPD. The review included 40 articles and found women experienced inadequate emotional and practical support as they felt unable to share feelings comfortably with family or health care professionals. The review found some women's biggest hurdle was openly sharing their feelings, which was reinforced by health professionals, partners and family through a lack of acknowledgement and effective practical and emotional support. Women reported fearing that their baby might be removed, being hospitalised or being placed on medication that would potentially have lasting side effects (Dennis and Chung-Lee, 2006; Letourneau et al., 2007). It is not to say PND would be curtailed or prevented if effective support were readily available. Rather, that an open environment for sharing the experiences of that distress may facilitate feelings of connectedness and well-being – a feeling that one is supported, which as Leahy-Warren et al. (2018) describes is often more important than the support itself.

Societal expectations of motherhood can exacerbate feelings of inadequacy and shame, which may inhibit sup- port seeking and raise fears of not being seen to be a good or capable mother (Hong Law et al., 2018; Negron et al., 2013). Research suggests there is a reluctance to admitting feelings of depression or distress and pressure to cope with what is seen as a mother's role, particularly among cultures where mental illness carries a heavy stigma and stoicism is employed. PPD may be negated by health care professionals, partners, families and the mother herself,

delegating failure and weakness to those who admit the need for support (Benza and Liamputtong, 2014; Dennis and Chung-Lee, 2006; Prevatt and Desmarais, 2018). Societal barriers may contribute to silencing some women who need to feel as though they can share information about their feelings and experiences in a safe environment where they can talk openly: some women may feel stifled and unable to 'unsilence their voices' in a public setting (Jones et al., 2014: 496). As noted, societal barriers may be exemplified by some mothers' groups which are designed to provide peer support yet have been found to intensify the need to portray the image of the ideal mother, which may impede sharing (Dennis and Chung-Lee, 2006; Letourneau et al., 2007). Research by Slomian et al. (2017) supports this, finding that first time mothers lacked 'reliable and realistic information' about the realities of the postpartum period (Slomian et al., 2017: 11). Hong Law et al. (2018) describe how social media can exacerbate idealisation of motherhood and how

others are perceived, which has direct implications for mothers who may be feeling pressure to reach the standards of ideal mother- hood. In their study which comprised 32 semi-structured interviews with first-time mothers in Australia, 6 to 8monthspostpartum,mothersdescribedfeelingguilta nd pressure to be better mothers than they felt they were (Hong Law et al., 2018). Addressing societal norms may aid in normalising the postpartum period and the distress that may occur within in, as would increasing culturally responsive care. These issues of adhering to societal norms, pressures to be a good mother, and feelings of inadequacies may be especially salient for women who are experiencing the additional pressures of living in a new culture (Tobin et al., 2014).

Critique of the literature on social support for postpartum women

Across different studies, it is difficult to determine what kind of support is being discussed. There are many references to the importance of social support; however, specifically which types of support are lacking or sought is not always clear (Ni and Lin, 2011; Reid and Taylor, 2015). Furthermore, much of the research suggests increasing sup- ports by family, peers and professionals yet fails to suggest in which ways this might happen and in which ways it would be most useful. Leahy-Warren et al. (2018) describe the need for individualised support; however, how this might be achieved is unclear. While there is research which explicitly details the preferences of new mothers' suggestions which would negate the need for women to have to ask for support, such as pre-planned interventions or apps, they do not address how women would access or opt into them (Hong Law et al., 2018). Conversely, research by Prevatt and Desmarais (2018) was very specific in how to address both increased supports and barriers to help seeking by making practical suggestions. These included the development of a post-birth plan and changing specific parental leave policy time frames and public awareness campaigns to address issues which relate to the need for support and stigmas around PPD.

While research in this area draws upon various and diverse research methodologies, which could be viewed as a strength, there are limitations within the specific studies. Much of the qualitative research uses small, homogeneous samples which are predominantly White, higher socio- economic, educated and English speaking (Letourneau et al., 2007; Rowe et al., 2013). Quantitative research tends to include participants who are married, fluent in English, educated and of higher socioeconomic status (Leahy- Warren et al., 2012). Much of the research includes only healthy, full-term, uncomplicated births; support needs and perceptions for women who experience distressing birth or have interventions due to early- or late-term babies are typically not included as participants. Moreover, women who birth at home, presumably with support, are often not considered, despite the needs this subset may have in terms of social support, especially as their choice to homebirth may impact their visibility to health care professionals and follow-up services on offer to those who go through hospital programmes. Some of the research measured the effects of social support at 6 and 12 weeks postpartum (see, for example, Darvill et al., 2008; Leahy- Warren et al., 2012; Letourneau et al., 2007). The first 3 months after birth may not be representative of the sup-ports a mother may receive; the baby becomes less dependent, the initial excitement of the birth, and visitors lessens and leave time has dwindled. Measuring support satisfaction and support needs well into the first year would be valuable. Many of the studies report support perceptions after minimal interactions – a once or twice administered self-report questionnaire or a once-off interview. This is despite research suggesting the need for an established, ongoing, trusted relationship in order for women to share their experiences. Support offered in the research included interventions and technology. It would be of value to con- sider interventions which were offered as standard opt-out options or were tailored to respond in real time. Further research into the types of devices and technologies women would enjoy using is warranted, given the current trend towards social media and applications and taking into account the possible stigma and shame that may prevent women from engaging otherwise.

By addressing many of the barriers and facilitators of support, it could be argued that although social support may aid in the alleviation of postpartum distress, it appears to be a marked experience of many women, despite the conditions of support on hand. Thus, Ussher's (2004) argument that postpartum distress is a normal function of motherhood is noteworthy.

Recommendations in the literature

Individualised home care

Recommendations for increasing social support include improving existing support such as empathetic listening by health professionals, increased home-based services, individualised care and providing community resources with local, consistent support (Dennis and Chung-Lee, 2006; Letourneau et al., 2007; Slomian et al., 2017).

Individualised social support provided at the 'right time and of the right type' was highly recommended for mothers postpartum (Barkin and Wisner, 2013; Chavis, 2016; Hong Law et al., 2018; Leahy-Warren et al., 2012, 2018: 220; Ni and Lin, 2011). Across many of the studies, face-to-face care provided in the home through informal care was desired (Barnes et al., 2009; Letourneau et al., 2007; Manuel et al., 2012). Programmes with home visits coupled with phone calls were also desired (Letourneau et al., 2007). Studies by Letourneau et al. (2011) and Biggs et al. (2015) found phone calls to be an effective way to mediate shame and stigma, while providing flexibility and privacy. In a study by Biggs et al. (2015), the majority of women would have liked visits to their home in addition to phone support. A systematic review by Shaw et al. (2006) and a meta-analysis by Nievar et al. (2010) found overall, women were more satisfied with the support interventions which included home visiting programmes, that they were effective for mental health and they improved maternal behaviour. Letourneau et al. (2011) recommend future in-depth qualitative research to assess the effectiveness of both in-home and telephone support. Interventions aimed at self-care, empowerment and quality time where the mother is nurtured through individualised care such as trusted one-on- one emotional support and sensitivity around judgements and 'ideal' mothering would also be of value (Barkin and Wisner, 2013; Hong Law et al., 2018; Leahy-Warren et al., 2012). Prevatt and Desmarais's (2018) recommendation for post-birth education and support plans would fit within the need for individualised care.

Peer to peer

Peer support is the provision of emotional, appraisal and informational assistance to address a health-related issue of a stressed focal person. A peer is defined as 'someone who possesses experiential knowledge of a specific stressor or condition and similar characteristics as the potential recipient' (Dennis, 2010: 561). Arguably, emotional support may be best provided by those who have faced similar problems (Taylor, 2011). Peer, mentor or group support has been extensively shown to be effective in this way (Biggs et al., 2015; Cust, 2016; Dennis, 2010). By drawing on the skills acquired by others, coping barriers may be overcome (Taylor, 2011). Although partners and family have been found to be relied upon most, peers provide an element of appraisal, security and self-confidence for new mothers (Darvill et al., 2010; Letourneau et al., 2007).

Findings suggest women seek role models to which they could emulate, in order to feel more confident; trusted relationships are sought (Ni and Lin, 2011; Rowe et al., 2013). Women want to share, to be heard and understood by some- one they feel has been through the same situation and can offer experienced encouragement and support (Corrigan et al., 2015; Darvill et al., 2010; Leahy-Warren et al., 2012; Negron et al., 2013; Ni and Lin, 2011). Several studies sup- ported this idea; women felt encouraged, supported and reassured by informal talking therapies, sharing similar experiences with other women and being able to air doubts, feel recognised, accepted and normal (Dennis and Chung- Lee, 2006; Hong Law et al., 2018; Ni and Lin, 2011; Rowe et al., 2013). Women explained wanting 'a mom, but not your mom' (Hong Law et al., 2018; Letourneau et al., 2007: 445). Rather than treatments from a professional, women in some studies have reported preferring talking therapies with someone 'non-judgemental' (Dennis and Chung-Lee, 2006: 323). A desire for a 'reference person' or a buddy to always have with them as a support and as someone to look out for signs of distress was expressed, as was the desire to share with both same-aged and older mothers as a way of finding company and perspective around what to expect (Hong Law et al., 2018; Slomian et al., 2017). These accounts strengthen the argument that a buffer aids in the experience of postpartum distress.

Education

Cultural awareness, public education, early intervention and an open dialogue around the postpartum period and its stressors have been flagged by a number of authors (Dennis and Chung-Lee, 2006; Goldbort, 2006; Hong Law et al., 2018; Letourneau et al., 2007; Manuel et al., 2012; Negron et al., 2013; Tobin et al., 2014), to promote disclosure of distress and increasing help seeking (Prevatt and Desmarais, 2018). Creating new avenues for support through the use of technologies such as Skype and applications for smart devices has been suggested by Hong Law et al. (2018). Increased screening of mental health and education in the form of postpartum classes held by professionals has also been suggested (Corrigan et al., 2015; Darvill et al., 2010; Letourneau et al., 2007; Prevatt and Desmarais, 2018; Slomian et al., 2017). These could incorporate topics such as expectations versus reality and mastering day-to-day tasks (Hong Law et al., 2018). Moreover, education targeting support networks, particularly men and partners could increase awareness of symptoms and risk factors (Castle et al., 2008; Hong Law et al., 2018; Rowe et al., 2013). Training for health care professionals in cultural awareness and responsive care and the

intricacies around the needs of women with migrant, refugee or asylum seeking

backgrounds is recommended, as well as increasing access to translators and community services (Benza and Liamputtong, 2014; Tobin et al., 2014). Campaigns including targeted verbal and printed information aimed to boost greater public awareness would address the stigma which affects many women's experience of speaking out when they are in need of support (Letourneau et al., 2007). Support groups and community health prevention initiatives, particularly interventions including other mothers, may benefit women and are frequently recommended (Dennis and Chung-Lee, 2006; Hong Law et al., 2018; Letourneau et al., 2007; Manuel et al., 2012; Razurel et al., 2011; Shaw et al., 2006; Webster et al., 2011). Finally, educating health care professionals on the importance of increased emotional sup- port and providing a space to share and give voice to the experiences and fears around the perinatal period may help mothers to process any disappointments and incongruences between what was expected and what happened during birth (Benza and Liamputtong, 2014; Rania, 2019).

Prevention

Negron et al. (2013), Reid and Taylor (2015) and Ni and Lin (2011) recommend bolstering family and peer supports and planning for the postpartum period prior to giving birth as ways to circumvent the need to actively seek support postpartum. Addressing family leave benefits which addresses the standard guidelines and which operationalise social support as the norm is recommended (Leahy-Warren et al., 2012; Manuel et al., 2012). Interventions which incorporate planning and pre-arranged support which negate the need for women to have to ask and which encourage prevention and information from reliable and credible sources are needed (Hong Law et al., 2018; Negron et al., 2013). Providing a wider assessment of overall health in the postpartum period would be of benefit (Corrigan et al., 2015) as would continuity of professional care (Rowe et al., 2013). Shaw et al. (2006) recommend more qualitative and non-randomised controlled trials to further understand sup- port postpartum.

Conclusion

Although it is well established that appropriately provided social support can buffer the effects of postpartum stress as well as provide practical and emotional assistance, over- all, research internationally suggests that the levels and quality of social support available are largely inadequate (Letourneau et al., 2007; Negron et al., 2013; Rowe et al., 2013). Facilitators to social support such as increased home visits, interventions designed to increase educational pro- grammes, culturally appropriate health care and communication with informal and formal support persons to normalise postpartum distress were evident in many studies with varying degrees of success in reducing postpartum isolation and distress (Hong Law et al., 2018; Nievar et al., 2010). Despite the success of the various strategies to facilitate social sup- port, the need for increased informal supports, individualised care, improved professional care, reassuring and compassionate health care approaches and the normalising of postpartum distress exist (Darvill et al., 2010; Hong Law et al., 2018; Leahy-Warren et al., 2018; Letourneau et al., 2007; Tobin et al., 2014). It could be inferred that in line with the research which suggests a certain degree of post- partum distress is to be expected and a normal part of transitioning to motherhood, that social support serves not to remove or prevent all stressors necessarily, but rather acts as a sounding board and buffer (Leahy-Warren et al., 2018; Ussher, 2004). Confounding these needs are the personal and societal barriers to help seeking which are presented in a number of papers across a number of cultures (Benza and Liamputtong, 2014; Letourneau et al., 2007; Migliorini et al., 2016; Prevatt and Desmarais, 2018; Tobin et al., 2014). The experience of receiving support is highly individual; the avenues through which social support may come are personal, societal and professional. This is further individualised through personal preferences and cultural norms for *which* type of support, *when* and *how* it is needed (Leahy-Warren et al., 2018). This highlights a one-size-fits-all style approach may not be effective (Chavis, 2016; Hong Law et al., 2018; Leahy-Warren et al., 2018; Ni and Lin, 2011; Small et al., 1994). If the facilitators and barriers are considered overall, despite the effectiveness of some programmes in increasing maternal satisfaction and maternal behaviours, the need for support remains not so much as a means to end suffering, but as an avenue in which the suffering can be verbalised and heard.

The evidence is inconsistent around the satisfaction of social support provided by friends, family, community and health care professionals with some research claiming each to be very effective and some claiming it insufficient and inappropriate (Corrigan et al., 2015; Dennis and Chung- Lee, 2006; Prevatt and Desmarais, 2018; Rowe et al., 2013). Much of the research indicates social support is an individualised need and the asking, the providing and the receiving of it would be more effective if it were designed and delivered according to those individual needs (Hong Law et

al., 2018; Leahy-Warren et al., 2018). This may be the ideal outcome however potentially cumbersome. Thus, it might be argued women need help to recognise their own support needs and possess the skills and confidence to facilitate the receiving of this support postpartum. In contrast, health care professionals, family, friends and the com- munity may need to increase their own awareness, repertoire and availability around identifying and providing postpartum support (Barkin and Wisner, 2013; Hong Law et al., 2018; Leahy-Warren et al., 2012; Negron et al., 2013; Razurel et al., 2011; Reid and Taylor, 2015). The increasing normalising of postpartum stress and the reduction of stigma around postpartum issues may aid in more open

conversation, expectations and practises. When considering mothers in paid employment and the extended period of time postpartum stress can be experienced, there appears a need to consider the types of support which may be of particular importance to this group of women who are combining the roles of mother and paid worker. Particularly in terms of societal barriers to support seeking, the workplace is an area which may be of importance as women may be expected (by themselves and employers) to fulfil roles in the same way they were before having children not taking into account the potential need for flexibility and individualised amendments to roles and schedules.

In summary

Much of the research around postnatal support fails to distinguish the specific type of support which is provided or lacking (Reid and Taylor, 2015); however, it is evident from the literature there exists a need for increased and better facilitated functional supports overall. Some women are not feeling adequately supported and face a range of barriers to seeking support. Emotional and appraisal supports are particularly required to facilitate open discussion and for the opportunity for those experiences to be validated and heard empathetically. When family, friends and significant others are not available – and sometimes even when they are – some women seek the individualised, informal support of peers who can provide a semblance of familiarisation and understanding to what they may be experiencing, so they may begin to feel 'normal' amid the new paradigm of motherhood (Marshall and Thompson, 2014; Ussher, 2004).

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3

Social Support: Australia and Sweden

"It tears you in two."

Participant 14

Preface to Chapter

Social support offerings in alleviating postpartum distress in Australian mothers, based on the evidence presented in preceding chapters, may be considered inadequate. Therefore, for the purposes of comparison in the search for best practice, research was also undertaken in Sweden, frequently recognised for being 'the best ' place to parent, offering equal parental leave and for being advanced in societal gender equality. The following research sough to collate and to understand the relevant state-supported social policy supports in Sweden, and to identify how they differed from those in Australia. Underlying this research are the specifications of those supports that are well utilised and those which are still required.

3.1 The Importance of State Provided Social Support

Social support is crucial to health and wellbeing (Negron et al., 2013). Marmot (2014), states that considering the major determinants of health are social, "so must be the remedies" (pg. 1103). Many studies show the links between perceived support received and mental and physical health (Negron et al., 2013; Sherbourne & Stewart, 1991; Uchino, 2009). Social support may be divided into Structural and Functional components as per Figure 2, however, the elements which make up Functional Support may be provided through formal/professional means such as policy, hospitals, childcare centres, or through informal channels such as friends, family, and colleagues. For the purposes herein, social support for new parents will be assessed on two levels; state provided support and informal social support. State support will encompass Informational and Instrumental support; government policies around parental leave and childcare and will include organisational practices, hospital based parenting groups, societal expectations and norms for the purposes of discussion (Brough, O'Driscoll, & Biggs, 2009; Hanna, Edgecombe, Jackson, & Newman, 2002). Informal social support will refer to Emotional, Appraisal and Social Companionship support provided by partners, family, friends, colleagues and others.

Parental leave in Australia is available to employees, upon satisfying the relevant eligibility criteria. Unpaid parental leave is permitted for up to 12 months with the opportunity to request a further 12 months. Paid parental leave is available from the government and from employers again, if eligibility criteria are met. Primary caregivers are allocated up to 18 weeks leave paid at the national minimum wage. Organisations may offer paid parental leave on top of this, varying from workplace to workplace and in amount and eligibility (Fairwork.gov.au). Should an employee

require time off to care for a child, carer's leave is available which is deducted from the employees' personal leave budget of 10 days per year. Organisations can instil practices independently of this, and as long as they are balanced with attitudes that support them such organisations reap the benefits of such practices (Brough, O'Driscoll, & Biggs, 2009).

Allowing a first-time new mother enough time to bond with her child without the pressures of returning to work has significant influence on her feelings of wellbeing and on the wellbeing of the child (Brough et al., 2009). As the new realities of managing dual roles of family and work set in new mothers may experience feelings of stress, overwhelming guilt and of being torn between wanting to be a good mother and also to provide financially as is often necessary. In fact, 70% of respondents in a study by Brough et al (2009) reported that the main reason to return to work was for financial concerns. In terms of timing, many women report feeling that the paid time off allowed is insufficient and contributed greatly to declining personal health, child-attachment and feelings of job satisfaction (Brough et al., 2009). This is of particular in Australia where there is an overwhelming preference to see mothers be full time homemakers rather than in full or part-time employment (Evans, Donelle, & Hume-Loveland, 2012).

Of the Australian respondents in the Brough et al (2009) study, 55% reported having no access to paid parental leave. The policies, practices and workplace culture of an organisation can influence the experience of the mother upon returning to work postpartum. Without family focused support or understanding and supportive management and colleagues, policies such as flexible working hours are largely inadequate (Brough et al., 2009). Moreover, new parents who are supported by

policy, workplace practices and a positive and cooperative culture are found to be more committed, assured and happier. For the organisation this means staff retention, increased productivity and team cohesiveness (Sontag-Padilla, Schultz, Reynolds, Lovejoy, & Firth, 2013; Taneja et al., 2012).

3.2 Australian Childcare Services

Childcare services such as day-care, out of hours school care, and nannies are widely used to help parents return to work. The average cost of childcare before subsidies in Australia is just over one hundred dollars a day, and out of hours school care is between twenty and sixty dollars per session. Childcare can range between $30 and $100 per day per child. Certain families are entitled to rebates of up to 50%, however not all; rebates are dependent upon various factors and unimmunised children are not eligible for any childcare or early learning experiences. Professional women in higher socio-economic groups are also one of the largest groups of non-vaccinators in Australia, thus childcare is at full cost to them (Edwards & Homel, 2016), and given that this research is focused on women in paid professional positions, it is fair to infer that these women would be adversely affected by this particular stipulation. Women in paid employment utilise these services and shift their childcare responsibilities to when they are home, before work, after work or on the weekends. Evans et al., (2012) found that Australians on-the-whole hold a moral view that mothers should be at home full time until children start school. It is not surprising then that mothers – responsible for the most time spent with children in the home - still attempt to provide as much time with their child as if they were not working, forgoing personal advancement or full-time work, grooming, personal care and leisure as a result (Craig, 2007).

According to the Australian Bureau of Statistics, in 2008 1.5 million Australian children twelve years and under attended regular childcare and 2 million Australian children had no usual out of home childcare. Nine percent of children aged 12 months and under were placed in formal childcare within a centre. This trend is influenced by the labour force requirements of men and women, with 45% of parents with children aged 0-2 both employed in two-parent families. For single parent families with children aged 0-2, 28% are employed, and where children are aged 9-12 years, 64% are employed. The use of childcare varies from 60 to 78% depending on the work levels and the number of parents in the primary home. Whilst work was the main reason given for utilising childcare, 45% of families also used it for personal reasons. The 2014 ABS figures increased, reporting that more than 48% of children under the age of 12 years, attended childcare. Women were found to be the main care givers even when employed, and as such relied on childcare as a means to balance the demands of work and family.

3.3 Australian Hospital Based Support

In a culture which perpetuates individualisation through early discharge from hospital post birth, new mothers may experience reduced connections and ties with immediate and extended family and financial independence – however, hospital initiated groups that provide these new mothers with connections to other new mothers or that provide training and skill advancement in a socialised setting are extensively used across Australia as a way to increase informal social supports and parenting know-how (Hanna, Edgecombe, Jackson, & Newman, 2002). The groups aim to connect new parents, mostly mothers, with other mothers in a peer-to-peer environment to promote and develop self-confidence, to provide informational and social companionship support and increase social networking. Providing emotional

support is not the purpose of such groups; informational support here is key, however the platform allows for the development of relationships from which this could emerge (Hanna et al., 2002). Groups such as these have been found to reduce the stress of early parenting through facilitating connections and discussions around issues which mothers find difficult to address with family and friends. Good facilitation is key to the success of these groups and the resulting wellbeing of its participants (Hanna et al., 2002). Many participants choose to maintain relationships with people they meet in these groups for many years after the formal program ceases. However, some peer-to-peer social interactions, which lack the facilitation to create trusted and cohesive environments, can have adverse effects (Hanna et al., 2002; Uchino, 2009). Some women may feel uncomfortable, left out, ostracised, unwelcome or uncomfortable in sharing, which may hamper the flow-on effect for emotional support (Hanna et al., 2002). Alternatively, unfacilitated groups may foster a competitive environment; with few informational or tangible support benefits, which may in turn, perpetuate the need for increased emotional support outside of the group.

3.4 Sweden – Best Practice

Sweden shares many social similarities with Australia. Both countries have representative democracies where the government sits to represent the people. Median age, male to female ratio, urban population percentage, birth, death and survival rates, are all on par. Yet despite women in Australia and Sweden having the same number of children and the same rate of workforce participation, the number of parliamentary seats held by women in Sweden is 43.4%, compared with the Australian figure of 28.7%; one area of marked difference. Ageing populations, high levels of independence and high rates of education and women in the workforce are

some of many factors which suggest Sweden as a comparable case study to Australia. Whilst the governmental structure differs between Australia and Sweden, there are many social similarities which make Sweden a good comparator. Rates of postpartum depression are similar; the rate in 2010 in Sweden was approximately 12.5% at 8 weeks postpartum and 8.3% at 12 weeks postpartum (Massoudi, 2013), while the rate in Australia is between 13 and 19% (Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015).

It is also the cultural norm for Swedish parents to return to work after having a child. Women make up almost half of the workforce in both Australia and Sweden (Massoudi, 2013a), and autonomy and family independence are high, with new Swedish parents relying less on extended family for care as in some collectivist cultures and more on government services provided, much like the Australian norm. In Australia, paid parental leave is provided by the government for up to 18 weeks to the primary care giver, whilst partners receive 2 weeks paid leave. Employees who have provided a minimum of 12 months service to an employer are entitled to 12 months unpaid parental leave from the workplace. Both parents are entitled to 12 months, generally at separate times, unless one parent wishes to use both 12-month periods.

To gain an understanding of whether state-based supports are insufficient in providing new mothers with the support they needed for mental wellbeing, or whether in fact what was missing was something deeper than state provided support, we turn to Sweden, 'the best place to parent in the world' (Culturetrip, 2018; WEforum, 2018). Sweden is publicly acknowledged on the internet, in news reports, and blogs as the best place to be a mother, and yet the reported rates of PPD

are equal to those in Australia. With high rates of equality, extensive parental leave and financial remuneration, free childcare and other accessible social supports such as free community play centres, Sweden offers an ideal backdrop against which to ask, what is it that mothers need, which might not be being addressed in Sweden or elsewhere?

3.5 State Provided Support in Sweden

Swedish state provided support aims to create "social conditions that will ensure good health for the entire population" (Marmot, 2014, p. 1103). Intensive parental social support is provided by the state as a way to support the equal sharing of work and parenting for the benefit of the man, the woman and child and thus the community (Hagqvist, Nordenmark, Pérez, Alemán, & Gådin, 2017; Marmot, 2014). Women's participation in paid employment is as high as is men's involvement in the home. Parents receive 96 weeks of paid parental leave (78 weeks paid at 80% of salary), three months of which is allocated to the father to use from birth until the child turns 12. This is in addition to 10 days of paid leave at the time of birth. The state also provides childcare and boasts one of the highest rates of children under two years old in care, schooling and 'vård av barn' (VAB), literally, 'care for a child' – paid leave which can be taken to care for a sick child at home (Budig, Misra, & Boeckmann, 2012; Hagqvist, Nordenmark, Pérez, Alemán, & Gådin, 2017). Overall, the Swedish culture is very much child focused providing comprehensive support that permeates policy, organisational approaches and structural social support.

Parental leave in Sweden is divided between men and women and is payable for almost 4 times as long as Australian leave. Payable for 480 days, paid leave can be shared equally between both parents in an effort to develop and nurture the right of

each parent to have an equal relationship with the child (Massoudi, 2013; Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008). In 2010, approximately 90% of Swedish fathers took some parental leave. Sweden recognises the positive biopsychosocial outcomes of increased paternal involvement with a child which include a reduction in behavioural and psychological problems, increased cognitive development and reduced delinquency in children (Massoudi, 2013a). Furthermore, parenting skills are seen to be developed through practice rather than feminine instinct, with research regarding competencies revealing more similarities than differences between the sexes (Massoudi, 2013a).

3.6 Social Trust

The strength and health of a society and the well-being of its members can be measured in part by levels of Social Trust. This confidence held in others is important in individualised cultures where independence is high and people outside the family are depended upon for support (Delhey & Newton, 2005). Social Trust in Nordic countries is recorded as at the highest level, reported at 75% as compared with the global average of 28% and the Australian average of approximately 50%. The Nordic region has been leading the way in terms of parenting and postpartum support structures, which supports the concepts of social solidarity and shared experience of a society who ultimately support those in need, presented by Rothstein & Uslaner (2005). Good government policy and rates of gender and income equality are all associated with Social Trust (Delhey & Newton, 2005). In the case of Sweden and PP support, high social trust bodes well; people who have high trust are more likely to have positive intentions for others, have increased positive social behaviours and are likely to contribute to social causes (Sønderskov & Dinesen, 2016).

3.7 Barriers to Seeking Professional Support in Australia and Sweden

Women in Australia and Sweden generally refrain from seeking help regarding postpartum emotional distress. It is commonly reported that across the world, help-seeking is seen to carry a stigma of weakness and shame. 'Help-seeking 'refers to the attempt to find assistance to improve a situation or problem (Rickwood & Thomas, 2012). There is a growing body of literature addressing potential barriers to help-seeking for PPD. Dennis & Chung-Lee (2006), report issues of shame, fear of being labelled mentally ill or weak, and the lack of knowledge or willingness to discuss the symptoms of PPD by family and professionals as key barriers to help-seeking. A need for but unwillingness to talk about their feelings leaves mothers dealing with PPD and parenting stress alone in many cases (Abrams, Dornig, & Curran, 2009).

3.8 Insights to Addressing the Gap

When viewed against Swedish standards of state-provided social support, it could be argued that Australian governmental policy, bio-medical offerings and psychological support are simply not sufficiently meeting the needs of new mothers. Sweden certainly provides a compelling example of best practice. However, rates of postpartum distress are similar to those in Australia which begs the question, is something missing from what is offered to new mothers, and if so, is it possible to be provided? Investigating first-hand, the Swedish experience of early motherhood provides insights into the very personal and real experience of individuals, which offers a gateway to then bridging what is required, and what more is offered.

4

The Swedish Experience

"If mums get emotional support then they can get that feeling that they are good enough, which generates a more positive spiral."

Participant 18

Preface to Paper

Earlier research on those experiencing postpartum distress in Australia concludes that current parental social supports are largely inadequate despite medical care, psychological screening and existing postpartum support structures. This led to the question, 'what it is then, that women or parents, are seeking which is not being met? Is it simply an issue of inadequate policy?' Understanding the Australian Support Structures for postpartum care is fundamental. Moreover, looking at the experience of parents in an alternate society where the parental support structures were considered 'best practise', yet incidences of postpartum distress were still high, appeared to be a logical and potentially insightful window into what is still needed to provide and maintain mental and emotional wellbeing and the experience of being appropriately supported as parents.

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Behind Perfect Postpartum Practices: An Exploration into Parenting Support in Sweden

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Annotation

Social support is said to provide a buffer against symptoms of postpartum distress. Research indicates Sweden offers the best postpartum social support practices. The social support offered is largely practical in nature. Rates of postpartum depression in Sweden are similar to those in Australia, despite far less state provided social support. This article explores Swedish mothers' experiences of the postpartum period and social supports offered in Sweden, and asks what is missing. Qualitative research methods were used including Thematic Analysis and Participant Observation. Major themes were identified and synthesised. Social support is often presented with little indication of the type, allowing for gaps in offerings. State provided social support alone is insufficient in alleviating postpartum symptoms of distress. The case for cultural awareness, emotional and appraisal support is made.

Introduction

Eighty-five percent of women experience some form of emotional distress in the postpartum period [1,2]. One in five women experience postpartum depression (PPD) with rates in Australia currently between 13 and 17% [3,4]. In industrialised cultures, mothers are increasingly experiencing pressures to be both mother and provider [1,5,6]. Despite the level of equality perceived in western cultures, there remains an equality gap when it comes to parenthood in home duties, mental and emotional loads, and policies and structural supports [5]. In Australia, forty percent of women return to paid work in the first year postpartum whilst performing 70% of all child related and household responsibilities [7,8]. PPD may affect not only the mother, but her partner, the infant, extended family and her environment [9,10]. The struggle to balance work and family life does not appear to be subsiding despite consistent campaigning, rising political awareness, and focus on parental supports in the workplace, namely, parental leave and gender equity [11]. In Australian culture, mothers returning to paid work is normal,

expected, and ties ubiquitously to an achievement culture of patriarchal success [2,12-14]. Imbedded in the practice of women returning to work are gendered roles in the home, self-identity in the workplace, and expectations of productivity and achievement in both [5,6,15,16]. Various interplaying internal and external factors including hierarchy, role division, family or childcare arrangements, the flexibility of the workplace, health and care of the self, children and or family must align in order for successful work and family balance. The wavering of any one of them can impact the success of the entire structure [17]. Moreover, cultural beliefs and values provide the context within which these factors are constructed [2,13].

It is argued PPD is an inevitable, somewhat expected response to motherhood; a rite of passage inclusive of the internal struggle inherently linked to such transition [18-20]. This supports both an evolutionary view [21,22] and research by *Evagorou et al.* [2] and Harkness (1987) who found in nations of fewer accounts of distress, emotions were present [23]. However, rather than pathologized and shame inducing, emotions were buffered by compassionate and experienced informal social support, cultural acceptance, and high societal regard and value was placed on motherhood. There are a generous array of stories and accounts of women suffering during the postpartum period across time and culture [2427]. For over a decade, the work of *Mauthner (1998); Mauthner (1999); Mauthner (2010)* has showcased stories of dark emotions in the days after the birth of a baby [13,28,29]. *Mauthner (2010)* writes to the shame and stigma evident across myriad postpartum research [13]. The reverence of motherhood in some cultures enhances the social standing and thus, experience of women upon the birth of their child. These values are ubiquitous within the fabric of the culture and the ideals, beliefs and desires of inhabitants [2,19,23]. Culture plays a significant role in postpartum distress; the nature of taken for granted assumptions we all live by are, as defined, invisible to the individual.

Social Support (SS) is a crucial element in postpartum wellbeing [1,21,22,27,30-33]. It has 5 main categories

a) Emotional support through understanding and the encouragement to express feelings
b) Informational support through advice and guidance
c) Tangible or instrumental support through material, monetary and behavioural aid
d) Positive social interaction referring to having fun with and just being with others and
e) Affectionate support, through expressions of love and affection [34-36].

These elements may be provided through formal or professional means such as policy, hospital care, childcare centres, or through informal channels such as friends, family, and colleagues. For the purposes of this paper, social support for new parents will be discussed on two levels; State Provided Social Support (SPSS) and Informal Social Support (ISS). State provided social support will encompass Informational, Instrumental and Social Companionship support; government policies around parental leave and childcare and will include organisational practices, hospital-based parenting groups, societal expectations and norms for the purposes of discussion. While informal social support will refer to emotional and appraisal support provided by partners, family, friends, colleagues and others. Informal Social Support has been shown to provide solace, and a buffering to the experience of PPD [37], reducing the need to pathologize the woman's experience [2,23]. The SPSS provided to Australian mothers may not meet the needs of mothers *(AUTH, 2020)*; it includes 18 weeks leave for the primary caregiver, 2 weeks leave for partners, perinatal hospital care, parental support groups and some rebates on paid childcare if eligible. Much of the literature fails to identity which forms of support are being provided which are most successful, and which may need more attention *(AUTH, 2020)*. However, research by *Small et al. (1994); Small et al. (2011); Mauthner (2010); Oates et al. (2004)* found talking therapies and lay support from experienced, non-judgemental women is beneficial [13,24,38,39].

There are many social similarities between Sweden and Australia, making Sweden a good place to examine and consider, against an Australian context [12]. Sweden offers parents equal parental leave over 480 days, VAB care, state-subsidised childcare and open childcare drop-in centres, amid a state focused on high equality and shared parental responsibilities. SPSS provided in Sweden far outweigh those available in Australia, and yet rates of PPD are not dissimilar, currently at 12% and 13% respectively [33,40,41]. By turning to Sweden as an example of best practice SPSS, ascertaining what is missing in terms of support may be possible. Sweden, much like Australia has a strong cultural expectation that women work as well as parent, with female employment rates at 81% [12,33]. Women in Sweden are more likely to take the first year off, with their partners taking over parental leave until the child is 15 to 18 months old [12], at which time the child goes into state

subsidised childcare. Parents have the right to negotiate the percentage they will return to work and have access to flexible, transferable carer leave allowances for the care of children. Swedish SPSSs are well utilised and held in high regard [33,42]. Cross cultural research tells us the prevalence of PPD is common across cultures [2,13,22,23,39]. What has been found to impact the severity and presentation of PPD is the level of SS and significance attributed to the postpartum period. Countries where dedicated time and attention are given to the postpartum period seem to do well in transitioning new mothers through their struggle and into a new reality [13,23,30]. Such generosity in Sweden may appear as strong SS, however, any diversions from this socially mandated strategy are considered inappropriate and curious, curbing the freedom for parents to choose how and when they return to work [33]. This research sought to understand the cultural, lived experience of social support for women returning to work after a baby in Sweden, and identify other related elements such as culture, feminism, internal expectations and emotional support [12]. It asked what, if anything, was not being addressed in terms of postpartum social support and wellbeing. By investigating experiences of the postpartum period in Sweden, this research sought to explore why despite the immense difference in state provided support in Sweden; addressing 3 of 5 social support elements, rates of PPD are similar to those in Australia. We asked the following research questions, 'What is the emotional PP experience of parents in paid employment in Sweden?' and 'Is there something missing in Sweden in regards to postpartum social support?'

Method

Procedure

Twenty-eight semi-structured interviews were conducted in person, one conducted by phone. The author conducted all interviews between September and November 2017. Data saturation was achieved by the 11th interview with no new themes emerging *Baker & Edwards (2012)*. Participants 12-28 were interviewed despite this, as the researcher desired to obtain as much data as possible in the unique overseas opportunity as well as participants' heightened knowledge and status in relation to the subject matter. Interview questions began broad, and prompts were used to explore specific research areas, or in response to answers. Thematic Analysis (TA) was conducted as per *Braun and Clarke's (2006 & 2013)* methodology [43,44]. Transcripts were analysed following the interview and used to inform subsequent interviews. Data was manually analysed and evaluated using codes in direct relation to the research questions. Daily fieldnotes were taken by the researcher. Emergent themes from the individual data were reviewed against the field notes for a broadened perspective. The field notes acted as an Audit Trail, documenting emerging themes, notes, correspondence, organisation and conceptualisation *(Tracy, 2010)*, enabling researcher reflexivity and a credible, authentic research process *(Tracy, 2010)*. To that end, it is noted the researcher has previous personal experience in maternal and paternal PPD.

Critical ethnography with Participant Observation

The researcher spent 3 months seeking to understand the cultural embeddedness of social structures within the Swedish community in relation to childcare, parenting and women's health postpartum [45]. The anthropological method of ethnography works well in this study as it encourages the questioning of taken for granted assumptions around motherhood, equality, expectations and work-life balance. Borrowing from this method in terms of style, the research was undertaken as Participant Observation; a qualitative method in psychological research allowing for the researcher to be present and attentive to the "material presence" of how people live their lives in actuality [33,46]. In as many contexts as possible, the researcher became involved in the daily lives of the participants. Observations and conversations were recorded where possible and field notes were collated and recorded at the end of each day. The researcher spent significant time in formal and social environments and focused on the perspectives, subjective understandings and meanings participants placed on motherhood and the social structures they lived within. Through observation, interviews and interactions, knowledge about the layers within the culture was gleaned and biases reduced [46,47]. *Cook (2005)* describes critical ethnography as a useful tool for health promotion by challenging the norm from within [48]. Each research step built upon the last in an iterative-inductive approach and research questions were designed based on potential avenues of exploration developed as the research was conducted. Key informants were identified and further exploration occurred in in-depth interviews. Research involved consultation with university professors, government bodies' and professionals sourced to establish base knowledge and a guide for questioning.

Negotiating participant observation in Sweden

Swedes are known to be very individual and private people which made initiating conversations challenging. The work place facilitated a sense of

comradery and commonality which was helpful. Outside the workplace, people were removed and private and often attempts for small talk was difficult, unwelcomed or refused completely. The researcher's daughter was often 'a way in', as she was commonly addressed before me; many invitations we received were for her benefit. A strong child focus in Sweden became apparent.

Qualitative Interviews

Semi-structured interviews were used to gain insight into the experiences and perspectives of the participants [44]. The interviews were audio recorded and transcribed verbatim by the researcher. Questions were loosely formulated, each interview informing the next. When conversation veered off topic, the researcher guided the topic back with open questions to facilitate an interview which provided meaning to the work.

Thematic Analysis

Thematic Analysis (TA) is a technique used to analyse qualitative data as reported *by Braun and Clarke (2006)* [43]. Participants were identified through purposive sampling and snowballing. Upon completion of interviewing and transcription of the data, the following steps were undertaken:

a) Reading and familiarisation of the data, through immersion
b) Coding of the data, identifying the details which relate to the research question c) Searching for emergent themes within the data,
d) Reviewing the themes and searching for connecting and nested themes,
e) Defining and naming the themes and
f) Finalising the analysis relating back to the research question and the larger body of literature [43].

Emergent themes from the participants' data was triangulated to provide an accurate and strengthened perspective and to offer a richer, more rounded account of the themes, and provide a more credible, deeper understanding and interpretation of the data. The Audit Trail provided further rigour and transparency to the process and enabled self-reflexivity. The researcher has studied psychology and anthropology, and has been influenced by interdisciplinary approaches in relation to questions of women's mental health.

Theme Analysis

Themes were built from observations, patterns, and, codes which emerged from analysis. The themes, more intricately described below, are herein defined and situated within the literature.

Trapped in Excellence – State over Self, draws on the global positioning of Sweden as having high social trust, offering best practice state provided social supports for parents, the pride of the people in that standing, and how despite notions of strong independence, the socially mandated rules define, and both expand and limit the experience of parenthood [33,4249]. The Paradox, expands more the paradoxical notions of freedom, trust, independence, choice and being compliant with governing and socially mandated laws [12,13]. The third theme, *The Good Girl-The Better Man,* draws links to the myriad research around the notion of The Good Girl in Sweden, whilst being situated within a broader context of feminism, equality and parenting roles. It explores the pressures women experience to perfect in work and motherhood, alongside a gap in equal measures and expectations against men [5,50]. *Emergent Voices-Seeking Authentic Validation* supports the work of *Mauthner, 2010, Leahy-Warren and Corcoran (2012), Negron, Martin and Almog (2013), Blaffer Hrdy (2009), Small, Taft and Brown (2011), Oates, Cox and Neema (2004)* [3,13,22,27,38,39] and others, in finding the need for validation and emotional expression from and to informal social supports.

Naturalistic Data

Some findings and data were gained from the general population where consent was not always achievable. All names and locations were changed or omitted from the writing up of the data. Field notes were viewed only by the primary researcher and supervisors and are filed securely on a password-protected laptop.

Participants

Ethical considerations

Participation in the project was voluntary. Given the qualitative nature of the research a number of ethical considerations apply. Confidentiality was maintained where appropriate. Copies of all audio recordings, field notes and transcriptions of interviews will be destroyed at the end of the project and a copy of the final transcripts will be provided to the primary supervisor on a USB. This USB will be stored for a period of seven years, after which time they will be destroyed and the

identity of those who participated will remain confidential.

Participant Recruitment

Upon arrival in Uppsala, initial local contacts were provided by the host at the Acadamiska Sjukenhust. The researcher was based at one of the University office complexes, and staff and visiting researchers were made aware of the research and the researcher's role as participant observer through email correspondence, posters, and flyers placed in the staff rooms and informally as people were introduced. Many informal conversations transpired and the researcher would ask questions centred around the main themes of parenting policy, parental distress and social support in Sweden. Fika, a Swedish custom of sharing coffee and morning or afternoon tea was an opportunity rich with commentary about such topics. The researcher would pose questions, make observations and partake in discussions with between three and twelve people at a time for thirty minutes, after which everyone resumed work. From these conversations, further connection was made with individuals for in depth interviews where topics were delved further into.

Informed Consent

A flier for recruitment was distributed to appropriate contacts. Participants who expressed interest received an information sheet outlining the nature, purpose and possible risks and benefits of the study. Information about the project was discussed in further detail before the consent form was signed to ensure a complete understanding was met. A consent form was provided and completed at the time of the interview. A copy of the Consent Form, Information Sheet and Complaints/Services Sheet were provided to the participants. If a participant became distressed during the interview, the researcher was mindful to proceed with care and debrief the participant afterwards in terms of seeking support if deemed necessary by the participant.

Participant Characteristics

Parents who spoke English, were educated with at least post-secondary qualifications, were employed, and over the age of twenty years were recruited using purposive sampling. The recruitment process resulted in 28 interviews. Twenty-seven participants identified as Swedish, one had grown up overseas but had given birth to children in Sweden. Participants were broken into two groups; parents and professionals. Although all participants had children, the interviews were slightly different if the participant was recruited as an industry professional or professor in the field of the related research. Participants spoke about their experience of parenting and working, and the professional cohort also shared insights from a professional perspective.

Parents

There were 13 participants in the parents' group; four men, nine women. Ages ranged from 26 to 60, (M=35.5). One of the men was on parental leave, one woman was working at 87.7% and the others were all at 100%. The average number of children was 2, and the average length of leave was 9 months.

Professionals

There were 15 participants in the professionals' group; 2 men, 13 women. Participant ages ranged from 29 to 62 (M=45). One participant was retired, two worked at 80% and 90% and the remaining 12 were employed FT. Although an older cohort, the average number of children was still 2.

The Wider Population

Observations were made, and conversation were had with members of the community in cafes, parks, museums, libraries, school, open preschools, public transport, social gatherings, private homes and public spaces. The researcher spent significant time with three families in particular, in their homes, at family yoga and at festivals. Information was gathered from posters, brochures, slogans, group conversations, cultural activities and norms. The researcher attended the Nordic Marcè Conference during which observations, conversations, research and norms were observed.

Results

Analysis of the individual interview data and field notes generated 4 themes; Trapped in Excellence-State over Self, The Paradox, The Good Girl-Better Boy, and Emergent Voices. The benefit of immersive participant observation as a working pregnant mother was that as an outsider it was possible to see and question the way of life of a mother through a researcher's lens. Stepping outside of our own environment expands one's view and allows one to question taken for granted concepts and norms. Observations were drawn upon to further inform and develop the themes as they emerged.

Trapped in Excellence – State over Self

In Sweden, the notion of choice and freedom relating to paid work was overcast with expectation and societal pressure; it is widely understood that the woman will return to work. Whilst not legally mandated, there are clear societal standards, and judgment of those who deviate from the convention. Independence and freedom were highly valued attributes of Sweden's culture, yet participants were lacking in personal freedoms around family structure. The state provides generous parental leave days, flexible work options and shared leave; the parameters of which were tightly adhered to. Women are expected to be in paid employment, with children in childcare before the age of 18 months. There was a strong rhetoric around parenting as learned, rather than instinctual. The implications of this conviction is that anyone can parent - the primary role does not sit only with the mother, supporting her return to paid work. State provided social supports were observed and revered, despite emotional or personal desires.

"To stay home for 3 years with my kids, it would be nice, but it's impossible in Sweden. You *have* to work; everyone *have* to work." FP15.

The same expectations exist around returning to work too quickly, supporting the narrow band within which leave was socially accepted.

"It's really positive to spend time with your kid, and you're a horrible mother, societally speaking, or even company level, if you come back to work, especially if you come back to work in under 6 months...you're kind of expected to be off somewhere between 6 and 12 months if you're a new mum." MP17.

There is a lack of freedom for mothers and a struggle for balance, freedom and desire, as revealed by the participant 12;

"To say I really want to get back to work is a little bit of a [taboo], because you get such a good possibility to be with your child so long, everyone knows it's good for the child but no one is saying whether it's good for the mothers" FP12.

Many participants felt torn between work and children. Despite the dedicated time they were able to spend at home in those initial months, leaving children in child care most days was difficult. A clear example of how the Swedish culture so strongly dictates their choices and ways of being, despite the physical and emotional reaction women may experience.

"Both economically and in the looks of what is right and wrong in Sweden, it's not acceptable to be home, you need the money and that is important, we like our childcare, we think our children are safe when we leave them, it's not, of course, it's hard when they're crying and so on, but we still trust it." FP25.

The emotional and mental impact of this was evident in more than one interview, as many women talked about returning to paid work and placing their children in childcare.

"It puts you in two...torn...tears you apart." FP14.

Participant 16 cried through her interview; she had just taken her son to childcare,

"I am working full hours and so is my husband so that's hurting me in my heart, that I don't see him for more than three hours (crying) I am sorry...it's hard for me not being with him." FP16.

This theme speaks to the high level of social trust in Sweden. It was clear through interactions, interviews, social engagements, and participant observation that societal rules were followed and respected, and seen as beneficial for a well-provided for society. There was a consistent expectation and rhetoric that Swedes should be grateful for provided services such as day care. Equality, independence and progression were highly regarded aspects of the Swedish culture supporting their high global rating of social trust. This collectivist approach overshadowed many of the individual experiences of participants. Participant 3 put it simply;

"You should follow the rules of the way things are" FP3.

Participants displayed great pride in their governmental and social structures. Equality was something to be proud of, something they excelled in. Participant 7 demonstrated this as she spoke about working in another country as a younger adult and how she moved back to Sweden because she could not accept the lack of equality.

"It was supposed at that time that if you got married and if you got kids, it was well, the woman should stay at home and the man should work. So I decided that I had to go home, otherwise I cannot survive. I felt that if I had to accept these rules, it's going to be like a violence against myself." FP7.

When discussing equal parental leave and the flexibility around work many participants stated

their pride and luck as a pretext to their concurrent suffering and frustrations by the same values.

"It's extremely generous of course, but also I think children are going to the day care centres when they are so small" FP13

Others were able to see through the societal norm of governmental pride and discuss an underlying flaw in the fabric upon which their cultural pride was based.

"They created this fantastic society and I'm really lucky for being a Swede, but I can see a problem here, that's like, people have a shame to get help, it's so deep in our genes, in our political genes." FP15.

"It's [day care] extremely generous of course, but I also think that children are going to the day care centres when they are too small...but that is something that you can't discuss in this society." FP13.

"I think we are trapped in some way, that we imagine that we are so equal, and are having this perfect society and equality, but we haven't." FP15.

There were occasional accounts where the participant would feel a sense of relief once their emotions and experiences about how difficult the parenting structures were shared, either directly or in reflection when they had shared with others.

"I started to be more open about things and I think that made it easier...I got a lot of positive responses from my friends saying, 'I *know*!! It's horrible isn't it!'" FP3.

"Sometimes you meet a mum you know and you chat and it's so nice to hear that others are in the same situation and that its normal, I think that's the most comforting thing" FP6.

Through these accounts, it became clearer that although the system and social structure was designed around women returning to work, and although the government supports were in place for day care and workplace flexibility, there was something missing. Women's needs were not being addressed. The excellent rules and the pain came hand in hand.

"We are very proud in Sweden that so many women are working...we are extremely proud of the parental leave system, and at the same time we saw that the one who was paying for it at the end was still the woman". FP25.

The Paradox

It became evident many people were existing in an often-unwitting paradox, with notions of freedom of choice and equality coupled with conformity and adherence to rules and norms.

"We [Swedes] are very individualistic and we don't listen to the church and we don't listen to um, institutions, we want to do what we want to do, we will decide for ourselves. Despite this, all people in Sweden go to the BVC, the child health care centre, and the program is the same for all children and everyone accepts it." FP13.

Participant 3 demonstrated the paradox in thinking in regards to work and parenting,

"I think it's exceptional and I am so lucky that we can have it, it's amazing...it's also very flexible and positive with children and how to combine it" FP3 and then this...

"You aren't equal! You have to have some charade or show how equal you are...at the same time, it's not" FP3.

"You're supposed to work full time otherwise you're not a good woman because of feminist reasons...you have to be equal to the man and do the full time and think about your pension, but you have to pick the kids up earlier anyway because they can't stay at day care for so many hours because then that's not good and you're not a good mother." FP3.

Women are expected to work from 15 months, and yet as Participant 3 stated, when wanting to take her older child to childcare so she could be home alone with her newborn, she was told,

"why would you want to leave them with us when you are home? The best place for the child is with you." FP3.

The inner conflict this created for mothers was salient. When discussing having an older child in day care while a parent was on parental leave with a baby, one participant responded,

"Many people are saying, 'why are you having more children if you don't want to be home with them? Why should you have the older one gone when you are at home! You should take care of

your children! Why is it better for them to be with strangers?" FP3.

The Good Girl – The Better Man

The notion of being a 'good girl' was discussed by 12 participants.

"In Sweden we have this expression, *duktig flicka*, um 'good girl'. You know you try to do everything good and be a good person...to do everything for everybody...I wanted to be this good, perfect mum" FP3.

Many participants spoke about the pressure to live up to internal expectations and pressure to be good at everything, and the guilt they would feel if they couldn't manage it. Some spoke of having to let certain things go in order to fit everything into the day, and how regardless of what they did achieve, the focus was on what they had not.

"It's the emotional pressure...and the guilt, 'I should do'...I should spend time, I really should do this, I should care about how I work, I should take care of my children, I should...I should also do this and this and this and there's only 24 hours in the day so you have to skip something, so there's guilt." FP20.

Some participants were insistent men were no different to women in terms of parenting. Parenting was considered to be learned, not instinctive. Men and women would embark on the project of parenthood together and learn as they went. Some participants mused the men would essentially work it out through trial and error when the parental leave handover happened; all participants were confident and gave no thought to the possibility their men could not handle it. And yet women participants talked about still doing and feeling more than men, discussing the inequality of praise for staying home, and that men get the 'easy year', after the hard work of a newborn was done. Men were said to be more present with the children, not giving as much consideration to planning in advance and thus not carrying the mental and emotional burdens of what was happening next.

In the male participants' manner, demeanour, and words was confidence and self- belief, and perhaps more significantly, an absence of self-doubt, questioning or striving to meet personal or societal expectations in terms of parenting. It was mirrored by women who displayed confidence in dads when discussing leaving the children and returning to work. They spoke of shared missions and projects, of equality.

"One thing you have to remember about Sweden is that we have fantastic fathers". FP8. "It's *we* that takes care of our child...we are like a union, it's something that ties us

together, it's *our* project in life" FP1.
"We still admire dads who stay home, we are very proud of it and we think it's

absolutely natural, but it's AMAZING at the same time – he's a hero." FP25

The majority of male participants stated they didn't care what was expected of them; throughout the interviews it was evident men didn't carry the same burden of high internal and external expectations.

"The picture of what a dad should do – I don't really care about that...I haven't read any books or blogs about how we *should* do it, so it's kind of ...it feels natural to me. and if I am doing anything wrong, then I don't know about it (laughs)". MP10.

"He is happy just being with his kids, he enjoys it and I think he is more focused just on the kids. Somehow I think men find it well... him anyway... they're more rational...they find it easier. I think they are more, umm, present. When I am playing with the kids, I am thinking of all the things I am going to do after. He plays, he plays, that's it." FP6.

Men were commonly aware of the issues facing their partners, describing their struggles and emotional distress as standard since the birth of their child. A lot of it was put down to the need and desire of the woman to work. One of the male participants, spoke about his wife and her struggle with isolation and being away from work, where she had a strong self of identity and purpose.

"She got really stressed, had breakdowns, she had some when she was on leave, she had a nice breakdown after 4 months after he was born and another one at 6 months. Just being at home, being isolated, being socially isolated, that was a big thing... even if people have social networks, they still breakdown wanting more. I think that definitely happens. It definitely happened to her...She craved working, she craved being challenged, she craved not having conversations about poop and food." MP17.

Emergent Voices – Seeking Authentic Validation

Whether geographically, emotionally or culturally, many Swedes were reserved and private. Despite the state provided supports, and participants being

aware of their cultural propensity to keep problems to themselves, they spoke about unrest within the structures they adhered to. Participants spoke about needing more in the way of informally structured support; from more lay, peer support to psychologists' support. Being independent and provided for curbed the propensity to seek outside support; as such, isolation was widely experienced. Personal feelings were largely pushed aside for the greater good, and talking about them was seen as being ungrateful for the world-class revered policies afforded them.

"You don't want to show others that you in some way can't take care of your child...we don't really share problems...any problems...that's the general rule in Sweden." MP2

"We have an equal society in Sweden, I think that makes people not struggle as much. It's like, well we are equal so we don't have to struggle to keep it up, to keep equality up...you think it's good enough. But it isn't. This is a fight that has to go on." FP15.

With such accessible, mandated SPSS there were fewer socially constructed and organic options for ISS support.

"It's hard to find help outside of the state provided help because everyone goes through these channels so there are not a lot of alternatives." FP12.

Women found comfort in the authentic emotional support they were afforded, and in the authentic, experienced, emotional support they afforded others.

"What did help was they listened a lot and um they just gave me kind of emotional support, I mean if you like, I was like, validated I suppose just feeling that, they get my situation and I felt they listened to me and that was kind of what I wanted to hear" MP21.

"You need to be seen, you need to be heard, there is someone there looking at you, focusing on you, and you know close the door this is your time where you know and they're asking and they're listening to what you are saying, so they're giving you time and they're giving you room and space." FP 29.

Participant 28, a clinical psychologist commented;

"They want authenticity. I mean the value of authenticity as in someone's own real experiences is just valued completely differently to expert opinion...anything related to everyday kinds of issues which is more about values and opinion or where there is no one single solution...then expert opinion is neither valued nor sought and it's not believed to be as important as real authentic." FP28.

Ethnographic Observations

There was a strong, overt lack of resistance to men being primary care givers. Parents were deeply across their working rights and leave arrangements, and by the pride and importance placed in Swedish policies. Dissonance and frustration amongst women was common. Whilst proud, they were keenly aware of the dichotomy in which they lived and how hard it was to break free of it. As a pregnant woman, based in Sweden with a 6-year-old daughter, social support was something very much needed. Some social connections were made quickly and kindness was shown by way of time spent, meals shared, invitations into homes and out for Fika, and most pertinently, assistance with my daughter when needed. The smallest gesture could make the world of difference when it was offered with the tone of compassion and understanding. It was far more than a formal appointment could offer. The kindness and interest in my daughter, which played into Sweden's ubiquitous child-focus; museums, books and monuments dedicated to *Astrid Lingren*, author and advocate for raising strong children, especially young women were well established symbols of the engrained equality and strength women embodied, touted and strived or.

Amid an excess of pride, principles and parental and equality practices was the term "lagom" meaning 'just enough'. This was bemusing and juxtaposed against the generosity of SPSS. Swedes did not appear to live lavish lives, rather a modest existence where the necessities were provided and to brag was distasteful. Schools were seen as equal, clothing understated, and dinner at friends was modest. Just enough choice in the cafes, just enough food on the plate, just enough expression. Akin to being middle-of-the-road, having low expectations, or perhaps, conforming, lagom focuses on what is absolutely essential, knowing when to stop and not doing anything superfluous. In a state where 'just enough' is seen as ample for a contented life, what does that say about the length and structure of parental leave in Sweden, and critically, what does it say about ours?

Discussion

Research into postpartum social support is vast, yet this paper is the first to explore culturally and experientially the darker side of what is touted to be

best practice, for the purpose of identifying gaps and reimagining the way SS is offered in Australian society. It adds to the extensive literature about postpartum support needs and the challenges of the work/family juggle in Australia. The findings support certain feminist and evolutionary theories of PPD as universal in nature which goes some way to explaining the similar rates of PPD in Sweden and Australia despite gold standard SPSS [1,20,21,22,39]. Conversely, SS across cultures has been found to reduce PPD symptoms, opening the question once more. Research by *Oates et al. (2004)* suggests women would feel adequately supported with SPSS including professional talking therapies, yet that is not supported by these findings [39]. Women postpartum required much more than the SPSS, revealing deeper issues rooted in the cultural and intrinsic nature of motherhood, and of loneliness. There is vast importance in the cultural practices and value systems of a society and the associated beliefs of the people, in terms of the internal and external experience of mothers and the way motherhood is constructed and responded to, as demonstrated by the valuable work of *Mauthner (2010), Evagorou et al. (2016), Ussher (2004), and Budig et al. (2012*) [1,2,5,13]. Certainly, it is a far more complex issue than simply good policy. Findings support much of the research which claims emotional support is a key and fundamental issue in maintaining wellbeing postpartum, and in calibrating the expectations and realities of mothers [2,13,33]. In contrast to the work by *Oates et al. (2004)*, the findings suggest the emotional support required is better sought from peers and other mothers, rather than with professionals. This supports *Mauthner's (2010)* finding that need for professional help is not universally expressed [13]. Without addressing the influence of culture, the perpetuation of current practices will continue to undermine the SS offered by the state. It is important to define and break down support needs and address them individually, rather than partially addressing them as a whole, and labelling it as SS. This notion supports previous research by the *AUTH (2020).* In Sweden, what women reported missing was emotional and appraisal support-recognition of the distress, validation of her experience. This supports work by *Wisso and Plantin (2015)* who found SPSS was insufficient in Sweden, and emotional support from friends, family and the workplace was beneficial and necessary [33]. The emotional support received in Emergent Voices, did not diminish the postpartum pain, rather it provided validation for the experience of being a mother in an industrialised country. PPD was still experienced to varying degrees by the participants, despite the SPSS. This affirms the notion that when practical support is offered, a need still remains for Emotional and Appraisal support which may be the elements necessary to provide a buffering to the inevitable, and culturally sustained emotional experience of transitioning to motherhood.

Many of the supports offered in fact added new elements of stress and guilt. The separation anxiety experienced by parents coupled with the disapproval of child care providers of mothers who sought practical relief from toddlers, confounded many women's distress by adding complexity and depth to the already paradoxical experience. In congruencies around the motherhood role and the importance of staying home with children in a culture designed to have them in full time care created internal conflict. Much has been written about the Swedish concept, "*duktig flicka-good girl*", and it resembles many women's' experiences across many cultures. Participants kept quiet about the experiences they were having, instead harbouring feelings of failure and inadequacy, and a sense they *should* be happy, they *should* be grateful, and above all, they *should* be able to manage it all, especially within this supportive and equal society [13]. This thinking resembles the biomedical notion that the problem lies within the woman, rather than from social influences, despite the construct of these thoughts being cultivated by the cultural values and beliefs of the society. There is a combative element to two driving Swedish principles one of independence and freedom, sound discernment and one of having just enough. The individual mother is lost in the greater good of Sweden's exemplary reputation for policy and state-provided postpartum support. At a systemic level, the societal narratives of motherhood, equality and individualistic achievement-based culture have much to answer for in terms of unfulfilled promises of women's equal standing, 'parenting as learned' and a conforming societal approach to a very individualistic experience. The emotional postpartum experience of parents in paid employment in Sweden is one of great paradox; pride and gratitude; guilt, loneliness and pain. This research found that the transition to motherhood and the postpartum period are personal, emotional experiences, and should be met with personal and emotional support.

Strengths and Weaknesses

Given the reported nature of Swedes to be private, and their high level of social loyalty, discussing sensitive issues with a researcher may have influenced responses. Conversely, the research being conducted by a pregnant mother with personal experience of PPD, in a foreign setting may have built prompt rapport and primed for an open and honest discussion. Only highly educated people native to Sweden participated. The experience of immigrants or diverse groups were not explicitly explored beyond friendships and

insights garnered by the researcher. The weather and location of Sweden was something many of the participants noted as having an effect of wellbeing. We did not focus on these elements for this study. Limitations included language and a general of lack of local knowledge. As with any ethnography going into the field and having to learn how to meet people and be accepted into the group was challenging, as was collecting data in a short period of time. This study was qualitative and focused on getting rich data from participants which would allow a deeper understanding of their lived experience, and may not be generalisable.

Implications

The findings of this research has implications for holistic health promotion, perinatal education, mother-centred postpartum care and informal talking approaches. It provides strength to the notions of connection and companionship, accessible, experienced emotional support and the apparent need for an increase volunteer and informal services, in all sectors. There is potential for innovative solutions which address and expand immediate needs for support. Some of the implications might be related to funding, policy and program development. There is a gap between what is offered and what is needed, which may inform decision making around each element of SS and offer some specific appraisal and emotional support to assist mothers.

Conclusion

State provided support is not enough to significantly reduce the experiences of PPD in women in paid employment. Policies and allowances which promote individual choice regarding leave and work, and which provide emotional and appraisal support may foster more positive outcomes. Cultural influences around what it is women are seeking when setting out to achieve success in both motherhood and professional spheres must be considered. This is important as it treats/considers both the origins of the desire and resulting distress, as far beyond political or economic. Sweden showed us despite the beliefs, values and practices of equality and work being deeply entrenched, that motherhood still pulled heavily at the women. Learning from the experiences of women in Sweden, and relating them with the myriad experiences here in Australia, it can be concluded state provided social supports, go some way towards providing what is necessary for a successful transition to motherhood, yet fall short in terms of addressing the emotional and appraisal needs of the mother. If Australia is to learn from the experience of Swedish mothers, it must heed the equal importance of ISS and SPSS when informing policy; it must adhere to the intrinsic importance of culture on the societal and individual experience of motherhood and respond in accordance with systemic and long term benefit to mothers and the state; superficial and political notions of equality and support do not extent deep enough.

Location and Funding

Contacts were made with Swedish professors of psychiatry and obstetrics and gynaecology at the 7th Annual Congress for Women Mental Health in Ireland. An invitation was extended to be a visiting researcher in Sweden. The conference in Ireland and the research in Sweden were funded by the Westpac future leaders scholarship which the researcher was awarded in 2017. The research took place in Uppsala, Sweden for a period of 12 weeks. The researcher was based at the Akademiska Sjukhuset, Uppsala. The researcher, resided in university housing. Combining ethnography and participant observation, the researcher was immersed into Swedish culture, 16 weeks pregnant and residing with her daughter, aged 6, allowing first-hand experience with the schooling system, the midwifery and primary care facilities experience as a mother in Sweden, with few ISSs.

Ethics

Ethics was approved prior to arrival by the University X's ethics committee H-2017- 72 and was approved by the host in Sweden. Information and Consent forms were sent to the host for approval, and no further ethics were required.

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5

Practical Application in Industry

"Women experiencing postpartum depression are engaged in struggles of attempting to conform to culturally derived and interpersonally upheld expectations of motherhood, but in doing so feel disconnected from parts of themselves, from other people, and from the surrounding culture."

Mauthner, N. 2010

Preface to Chapter

This third section is a departure from the previous two. Papers one and two are psychological studies of the lived experience of Postpartum Distress; the former a narrative exploration of social support, the latter a qualitative study undertaken in Uppsala, Sweden. The third section takes up the story with greater emphasis on the origins of The Village Foundation (Village) as both a business management consultancy and an exploration of the thought lines about its socio-cultural features. It is the contention of the third piece that Postpartum Distress as a lived experience belongs as much to a socio-cultural understanding as a bio-medical one. Furthermore, Village as a practical, applied approach to addressing PPDS in the context of the workplace and the wider community belongs to new social movement (NSM) specifically designed to address the needs of women and new mothers experiencing the debilitating effects of PPDS.

5.1 Lived experience

I experienced a rapid decline in wellbeing after the birth of my first daughter. Despite years of yearning and preparing for her, the reality certainly did not align with my expectations. There was such a build-up of excitement and anticipation from people around me; little did I realise how quickly this waned once the baby was born. I longed for ceremony; recognition of this amazing thing we had done – this amazing new being I had birthed and was now dedicated to caring for, forever. I had hoped for fulfilment and acknowledgement for all the small wins throughout the day that went unseen and were insignificant against the plethora of highly valued workplace achievements I had once been known for; had derived a sense of worth from. The issues I faced postpartum were deep, complex and multifaceted. They were a blend of internal and external factors which colluded to confuse and deplete me. It wasn't one thing, but all things. It was the lived reality, the norm, the unsaid experience of motherhood that I was expected to accept and manage emotionally, mentally and pragmatically as though it was natural to me; as though this was standard, and I needed to naturally and immediately align. To pinpoint one location of the stressors is impossible – they were in my relationship, they were in my sense of lacking achievement and pride, they were in the physical demands, they were geographical, societal, hormonal. And yet, with each conversation, with each counselling visit and with each doctors appointment, it was me, who wore the burden of all these elements. There was something wrong with me, my brain, my hormones.

I knew my emotions and experience in the postpartum period were circumstantial. There was nothing 'wrong' with me. I was sad, angry, frustrated, lonely, bored and lost – it is true that I was the one feeling these things, and yet, I knew that I was not

the cause. I was in my mid-thirties – well entrenched in 'who I was', had a corporate career, a husband who loved me - I felt ready. In other words, I had made the reasonable assumption that I was well supported and placed to transition to motherhood. And yet in hindsight I realise how you can never really be ready for such a life-changing experience. It is true that my expectations did not match the reality of having a baby. My mum had died 3 years earlier and so there was a missing part to this understanding of motherhood – her knowledge and experience, her love and care as I navigated the unknown. My extended family were interstate, my friends had either grown children or none at all. My self-identity was defined by my role in an achievement based patriarchal society and motherhood was never something I aspired to or held in esteem. It's difficult to 'achieve' when home with an infant, and the monotony and repetitious nature of early motherhood holds little reward personally or societally. My husband, father of two older children worked full time, mostly interstate, leaving me alone the majority of the time. Day after day, night after night, it was just the baby and me. It felt wrong to put so much expectation on him to be there physically and emotionally whilst he was providing for us. He struggled with parenting again, with sharing me and with the drastic change in our lifestyle, and that affected me deeply. All these factors resided outside of me, and yet, I was labelled as depressed, as sad, as different, and the onus was on me to change that. I was offered medication as a final validation that it was me that was wrong.

5.2 The Biomedical Approach to PPDS

The biomedical approach to PPDS not only burdens mothers with diagnoses and blame, but misses the point, "insufficiently" explaining disease (Mauthner, 2010; Oakley, 2019, p. 28). Whilst hormonal and medical causes may form part of the

picture, the emphasis on them shifts the focus from the contributing cultural, feminist, and social factors (Simpson & Catling, 2016). PPDS is pathologized within a cultural structure which values science, pathology, stoicism, patriarchy and quantifiable achievement. Oakley (2019, p. 12), discusses the medicalisation of health as a "dominant ideology of our times" – one in which motherhood, emotional expression, and postpartum ceremony go unrecognised, or carry negative judgement. The biomedical approach conceptualises postpartum depression as a disease, which places onus on the woman's physical and mental capacity. Situational and societal factors which may contribute are treated as secondary, are often inconclusive, contradictory, and are largely ignored in the literature and in practice (Mauthner, 2010). Social, psychological and physiological determinants are placed upon the mother and management of her mind and body are handed over to a medicalised, compliant industry of birth (Mauthner, 2010). Medicating mothers may appear to provide a solution; however, this automated practice may place mothers in a holding pattern and does little to address underlying factors preceding such diagnoses. Moreover, the medication option can place mothers in further turmoil as many worry about the effects on breastfed infants (Dennis & Chung-Lee, 2006). Treatment does not address the rates of PPD which are currently at 13-17% in Australia, does not address suicide as the leading cause of maternal death, and does not prevent the short and long term developmental damage and adverse effects to children whose parents experience PPD which has long term effects on the future wellbeing of Australia (Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015; Thornton, Schmied, Dennis, Barnett, & Dahlen, 2013). Medicalising women's postpartum experience has problems rooted in feminism and psychology, neglecting the active role of women and situating them as passive and powerless (Mauthner, 2010). Birth, or becoming a mother, which could be described as one of the most powerful

experiences one could have, instead leaves many women feeling disempowered (Draper, 2013). The biomedical approach to PPDS does not go far enough to address the needs of parents or children; it fails to fully incorporate all the elements needed in understanding and addressing PPDS. Sociocultural factors impact women's expressions of PPDS, and it is ethnocentric to ignore these accounts and accept the biomedical as anything other than reflecting cultural values; the problem is complex and culture specific. Looking at the impact of culture on development holds firm the notion that from childhood our values, ideals and beliefs and informed, by the larger picture as a subconscious reference to what is 'normal' and from where we derive our sense of self, our attitudes towards roles, achievements, 'individual' values and goals (Velez-Agosto, Soto-Crespo, Vizcarrondo-Oppenheimer, Vega-Molina, & Garcia Coll, 2017). Thus, motherhood is prescribed as a predisposed value which we embody, despite the emotional and biological pull many may experience (Yearley, 1997). Internal conflict between biology, the idealisation of motherhood and the cultural, subconscious view of motherhood is played out within the norms of culture as demonstrated by expectations around work, childcare, home-duties and what it means to be a stay at home, part-time, or full-time paid working mother (Yearley, 1997).

Widening the Lens

What is needed is an extended paradigm within which PPDS can be explored and in moving from a biomedical lens to a cultural lens, shifts the focus. "When anthropologists examine people of different cultures to determine how mental illness unfolds in diverse societies throughout the world, the basic premise is that the environment, culture, society is at the core of the individual's cause of mental illness" (Goldbort, 2006, p. 122). This opposes a medical model which "locates

mental illness within the individual as occurring from organic brain disease, resulting either from physiologic, biochemical, and/or genetic cause(s)" (Goldbort, 2006, p. 122). The effects of PPDS may be wider felt than expected, and last far longer than the immediate postpartum period. They affect the mother, the child, the mother-child dyad, siblings, the father, the marital relationship and the extended family. Women, regardless of whether they are diagnosed with PPDS, all go through significant changes upon becoming a mother and do so largely within a culture which expects them to not only cope, but to embrace motherhood naturally. The stressors of parenting and working can affect the mother's confidence and experience for years, often silently. Women reportedly do not seek help when struggling to cope but try harder and put on a braver face.

Across the world in various cultures there are reports of a period of unrest, sadness, depression and transition after the birth of a child – this is not unique. The cultural differences in how this period is managed, however can play a significant role in the ongoing experience and the lasting effects for the woman and child (Evagorou et al., 2016). Understanding ubiquitous cultural norms can inform us of the expectations and values placed on ourselves and others in relation to motherhood and work. Despite variations across the world, the immediate postpartum period has evidenced a time of transition and sadness. What seems to change, is the personal and societal response to the postpartum period, and the length and depth of how it is experienced.

Explanatory models give women a voice regarding their problem's aetiology, importance and treatment (Kleinman & Benson, 2006). By engaging in an open conversation about a person's individual experience a richer, more personal account

is gained. Alongside a biomedical diagnosis, this may open the discussion and understanding around the struggles of each person experiencing PPDS. Through open inquiry, what is really happening for the individual and what the person feels is at stake is revealed, outside of the labels of biomedicine. The focus moves from labelling, prescribing, diagnosing and stereotyping which may shape and restrict women's experiences, to an individual, multifaceted one (Kleinman & Benson, 2006).

More than generalisable rules, laws and behaviours, culture is reciprocal in its influence, experience and expression, designing and being designed by each individual. Culture is far from external, rather it is dynamic: a continuously living and developing construct influencing and being influenced by daily actions. To see culture as separate from us is problematic, although understandable, as it is our ubiquitous understanding of ourselves and our world. When we step outside of the cultural norms that are taken for granted and look critically at a situation, the way it has been formed may be more clearly seen. It also allows us to widen our understanding of normal, and to identify ourselves within an ethnocentric viewpoint of 'one correct way' to include other opinions as an alternative foundational understanding to mental health, and a problem such as PPDS should be no different.

Beyond Biomedical

There are various theoretical explanations of the PP period which extend knowledge beyond the biomedical framework, providing a wider understanding of PPDS (Blaffer Hrdy, 2009; Evagorou et al., 2016; Harkness, 1987; Mauthner, 1998, 1999, 2010; Tracy, 2005; Ussher, 2004). For the purposes of this research, the cultural, feminist and evolutionary approaches are predominantly drawn upon, though all

provide relevant and important arguments. Contention exists as to whether the functions of the female body, or motherhood, are special, or are reducible to socialised functioning which lacks individualism (Lupton, 2012). Further, the argument of natural instinct versus motherhood as learned is a continued feminist debate (Miller, 2007). Applying a critical lens, it is apparent that the transition to motherhood is laden with emotion, potential loss and grief. This rite of passage has been described as a "reasonable" response to motherhood as women lose who they are in order to become something new (Ussher, 2004; Yearley, 1997). Ussher (2004), describes the experience of PPDS as something to be expected given the changes a woman undergoes when becoming a mother, including incorporating adjusted expectations of reality. If popular media is to be believed, we would be guilty of thinking that the early days of motherhood are blissful and joyous without the darkness of grief, mourning, and adjustment (Mauthner, 2010). Not only is life different postpartum, but the locus of our attention and the very core of who we are is changed forever – that this should occur without such transition is, at least, unrealistic. What makes this transformation more difficult, potentially perpetuating the experience of distress into longer term depression is the societal response to motherhood: the quality of support, and the circumstances that surround the transition, embedded in cultural beliefs. It is argued these have been historically informed and developed by a strong male point of reference in terms of research, values, employment and assumptions of gender roles (Neuman, 2003). Applying a feminist lens to this research allows us to see the problem and the solution from an alternative viewpoint from the "male-oriented perspective that has predominated in the development of social science" (Neuman, 2003, p. 88). Moreover, it engages the researcher with the data in a far more personal and interconnected way; rather than objective and removed, the researcher, and indeed the researcher and participants in

this case are "fused" with it (Neuman, 2003, p. 88). It affords us the scope to see beyond the norm and delve more pertinently into the subjective experience of women, in what is still a very women centred area of focus. In the case of this research which has been conducted by a woman and mother, it is fitting to apply such a lens to the subject.

The biomedical model can also be defined by what it is not, or by what it fails to address, in this case, current work-life experiences, cultural norms and attributing burden of responsibility to factors outside of the body. Drawing from anthropological and evolutionary perspectives, we can assert that western society fails to provide the necessary emotional and societal needs of a new mother; "if a new mother is to be able to nurture her child, she herself needs to be nurtured" (Kitzinger, 1983, p. 227). By widening the lens and applying a cultural perspective to the aetiology and management of PPDS the burden on women is reduced, and society and industry share increased responsibility. This shift allows for more practical, holistic, humanistic measures in addressing the postpartum period, and deepens the insight into systemic, cultural factors.

Evolutionary Insight

From an evolutionary perspective since becoming bipedal, birth is a necessarily social act, with importance placed on the like experience of female birth companions for compassion and understsanding, as well as safety and practical aid (Davis-Floyd & Sargent, 1997). Blaffer Hrdy (2009) and Tracy (2005) provide evolutionary explanations of PPDS which posit a strong correlation between postpartum depression and a lack of social support, suggesting that psychological pain indicates a "social injury", much like a physical one. Tracy (2005) supports the assertion that

PPDS is not a dysfunction, but rather signals that the mother is suffering the social cost and inherent taxing nature of carrying and rearing a human child (Ussher, 2004). Evolutionary theory outlines the predictions for PPD, the first being a lack of social support, and postulates that whilst the potential for PPD is universal, if there is sufficient social support and relatively little social cost to the mother, the rates of PPDS should be low in that society. Evolutionary factors protecting the vulnerability of new mothers include rest, and social recognition of the motherhood status through rituals and acknowledgment. Unlike cultures where the more children a woman has the higher her social status, our culture does little to support new mothers' social status. Parental leave aside, parenting in and of itself is not celebrated or revered beyond the theoretical. This research is scaffolded on the idea that culture plays a pivotal and unequivocal role in who we are, and how we feel, think, behave and express ourselves. Miller (2007) uses Sweden as an example of culture being designed and embodied, as discourse around motherhood parallels with that of equality. Rather than existing outside of ourselves, it is the very fabric of who we are and how we make meaning of our world, which impacts our personal experience of motherhood – "culture provides the means, activities, and meanings of every human activity within a particular social origin" (Velez-Agosto, Soto-Crespo, Vizcarrondo-Oppenheimer, Vega-Molina, & Garcia Coll, 2017, p. 904). Our cultural view of motherhood ranks low in our neoliberal, competitive and achievement based culture. As the world moves forward and away from seeing and treating women as second class citizens, and from the baggage and legacy that is still evident within the system, this needs to be recognised. Bronfenbrenner's ecological theory explores the links between the continuous biological and psychosocial factors which influence and shape development and wellbeing in an individual (Mutumba & Harper, 2015). This framework still portrays culture as existing outside the person,

having influence as one of four separate systems of developmental influence. Whilst it has value in demonstrating the level of influence on an individual at all levels, it fails to demonstrate the implicit nature of culture existing both internally and externally to oneself. Velez-Agosto et al. (2017), instead explain the case that culture is not separate from us, rather it forms a central part of us – our thoughts, cognition, memory, beliefs and values – which engages with outside influences, and then feeds back.

Following on then, individuals are as active in shaping culture as they are in being shaped by it, which opens the possibility for changes and shifts which are contrary to homogentisic practise. Whilst culture provides the immediate context for human development , each individual upon internalising cultural values and practices adds their own individuality to them and to greater society, further perpetuating the changing paradigm of culture (Velez-Agosto et al., 2017). Australia as a multicultural country has a unique opportunity to explore various theories, methods, practices and rituals for validity in working with women in the postpartum period. In 2019, there were over 7.5 million migrants residing in Australia representing almost 30% of the population, and every single country in the world (ABS, 2020). When we can look at society as multifaceted, with varying alternative norms available to us, we see culture for what it is: dynamic, fluid and mailable. When this is consciously embodied, we become the storytellers for how we live, for what is normal and for what we need to be well. These theories supplement and extend the current understanding and treatment of PPD. Despite this, none of these theories directly addresses the current experience of motherhood in the workplace. By drawing from various approaches to PPDS, this research offers a consolidated holistic theory to PPDS.

5.3 Cultural Social Support Implications on Health

The argument that support has integral links to physiological health sits within the biopsychosocial model of health and wellbeing. That each element of wellbeing, the biological, psychological and social, influences the other is well supported and has become far more acknowledged in the past 25 years (Suls & Rothman, 2004). Taking into account research by Velez-Agosto et al. (2017), that culture and biology are inseparable components for individual development and adding to that the biopsychosocial model when addressing parental support, it is clear to see the importance of such an area on all members of the family and their development, health and wellbeing. Yearley (1997, p. 24) explains that, "culture is acquired almost unnoticed, as a result of an individual growing up within a given society and gradually acquiring the unique cultural "lens of that society". Further, Uchino et al. (2009; 1999) demonstrates the links between such ubiquitous development and its effects on the physical, providing a diagram, which explicitly shows the connections between support and psychological and physical outcomes. Budig et al. (2012, p 164), explains that policy and decisions concerning parental experiences and practices are not made within a "cultural void", rather policy and practice interact with all facets of societal life. Addressing support needs for new parents may act as a preventative solution for many of the psychological stressors they face which in turn has the potential to positively influence their physical, mental and emotional health long term, the wellbeing of other family members and the immediate physical and emotional development of their infants. Improved health and wellbeing for all family members has the flow-on effect then of influencing organisational health and community health (Hanna et al., 2002).

By adopting a cultural explanation to PPDS it provides a pathway to addressing the problems of PPDS through non-medical interventions, that is through building and maintaining effective social relationships. After the birth of a child, it can be argued that the lives of its parents are changed forever: their focus, their demands, their values and expectations. Returning to the workplace can challenge an individual's notion of who they are and increase cognitive dissonance with regards to their roles in the workplace and in the home. The problem facing many parents either with or recovering from PPDS and returning to work, is the notion of wellbeing, balance and self-identity in a culture which largely values achievement and undervalues motherhood (Yearley, 1997). Ironically, although largely silenced in the workplace, this experience of being torn, of feeling guilty and of being unable to find balance is very familiar. The emotional and mental loads and the torment facing many parents as they return to work is largely invisible within the corporate sector despite a growing offering in parental workplace support.

Informal Social Support

Peer to peer support refers to the support one gains from another who has similar lived experience, facilitating the transition to motherhood (Dennis, 2003; Leahy-Warren et al., 2012). Unlike professional support, it may offer more practical day to day advice and provide the feeling of connection within the community (Caramlau, Barlow, Sembi, McKenzie-McHarg, & McCabe, 2011). Many women suffer silently with the pressures of managing motherhood and professional life. There is extensive literature on the benefits of a 'community' raising children and of women preferring non-medical settings and language to deal with PPDS symptoms (Abrams, Dornig, & Curran, 2009). Peer to peer support offered via telephone for PPD has been shown to have positive outcomes for the callers, reducing distress, increasing wellbeing,

feelings of hope and confidence in their parenting (Biggs et al., 2015). Women report feeling reassured after speaking with other women and expressed their satisfaction in feeling heard by non-judgemental trusting women who had an understanding of what they were going through (Biggs et al., 2015). The process of peer support enables choice and personal skills development through a mutually supportive relationship and a sense of connection with others (Caramlau, Barlow, Sembi, McKenzie-McHarg, & McCabe, 2011). Social support has been found to positively impact physical health with Uchino (2009) finding that social relationships influence the cardiovascular, immune and endocrine systems. Overall, support has been found for the benefits of peer to peer programs (Biggs et al., 2015).

Mentorship

Positive deviance refers to the ability of some to overcome adversity where most struggle when faced with similar circumstances. By drawing from the strengths and strategies of these people it is hoped that the community may benefit. This way solutions "exist within communities" and come from within those who have lived experience rather than theoretically imposed- healing through acceptance of themselves and decreasing expectations through the lived reality of others is facilitated (Mauthner, 2010; Oates et al., 2004). Parents are seeking role-models and supports in the workplace and suggest that increased training in workplace parental supports would be beneficial (Work, Karitane, & APLEN, 2019). Mentors and leaders have the potential to inspire and give hope to those facing adversity of a similar nature (Baxter, Taylor, Kellar, & Lawton, 2016). Punnett (2006), evaluates what makes women successful and describes various components for how women could manage dual roles whilst they "adhere to the male model of the career" (Punnett, 2006, p. 61). Self-efficacy, personal belief and social supports are key findings. Whilst

explaining the importance of culture and how deeply it determines behaviour, (Punnett, 2006) describes the important role of mentoring and connecting both formally and informally with other women as a prerequisite for success. Cheung & Halpern (2010) present a model of leadership based in gender and the success of a work-family interface. When asking what we can learn from women who are doing both, and have moved past the early postpartum days, is it best to focus on those who have done so in a successful way so as to capitalise on their methods? Research by Cheung & Halpern (2010) focuses on corporate working women who are leading "dually successful lives" (Cheung & Halpern, 2010, p. 183) and are doing it well. For mothers who may be suffering, mentorship as opposed to peer-to-peer support, provided a 'time-gap' in experience, which dissipates competitiveness and 'brave face' - within the gap of lived experience some women may find it safer to talk and share openly.

Policy Implications and Health

Physical, mental and social health of all Australians is not only the responsibility of individuals but, it has been argued, largely rests on the government (Organisation, 2014). The United Nations Sustainable Development Goals call on governments around the world to address various social needs of citizens, further confirmation of the responsibility of governments for the wellbeing of its people. In an individualistic culture it can be easy to forget that the state has a responsibility for the promotion and protection of complete health as a matter of fundamental human rights (Organisation, 2014). Healthy child development and the reduction or absence of disease is not sufficient in the striving for mental and physical health, and social wellbeing. Focus on the biomedical alone is to ignore the immense effect social, educational and behavioural aspects of health have in the short and long term, and

their cumulative effects on society as a whole (Huber et al., 2011; Umberson & Karas Montez, 2010). Addressing comprehensively all elements of health and it's determinants such as social inclusion aligns well with Hertz' (2020) definition of loneliness as "personal, societal, economic and political" (Hertz, 2020, p34), and further, being "ignored, or unsupported, or uncared for also by our fellow citizens, by our governments, by our communities by ourselves" (Hertz, 2020, p29).

Social factors form the basis for many health factors (Marmot, 2014). Social relationships can affect all aspects of human health, at all ages, benefiting health in myriad ways including behaviourally, physically, and mentally through the quality and presence of social networks, social supports, inclusion and control (Umberson & Karas Montez, 2010). Equally, social isolation negatively impacts these areas and can directly and indirectly impact individuals in the short and long term. Healthy social ties positively influence health behaviours through information, habits, networking responsibility for others and by creating and expressing norms. Mental benefits of social ties include an increased sense of self, control and value through social emotional support. Feelings of worth and recognition increase wellbeing and decrease the effects of stress. Through emotional social connections increased feelings of acknowledgement impact the sense of "meaning and purpose" in life which directly affects the physiological experience (Umberson & Karas Montez, 2010, p. 56). Physically and mentally, lack of social relationships can negatively impact wellbeing, mortality rates and child development and behaviours; implications for community health are thus compounded, and costs to government and society are considerable (Evagorou et al., 2016; Hanna et al., 2002; Umberson & Karas Montez, 2010). By focusing on the social aspects of wellbeing with a long-term and preventative approach there are two elements which should come squarely into

focus: that the quantity and quality of social relationships have the ability to shape and develop healthy individuals and populations and conversely if ignored, to exacerbate illness, disease and poor wellbeing (Umberson & Karas Montez, 2010). The behavioural and mental ultimately directly affect the physical and thus social relationships should provide a strong basis for health policy development and reform.

Health policy is a clear conduit for the promotion and maintenance of healthy populations and the economic health of a country (Umberson & Karas Montez, 2010). Health therefore should be at the forefront of all policy design. Marmot (2014), argues that what determines health and wellbeing are largely social factors. "Social determinants" of health are visible and important to life quality and longevity and social elements such as stress, social inclusion and work, have a substantial impact on health. Interventions and policies should consider these social determinants and be structured in support of them for the benefit of men, women children and societal wellbeing as a whole (Marmot, 2014, p. 1099). Investment in social population health benefits individual, familial, societal and governmental levels economically, mentally and behaviourally. As one supports the other, mutual long-term benefits are gained. Policy with a social focus benefits the population and minimises individual and governmental costs. By avoiding policies which burden individual members of society more than others, or decrease equality and add pressure to social ties, and instead focusing on the promotion of social ties and the increased wellbeing they bring to all levels of the population, there is an opportunity to promote and maintain long term population health.

Five of the ten social determinants of health as recognised by the WHO are directly related to early parenting: stress, early life, social exclusion, work and social support (Marmot, 2014). Countries such as Sweden create policies that will address the wellbeing of the "entire population" (Marmot, 2014, p. 1103). Meeting human social needs such as these will inevitably improve physical and mental wellbeing as is well documented (Marmot, 2014; Umberson & Karas Montez, 2010). Reducing social inequalities in regard to parenting in countries like Australia not only meets human needs in terms of social and emotional support but could potentially increase the wellbeing of men and children not only as a follow on effect from improving maternal health, but in addition, with a new experience of inclusion and bonding we in Australia are largely unfamiliar with. As Australia strives and sets the climate for increased equality, these issues become that of "social justice" (Marmot, 2014, p. 1103).

The responsibility of corporate and political stakeholders to take the mental health and wellbeing of mothers in the workplace is salient, and currently does not go far enough. Both sectors should be taking it further – there is enough research to support the need. The United Nations Sustainable Development Goals and the WHO guidelines are a call to governments to take seriously the various social needs, of the people, and to confirm the responsibility of governments for the wellbeing of its people.

Economic Implications

The effects of PPDS to the individual and infants are well reported. The economic ramifications for Australian industry are also vast. Reports conducted by Deloitte (Economics, 2012) clearly outline the immense cost to Australian industry. Today

over 40% of women return to the workforce in the first year postpartum and often to their detriment. The first 4 months after parents return from parental leave are critical. Many women withdraw from the workforce, reduce their roles and suffer increased distress, and this directly impacts the competitive advantage and profits of the firms losing these women (Taneja, Pryor, & Oyler, 2012; Work et al., 2019). This leads to a decrease in productivity and staff retention and an increase in leave days taken and costs to the company (COPE, 2014). Loss of productivity due solely to perinatal mental health costs Australian industry over $700M per year (Australia, 2019), and approximately $4000 per person, man or woman (Economics, 2012).

Taneja et al. (2012), asserts that women significantly contribute to industry in terms of growth, and profitability, and investments in women provide sizeable returns both socially and economically. They go on to explain that profits and productivity related to female retention and work satisfaction are critical metrics.

"If the prevalence of women affected by perinatal depression was reduced by just 5% (15,500 women) in 2013, total costs in the first two years could be reduced by $147M" (COPE, 2014). There are staff replacement and re-training costs to be considered; disruptions to teams, morale, culture and overall cohesiveness. It impacts all members of the family and spreads into the community. The problem is not new; however, it is increasing across the globe with industrialisation, increasing costs of living, social media trends setting abhorrently unrealistic expectations and the increasing internal and external demands on women's time and abilities, but with no equivalent change to policy and wider societal views.

5.4 Contributions to Knowledge

5.4.1 The Biocultural Model of PPDS

PPDS is not simply a biomedical problem; although it can present and be treated that way. In part, its aetiology is far better explained by combining culture and physiology; by understanding that physiology in its physical, mental and emotional forms is culturally derived, that is biological markers are activated to indicate a deficit in social elements and thus PPDS follows a larger cultural experience. Further, rather than viewing PPDS as a problem, it is recognised, welcomed and understood for being an understandable response to motherhood, in need of appropriate support and recognition, particularly in our cultural reality which may exacerbate problems in an otherwise natural time of transition.

The Biocultural Theory derived from this research posits that our bodies and minds are directly linked to culture in a continuous feedback loop which consistently updates, validates or challenges and informs all elements. People can practise individual leadership and influence the order of society in their daily lives, by consciously modifying behaviours, by being open and genuine with their interactions with others. These "micro personal" actions can shape our democratic and cultural experience at a much wider level (Hertz, 2020). Hertz (2020) calls it 'personal democracy'. In short, we are expressions of our cultural beliefs and values and by further examining the rules of our society, we may more closely gain a broader insight into PPDS, into ourselves and vice versa, and it could empower us to facilitate change. Rather than self as a developed product of outside influences, this approach positions us as an actor engaged in the process. This theory supports and is supported by the research aforementioned, by the economic views of Hertz (2020), by the underpinnings of health psychology's Biopsychosocial Model, by the work of

qualitative researchers who have delved into the cultural explanations for PPDS such as Mauthner (2010), Harkness (2006), Evagorou et al. (2016), and Blaffer Hrdy (2009). This theory can be applied across cultures, as it makes no assumptions about the makeup and values of each culture, just that culture is integral.

Diagram 1: The Biocultural Model of Postpartum Distress

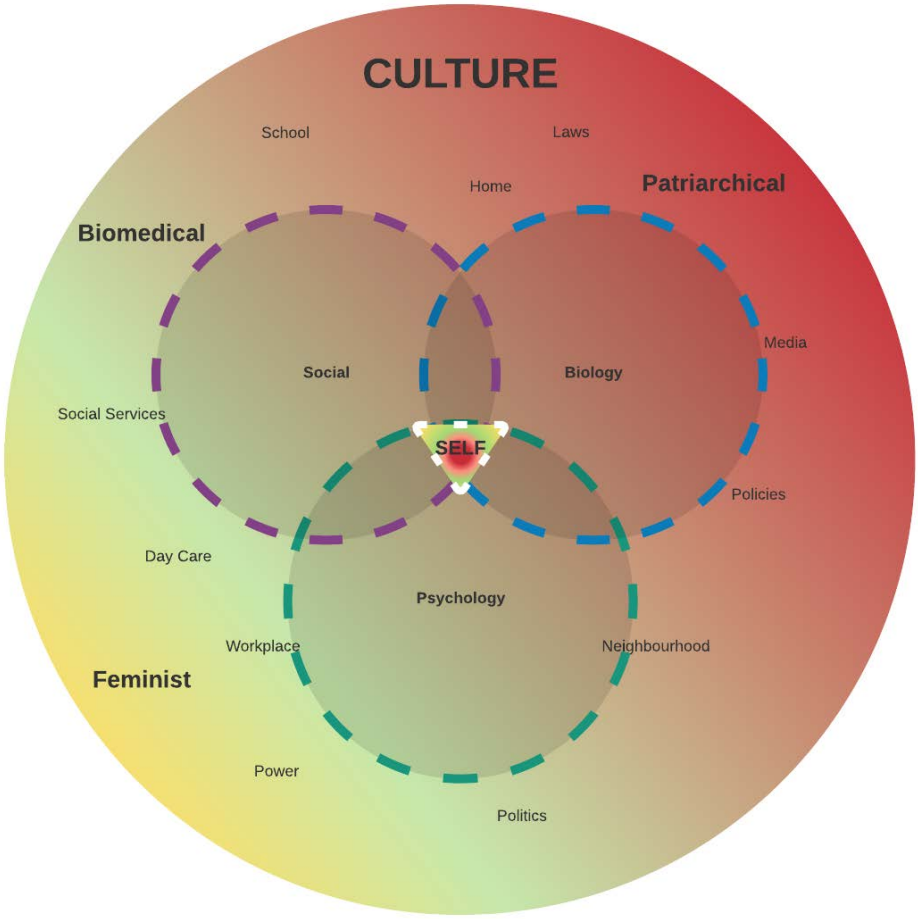


Diagram 1. This diagram depicts the self as the centre of various elements: all permeable to allow the perpetual feedback between social, biological and psychological factors. Culture, rather than sitting separately is blended throughout all elements, colouring all experiences and notions of self.

It is recognised that the world of a mother changes when becoming a parent: her focus, energy, priorities, habits and routines, and sometimes cognitive abilities. Up to 40% of women return to the workforce in the first 12 months after having a child, many – up to 80% - having experienced or still experiencing postpartum emotional distress (Evagorou et al., 2016). Whatever the severity of this experience may be, and regardless of whether it appears on the surface that support is required, there are appropriate, much needed measures that a company could take to ensure a smooth transition back into the workplace, with the wellbeing of parent and child in the short and long term is greater protected. There are numerous stories of women returning to the workplace after parental leave to find moved desks, disconnected phones, new team members, new supervisors and most distressingly, an expectation that they should be operating exactly as they were prior to taking leave.

A society in which parental leave is shared equally, where primary care is decided based on conscious choice and without fear or historic preconceived role construction, where the choice to stay at home to be a parent is not a sacrifice of status, self-identification, social standing or career trajectory, and where parenting isn't fraught with desperate loneliness and isolation, but instead, community, compassion and connection is possible. Cultural change of this magnitude is unlikely. In lieu of fundamental cultural change, despite the author's assertion that there is critical necessity for it, it is important to provide a level of support in a meaningful, accessible and relevant way, in current conditions. That is to a) recognise that a certain amount of distress when becoming a new parent is to be expected, b) that the current expectations and norms around motherhood are unreasonable and potentially damaging and c) that by addressing the issue at an individual and cultural level, we can enact lasting systemic change in attitudes and

beliefs which will in turn address the initial compounding distress. By normalising the postpartum distress one can experience, women gain a sense of control that may have been lost due to role transition and the impact of becoming a new mother (Leahy-Warren, McCarthy, & Corcoran, 2011). Scrandis (2005), found that 'being normal' was important for women in the postpartum phase and that women sought connections, which validated and empowered them through mutuality. Normalising the emotional experience and needs postpartum is important in providing an avenue for self-acceptance and acceptance of the rite of passage many women go through when becoming a mother, especially for the first time. This research supports Cheung & Halpern (2010), however heeds the extent to which 'managing it all' should be the goal. While normalisation of the distress following birth is beneficial in alleviating unrealistic pressures on mothers to be blissful and happy without a period of transition, it is equally important to draw a clear distinction between that and the unrealistic expectations of paid mothers to perform two full time roles in our culture. Further normalisation of this is dangerous and will only perpetuate the problem. We can learn and educate around accepting and expecting darker days as normal, whilst adjusting the way we approach the postpartum period and the mothers going through it. If we are to continue along the route of working and mothering, rather than simply normalising and internalising the distress, we need to vocalise it, so that it becomes apparent and clear that the experience is not rare but commonplace and damaging; this is crucial to creating the most flexible, transparent and workable arrangements for sustainable change. When people have a clear political goal, change can occur, again iterating the importance of individuals who decide personally, and then consciously act with others to enact societal change and make a lasting difference (Hertz, 2020).

When looking at the cultural embeddedness of our beliefs and desires, it is important to question how much choice we actually have. When applying this to mothers in the workplace we could begin to question, whether we are being internally driven back to work because we love the grind and the mental stimulation or whether we love the grind and mental stimulation because culturally that is what is valued, that is, where recognition and validation is found. How much flexibility do we really have? Even answering 'honestly' can only support the current culturally embedded paradigms. Internal inquiry once awareness and deeper understanding of culture's role in shaping our personal feelings, beliefs and desires, may reveal deeper truths. Do women whose social currency is increased with children crave paid employment? On a practical level, "culture needs to take an important role in public policy as the major informant of processes, contexts, persons, and time" (Velez-Agosto et al., 2017, p. 909). Research clearly shows that like-company, ceremony, ritual and acknowledgment during this time buffers the negative effect and provides a sense of camaraderie and normalcy through sharing experiences and emotions. In an ideal world, the status associated with motherhood would be ample, would be revered, and would provide a woman with a sense of self-worth and value in our culture which would rival that of career, education and equality. What effect would valuing motherhood to the degree that we value other achievements have on women? Would our craving for career subside? Would our sense of self identity be validated in the home? Would being, 'just a mother', be enough? As a researcher and a mother, I question whether with this shift in identity, self and societal values would in turn effect the rate of PPDS we experience.

5.5 Validating the Need for Change

Many organisations provide what looks to be a complete, content-rich solution for parental wellbeing: online forums, courses, fact sheets and seminars. They provide or outsource resources in line with current cultural paradigms and offer peace of mind for a company looking to meet 'deliverables' in Corporate Social Wellbeing. However, unless the offering addresses the complete human needs and stressors, simultaneously acknowledging the underlying cultural ubiquity of the problem through compassionate, in person, individualised care, the risk of parents falling through the cultural cracks is high. Further, it perpetuates the current way of being rather than enacting real social, systemic change and long term wellbeing.

This research sought to explore the current paradigm, and asks, how can we give voice to and support the experiences of working mothers within it? In an effort to explore the depth of the difficulties they continue to face despite workplace support offerings from industry, participants across corporate Australia were asked, 'what is the experience of parents in the workplace postpartum? And 'in terms of parental support in the workplace, what is missing, and what does work?'

5.6 Method

Ethics

Ethics was approved by the University of Adelaide's ethics committee H-2018-249.

Procedure

Qualitative Interviews were held with 16 highly successful leaders in the equality and wellbeing space: 13 female and 3 men. The author conducted all interviews, which began with broad open questions, and prompts were used to explore specific research areas, or in response to answers. Data saturation was reached by the 10th

interview. Key concepts were identified across the data after the transcripts were read and coded. Data was manually analysed and evaluated using codes in direct relation to the research questions.

Participants

Ethical Considerations

Participation was voluntary and confidentiality was maintained. Copies of all audio recordings, and transcriptions of interviews will be destroyed at the end of the project and a copy of the final transcripts will be provided to the primary supervisor on a USB. This USB will be stored for a period of seven years, after which time they will be destroyed and the identity of those who participated will remain confidential.

Participant Recruitment

Contact via email was made directly with senior executives in corporate Australia. Participants were selected by the researcher for the purpose of business development and market research. All agreed to be interviewed and recorded, and some have chosen to be de-identified. Interviews were undertaken in person, or via Zoom when COVID19 restrictions prevented face to face conversation. The interviews were audio recorded and transcribed verbatim for review.

Informed Consent

Participants who expressed interest received information outlining the nature, and purpose of the study. Information about the project was discussed in further detail before consent was obtained. If a participant became distressed during the interview,

the researcher was mindful to proceed with care and debrief the participant afterwards.

Participant Characteristics

Participants who spoke English, were educated with at least post-secondary qualifications, were employed in a relevant sector, and over the age of twenty years were recruited using purposive sampling. The recruitment process resulted in 16 interviews. Participants spoke about their experience of parenting and working, and shared insights from a professional perspective.

Table 1: Participant Characteristics

Participant #	Gender	Parental Status	Role	# Employees	Governance	Workplace
1	F	M of 1	Executive and Advisor	>20	National	Department of Prime Minister and Cabinet
2	M	Not a parent	Head of People and Performance	>250	SA	Private Sector
3	M	F of 2	Organisation Head	>20,000	SA, VIC, NT	Private Sector
4	F	M of 2	Department Head	>5000	SA	Academia
5	M	F of 2	Head of People and Culture	>4000	National	Private Sector
6	F	M of 2	CEO	Industry Provider	National	Private Sector
7	F	M of 2	Consultant	Industry Provider	National	Private Sector
8	F	M of 5	Governmental Head	Government and Industry	SA	Private and Public Sector
9	F	M of 2	Organisational Development Manager	>600	SA	Private Sector
10	F	M of 1	GM People and Culture	>600	SA	Private Sector

11	F	M of 2	Director	>100,000	International	Private Sector
12	F	M of 2	Governmental Head	>100,000	SA	Public Sector
13	F	M of 2	Chief Executive/Partner	<200	SA	Private Sector
14	F	M of 2	Consultant	Industry Provider	NSW	Private Sector
15	F	M of 3	Consultant	Industry Provider	NSW	Private Sector
16	F	M of 2	National Head of Diversity and Inclusion	>3000	National	Private Sector

5.7 Results

Analysis of the interview data generated the following three categories: Postpartum Stressors, Postpartum Supporting Factors, and Productivity and Wellbeing – all within the context of paid employment. Participants discussed the gaps, issues and origins of PPDS, and data was coded and grouped into sub-categories of Cultural Stressors, Workplace Stressors and Individual Stressors. Participants shared their experiences in terms of what worked to provide postpartum support in the workplace. Two main sub-categories were identified: Workplace Culture and Workplace Action. Leadership and connection featured strongly across the responses; having leaders who were emotionally and societally aware, willing to try new things and be open, honest and vulnerable made a difference to participants' experiences, as did regular connection through meaningful conversation, dedicated social gatherings with peers and education offered by external experts and the workplace. The interviews provided validation for both the necessity and the shortfalls of the current offerings of Workplace Parental Support (WPS) in corporate and government organisations and highlight the deficits of ignoring a humanistic cultural approach in favour of a biomedical one. Participants were asked to reflect on their experience in their professional capacity and in their own lives as parents.

5.7.1 Postpartum Stressors in the Workplace

Cultural Stressors

Cultural Issues addressed included the work/life juggle, childcare, societal attitudes towards motherhood, gender and role inequality and the low experience and exposure to children of new parents due to the individualist nature of family in Australia. Participants spoke about wider cultural norms and workplace culture, indicating a lack of policy and continuity around government and internal workplace practice. Culturally, issues such as competitiveness and achievement were raised as underlying factors of motivation. These were conscious and unconscious drivers of work ethic and behaviour.

Discussion around systemic change with Participant 1 indicated that in her expert opinion systemic behavioural and corporate change was important for policy to be implemented; that policy would follow the behavioural and trend.

> "If it's the norm in the private sector, then that's what would be expected in the public sector…the government is more influenced if the private sector companies start doing something and they see, oh ok, well this company's doing this …maybe we need to start thinking about what we're doing and whether that is adequate." FP1

Demonstrating the link in the Biocultural model, she continued,

> "If your work demonstrates the positive impacts of a different approach, people would take notice, and then it becomes something that helps to create change." FP1

Participant 8 agreed,

> "Most people spend a lot of time at work, and it is naturally going to be recognised as a place where we can enact some cultural change…I think the workplace as a focal point for change is actually a really important motivator, or educator, of change in this area." FP8.

Female participants talked about societal attitudes towards motherhood.

> "Within Australian Society we don't understand the value of having lots of kids" FP1.

> "There's just so many subtle messages all over society around how women should be behaving as mothers" FP6.

Participant 8 addressed the cultural bias and societal expectations around mothers returning to paid work; an example of the Biocultural Theory in action.

> "What we have to view is that raising children and wanting to stay home with children is not a bad thing. It doesn't make you a lesser person, it doesn't make your contribution to society any less. What we need to do is think of that as equally a valid contribution, and we don't. There's a stigma around stay at home mums." FP8.

Workplace Stressors

Participants themselves were demonstrative of the increase in workplace awareness for postpartum and feminist issues, with many as leads in Diversity and Inclusion.

Despite this trend, issues raised were still very much based in gender role inequity. Stigma around part-time work, the 'motherhood penalty', minimal focus on mental health and an inconsistency in standards and workplace policy (Budig et al., 2012; Yearley, 1997). Participants were leaders in the space of parental support, and yet the need was still very real and very relevant to their teams. Despite high levels of awareness, various programs and support offerings and a positive intention for creating positive and supportive workplaces, the majority of participants explained that the various issues as outlined in Table 2 were considered to be constant, daily issues requiring significant attention. When asked how often parental issues were coming up in the workplace responses were a resounding, "all the time, all the time. Always." FP12.

A lack of workplace awareness, internal and governmental policy was a key issue identified by Participant 6;

> "There just isn't an understanding that there is an adjustment period that takes people to come back into the workplace when it comes to parental leave. There is no legislative requirement for an employer to provide that kind of support." FP6

Participant 2 gave specific examples of how this manifests and the level of responsibility an employer should assume,

> "People coming back to new teams, new leaders and having no idea it was going to happen. Add on top of that potentially then going home and having not as much sleep as you should be having and then a screaming child. It's

> really on us to make sure their re-board is as soft and as stress-free as possible." MP2

Participants 3, 5, 9, 10, and 12 all discussed programs they have run within their workplaces but failed to manage and provide consistently. Despite acknowledging their value, they admitted to having many of them 'fall through the cracks' without designated people to maintain them. Participant 15, who works closely with large national corporate and retail organisations commented that "an externally run buddy system or mentoring for new parents is absolutely missing – it's what our clients are asking for, it's what they've been wanting." FP15.

Individual Stressors

One of the most common responses from all participants was around emotional support, and the need for an individual to feel their emotions and have them be accepted without judgement. Participant 6 explains that regardless of all the changes and improvements to support over her 12 years in the industry, that the emotion is still very real.

> "I don't think the emotion has changed…what's different is raised awareness that those emotions exist, that they're real, that they're justified and valid, that in fact we actually need to spend more time unpacking them and understanding them and responding to them." FP6.

Participants discussed outside influences which had a direct effect on their experience such as social media, a lack of sleep, post birth trauma, parenting guilt, fears and anxiety around asking for help, losing respect in the workplace, and not

measuring up to societal and internal expectations. Mental and emotional loads, and reduced self-care had increased mental distress in the workplace.

Many participants shared their own personal experience with failing mental health postpartum upon returning to paid work, and how it affected their own abilities to be productive and focused. These findings support the Biocultural Theory of interconnectedness and also identify where action can be taken most readily and appropriately. Upon addressing any of the factors under any of the three sections: culture, workplace and individual, a flow on effect is created into the other two sections which does produce change. Diagram 2 illustrates the enormous influence culture has on us as individuals and on our workplaces' structure, corporate cultures and practices. There is room, as illustrated, for change in each arena through education, conscious choice, behavioural change, and transformational leadership, which would in turn shape culture moving forward.

Table 2: Postpartum Stressors

Cultural Stressors	Workplace Stressors	Individual Stressors
Individualist /competitive culture Dual working parents Status of motherhood Societal norms and expectations Childcare Cost of living Minimal policies and standards Gender inequality Unconscious biases Low education/ experience of parents Slow cultural shift	Work cannot be paused PT job with FT expectations Corporate culture, ethics and or mindset Unclear pathway back to work "Motherhood Penalty" Generational Judgement Lack of consistency with programs Low people priority Stigma Low focus on mental health Inadequate support for women Opt-in programs Lack of policy and standards	Striving for strivings' sake Parental guilt Social media influence Silence/lack of sharing Trepidation, fear and anxiety Imposter. "Game-facing" Lack of sleep Home duties load Over-committing Wanting to best at both Mental/emotional burden Experience vs reality expectations Biology of birth Personal care and the alone-time dilemma Fear of asking for help

5.7.2 Supporting Factors for Parents in the Workplace

Workplace Culture

A humanistic workplace culture with values-based leadership was a prominent factor in what worked well for participants and their teams, postpartum. Leaders with a lived awareness of the work/life juggle, who were visionary, positive, self-aware, flexible and who advocated for progressive and insightful change were

strong factors in ensuring healthy experiences postpartum. Leaders and policies which allowed for expression, individualised care and flexibility were seen as key.

Participant 3 explained,

> "I don't attest to the old adage that home life and work are distinctly different and you should segregate the two, and that the moment you walk in the door you should be just fine, all fine. I think that's complete, absolute craziness because the reality is it's not the case…You have to understand and unpack what those issues are, respect the person – they might not want to talk, that's fine – but really try to understand what's going on" MP3

Participant 12 described how once become a parent, it remains the foundation of who we are and that needs to be recognised by great leaders.

> "It's a lifetime thing. It's part of your DNA. Leaders need to understand that it isn't the job…the tombstone won't say they died for the public service, the tombstone will say great mother." FP12.

Workplace Action

Flexibility and openness with employees were traits described by all participants as invaluable. In acknowledging the feeling of being disconnected from the workplace and being different upon returning in the early months postpartum, Participant 5 explained the importance of recognising and validating the experience,

> "It is quite powerful. We need to acknowledge it…give him permission to do things…that's OK…pre-children, pre-return, you could manage things but now things have changed. That's OK." MP5

Many participants described the impact that trusted, frequent conversations, dedicated support and honesty from peers and leaders had had on them. Participants 8 and 12 spoke about the life-changing effect flexible and innovative leaders had had on their careers and on personal transition back into the workplace.

Table 3: Supporting Factors for Parents in the Workplace

Workplace Culture	Action
Understanding, Empathy and Compassion Early preparation for parental leave/education An adjustment period/individualised care Visionary/courageous leaders Creating a sense of entitlement/belonging Openness around parenting Strong advocated for women/mothers Dad leave and associated stigma Feminist based emotional support Positive attitude towards progressive intervention Freedom of choice Values-based guidance Self-awareness Importance of policy and top down support Humanistic approach to policy and practice Workplace security and predictability re parenting Promotion parking Freedom to not feel guilty or sorry for parenting Community: reciprocal support, inclusive of PT staff Wellbeing to productivity awareness Focus on Enjoyment during leave Diverse Leadership Focus on intent, purpose and personal impact	Frequent discussions Trusted relationships Dedicated/allocated team members Honesty and transparency about struggles Open, honest and vulnerable leadership Social gatherings/coffees/dedicated time Mentors– good quality and trained Continuity of connection throughout leave Well managed transition back in post leave Dedicated physical space for child/parenting Dedicated teams and programs Flexibility/role share/PT structure Leaders leading by example Open workplace led conversation, validation Education and speakers Training for leaders

5.7.3 Wellbeing and Productivity

One of the most frequently recurring points made throughout the interviews by a majority of participants was that increased care and attention paid to new parents resulted in increased performance, effort and loyalty towards the company. This is an obvious and noteworthy point to make; when the individual is taken care of, everybody wins; the parent, the infant, the company. In addition, many participants claimed a sense of increased wellbeing and personal reward in themselves, by giving back and acknowledging staff needs in the workplace. As one participant put it, 800 staff equal 800 personal lives with their own needs and challenges. Add to that partners and children and there is far more to people and wellbeing management than meets the eye.

When asked what a dedicated program addressing the needs of parents would be worth to the organisation the response was overwhelming; ”brilliant”, ”worth millions”, ”very valuable”. FP12 (and others).

> “If you don’t have an employer or a way of going in and dealing with that personal issue, it will impact productivity. It will impact that person’s innovation. It will impact their creativity.” FP12.

> “We get a happier, engaged workforce that believe you are supporting them to be the best they can be…and then you get the best result out of them…our clients experience the best possible service levels and it sets everyone up for success.” MP2

> "You don't know stuff when you're a parent. No-one gives you a manual on how to do it. And actually, if you help solve some of those things outside of work then you're going to get more productive workers." MP3

> "You have retention, you have wellbeing. You actually have people who are healthy, happy, all of that. That is millions and millions of dollars 'worth of really good stuff." FP12.

All participants were in agreement that despite current offerings, there remained a gap in support for women if we are to "support the current model" of two parents in paid employment.

> "There's still space to keep promoting and educating, but there's a fear for asking…the gap is people's mindsets." FP9.

Participant 14 talked about the lack of efficacy many support programs have, and that real change came about by pointing out the unsaid discrimination, inequality and cultural biases when addressing women in the workplace:

> "I came to the conclusion a little while ago that programs are not really the way to have an impact. I can say things as the facilitator that women in the room can't say and I feel like that has impact. Making a statement that can make some people, more traditional people feel a bit uncomfortable. And a bit uncomfortable is a good space to be." FP14.

Summary

Mothers are facing stressors returning to work and attempting to balance work and family life and that many stressors were encountered daily (Radcliffe, 2013). Stressors are internal such as expectations, fears, anxiety about sharing their experiences and pressure to balance roles, and external, from the workplace and wider culture, all being situated within our cultural context (Hong Law, Jackson, Guelfi, Nguyen, & Dimmock, 2018; Work et al., 2019). Research by Taneja et al., (2012), is strongly supported, with leaders finding that investment in mothers yielded staff retention, increased productivity and overall wellbeing. It supports their finding that work-life balance and appropriate support has reciprocal benefits, positively impacting emotional, mental and economic wellbeing of the mother and the company. The need for empowering and transformational leadership and training is supported, and necessary for impactful change (Taneja et al., 2012).

This research supports evolutionary theory, that PPDS is not grounded in biomedical explanations, but social ones within which biological elements are instigated when sufficient social elements are missing. It supports the view that PPDS is a signal that the mother is suffering, which could be buffered and assuaged by appropriate political, cultural and personalised social support. Further, it is theorised that with the onset of PPD symptoms in the mother, the investment from others in their support should increase.

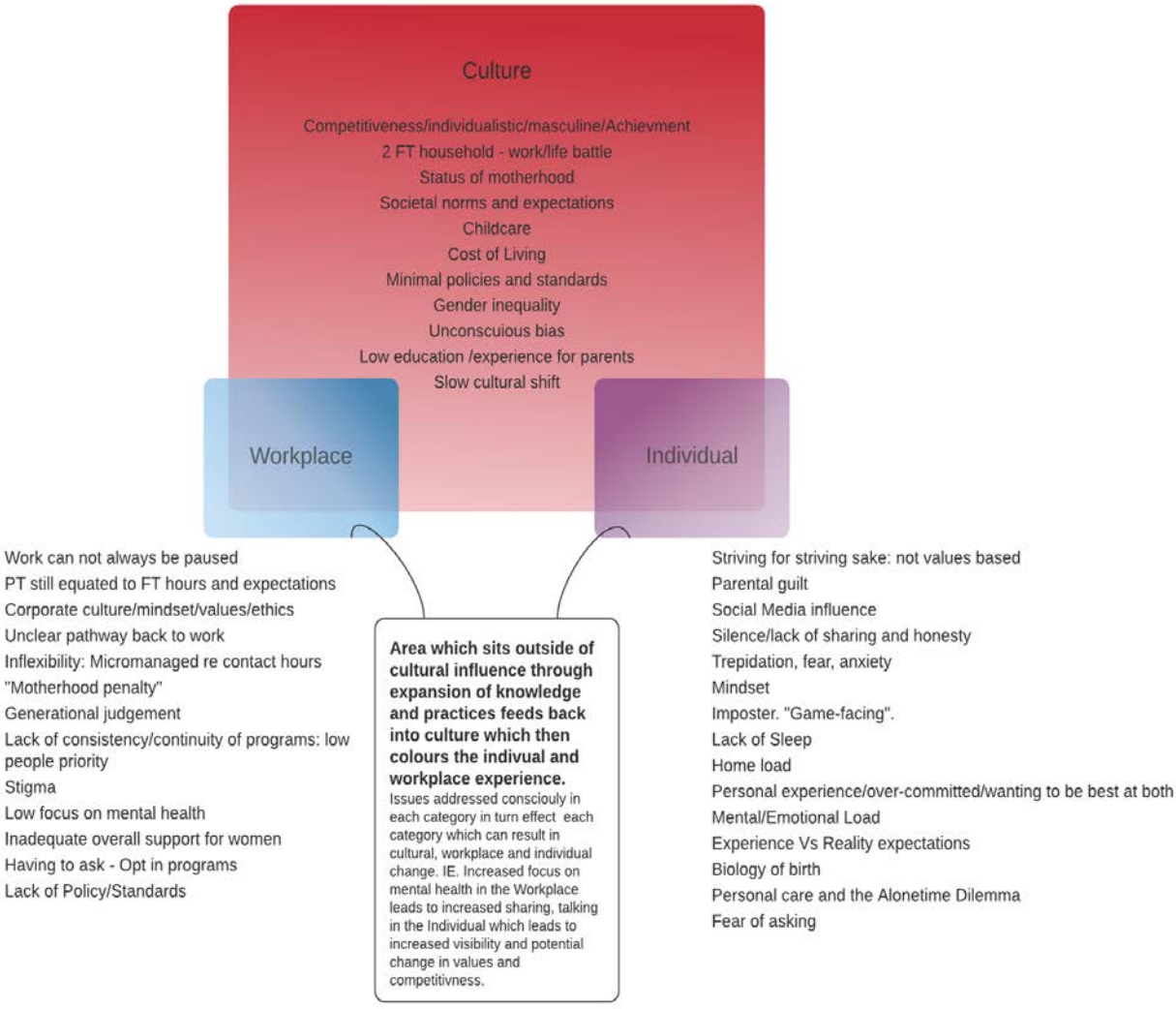
Research by the author in exploring what is missing in social support (AUTH, 20) and the effects of subscribed state-provided support (AUTH, 20) uncovers key humanistic needs of companionship, compassion and validation which are not inherent in the biomedical model. These tie -in with cross-cultural, qualitative explanations that personalised, non-judgmental, experienced care in the form of

companionship, mentoring or compassionate listening, is vital to allowing the process of PPDS to integrate, and facilitate wellbeing (Bilszta et al., 2010; C.-L. Dennis, 2003; Evagorou et al., 2016; Harkness, 1987; Leahy-Warren et al., 2012; Mauthner, 2010; Oates et al., 2004; Ussher, 2004). It supports the evolutionary model of PPDS as a signal for social injury and deficit and provides a plausible explanation for the varying experiences of PPDS across cultures. With an evolutionary, feminist, and social explanation of PPDS, we are no longer tied to a biocultural explanation of the natural yet complex process of transitioning to motherhood. We now understand that culture and biology interact to signal to a mother through the onset of physical and emotional symptoms, that she is suffering a social cost (Blaffer Hrdy, 2009; Tracy, 2005).

We cannot deny the biological aspects of pregnancy, birth and breastfeeding (Davis-Floyd & Sargent, 1997). Nor can we ignore the socialisation of boys and girls from birth to think and act according to categorical roles or the unconscious cultural expectations that women will care for children and men will work (Yearley, 1997; Gardiner & Kosmitski, 2005); These biases exist in the very fibre of who we are, as demonstrated by the Biocultural Model (Diagram 1) and as drawn from the various works of feminists, and anthropologists cited herein. "What we have to view is that raising children and wanting to stay home with your children is not a bad thing. It doesn't make you a lesser person, it doesn't make your contribution to society any less…what we need to do is think of that as equally a valid contribution, and we don't" (Participant, 8). Culturally, ubiquitously, and subconsciously, we value career status and education over motherhood. We value career, home ownership, holidays, and private schooling, and as Participant 6 asks, "who's brave enough to break the mould? And how do we judge them when they do?" Culturally and individually, we have a choice – do we find ways to cope with the current expectations, or do we

re-write the rule book on what is fundamentally expected? It is the assertion of this research that we can do both and leave space for choice in the very personal matter of the way we choose to live once we become parents.

Diagram 2: Workplace Stressors and practical application of the Biocultural Model



of Postpartum Distress

Diagram 2 is a practical application of the Biocultural Model demonstrating the interconnectedness of the Individual, the Workplace and Culture. Expansion of knowledge, challenging norms and conscious practice is shown by the area which sits outside of cultural influence. Issues in each area which are addressed with conscious intent in turn effect each other which results in personal, workplace and cultural change.

The interviews undertaken as part of this research reinforce the argument that the current offering falls short of addressing the cultural, individual and emotional needs of parents. These findings confirm the problem statement. Despite programs and awareness campaigns, there is a systemic problem facing many employers and parents. It is clear to see that by addressing the underlying emotions, the circumstantial factors and apply a face to face, individualised approach to PPD that immediate gratification may be achieved, for more than just the recipient.

5.9 Recommendations

5.9.1 Workplace Parental Support Standardisation

There are various terms used to describe the components which make up workplace parental support: Parental Leave, Child and Family Support, Parental Policies, Workplace Flexibility, Work and Life Strategy, Gender Equality Strategy, Work/Life Balance Policy, Workplace Family Support, Balancing Work and Family, Workplace Issues and as the WHO describes, 'family friendly policies'. There does not appear to be a global over-arching definition which encapsulates all of the areas in which parents may need support. This may provide a rationalisation for the "disparate system around child and family health services" in the workplace (Participant 6). Hence, for the purposes of this research and as a recommendation moving forward, in the Australian corporate and governmental vernacular, I have used the term Workplace Parental Support (WPS) which encompasses all aforementioned terms. It is hoped that by standardising WPS, it will facilitate less 'cherry picking' of parental support elements and promote a more holistic approach to workplace support offered.

5.9.2 Triple A Approach: Awareness, Action and Aim

The Triple A Approach to WPS (Diagram 3) addresses the points made by participants and creates the tenet upon which WPS is built. In response to participants 'interviews categorised under Workplace Culture and Action, and previous research, Village has designed the Triple A Approach to WPS, as part of its offering to corporate Australia. Village proposes that all support should include all three elements to be sustainable and effective in providing support across all levels from individual experience to corporate culture. Support built upon awareness is relevant, resolute and fundamentally determined.

Awareness

Awareness refers to the inequalities, the biases, and the issues facing women who are mothers in paid employment; awareness of current external biases in Australian corporate and governmental sectors, biases in society at large, and internal biases at the individual level. It refers to awareness of parenting struggles and inequality, visibility of parenting needs in the workplace and the effects they have directly and indirectly on mental wellbeing and productivity. It refers to an awareness that the problem is systemic and rooted in a system designed to perpetuate the status quo, within an individualist, masculine society and finally, an awareness of the difficulty this brings to addressing the core issues facing parents.

Action

Action refers to the practical measures taken daily to address Awareness and move towards the Aim. It requires the company and individuals within to take the necessary steps to change behaviour, policy, practices, corporate beliefs, and ideals in a way commensurate with positive progressive change towards the

aforementioned awareness and practical change. Action is broken into the Five Point Action Plan: 1. Leadership, 2. Procedure and Continuity, 3. Conversation, 4. Transition Expectations and 5. Connection. These are further detailed in Diagram 3.

Aim

Lastly, Aim refers to the end-game. Increased wellbeing, increased productivity, equality, equal parental policy, and ultimately, a cultural shift towards the social status and treatment of motherhood, and expectations of mothers in paid employment.

5.10 The Village Foundation – A Workplace Parental Support (WPS) Solution and Recommendations for Best Practice

Biomedical diagnoses and current culturally structured offerings for support currently lack effectiveness, and with a plethora of academic recommendations suggesting workplace and political reform, the author took action in designing a program which would address the needs so vehemently described in the literature, and which mirrored my personal experience.

The Village Foundation (Village) was developed to provide education, new thought leadership, training and facilitation of these concepts, behaviours and programs within large corporate Australia. Leaders from large national companies have embraced the opportunities presented around Village's best practice workplace parental support, which include face-to-face peer and mentor support through a specifically designed values based program. They understand the importance of leadership education, of flexibility and individualisation of the return to work praxis. Parenting portals, fact sheets and prescribed programs go some way to

providing effective practical support, but fall short when addressing the real, lived experiences of parents' day-to-day, emotional and experiential needs in the moments they need it most, and in a way that is authentic. Needless to say, best practice is not only best for the parent and the child, but undoubtedly for the long term productivity and culture of an organisation and the society in which it is run.

Within the Australian market there are several offerings to working parents. Many programs are opt-in, career-focused, policy-focused, or general in nature using a portal for downloadable information, face-to-face social and group facilitated programs are sporadic and inconsistent in application. One program in particular focuses on mental wellbeing and provides tools and advice yet upon closer inspection does not address the specific needs of new parents; rather it provides generic wellbeing advice which poses a risk of further alienating new parents with many new mothers feeling as though they no longer measure up or perform the way they did before going on leave. To then be asked to get '7-8 hours of sleep a night' is to potentially further create a disparity between expectations and reality, and a sense of not living up to what is expected personally or professionally. This is one example of generalised, generic, conceptual, cognitive-based, content-rich support. Research has suggested that what is necessary for new mothers, is an individualised, personal approach which address more than their practical needs. This research suggests that supporting the status quo is largely the problem.

The Village Foundation aims to facilitate a range of interactions and connections within Australian corporate organisations. Through extensive research we have developed a unique system which includes a software platform, mentor training, an ongoing connection program, regular communications and face-to-face events. This

product is unique in its technology platform and mentoring models. The software has been specifically developed based on research by Barkin et al. (2014), Darvill et al. (2010), Leahy-Warren et al. (2012), Letourneau et al. (2007), Negron et al. (2013), Ni and Lin (2011), Razurel and Kaiser (2015), Prevatt and Desmarais (2018), and Reid and Taylor (2015), to address social isolation and postpartum supports. The training and mentoring has been designed to addresses many of the concerns facing new parents today and understands that it is critical to take into account individual needs of parents in the workplace (Taneja et al., 2012). This is unique to the Australian and global market. Currently, options do not include mentorship, or a general, non-help branded approach. A case study in PwC US found all this to be the case and their services were taken from pilot to country-wide as a result. Parents feel supported, connected and more engaged (Demirdjian, 2009). There is a current drive to increase parental policies and offerings and this product and service have the potential to fulfil the need.

Much of the support on offer is not adequately addressing the cultural crux of the issue. The goal of the Village Foundation is to revolutionise the way we speak, work and behave towards wellbeing in the workplace and to advocate for change as the voice of women and mothers. By working with leaders to educate, influence, train, inspire, support and develop their personnel, a secondary aim is in improving workplace productivity, employee retention and employee engagement. In addition to the Biocultural Theory offered by this research, there are four new contributions by The Village Foundation approach; 1) To encapsulate all parental support offerings under one banner, being Workplace Parental Support (WPS), 2) To apply a Triple A Approach to WPS: Awareness, Action and Aim and 3) Provide a flagship

product designed to support Points 1 and 2, and 4) to posit Village within a New Social Movement (NSM).

Diagram 3: The Triple A Approach to Workplace Parental Support

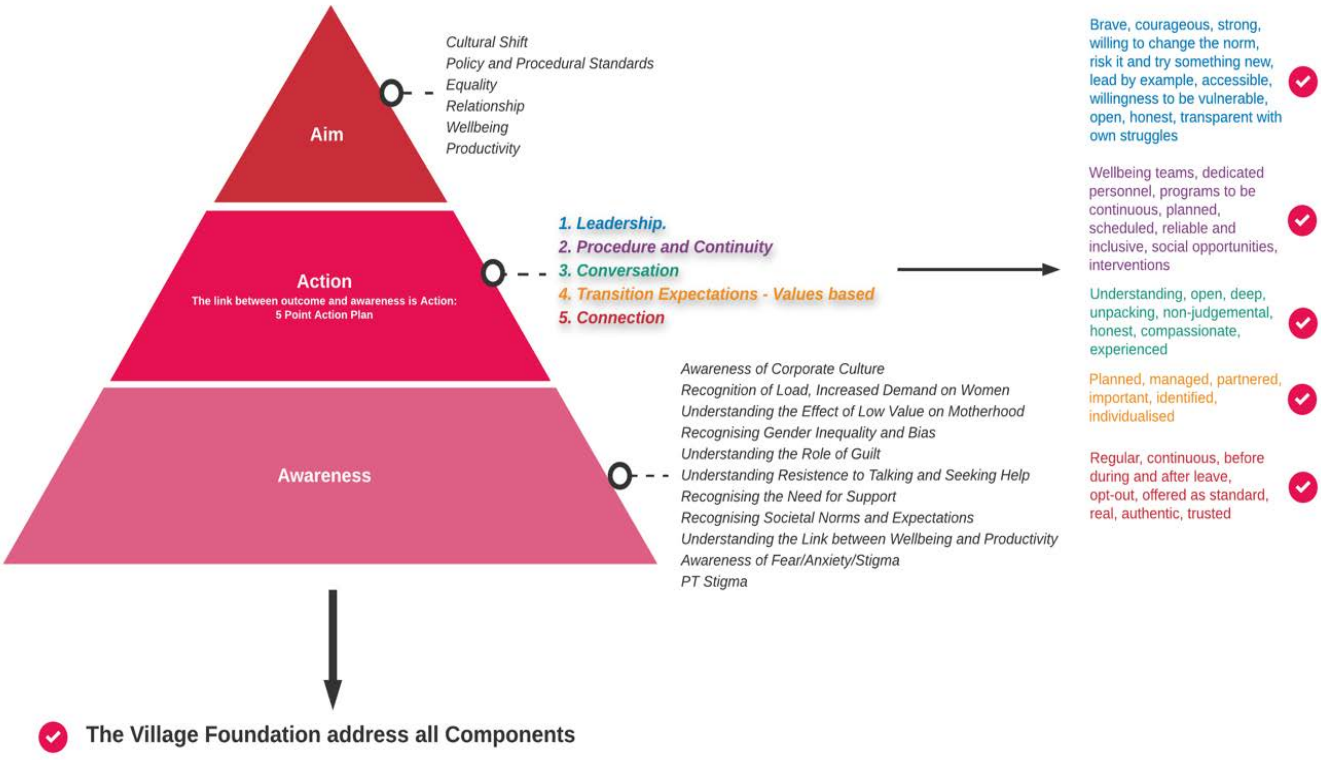


Diagram 3. The Triple A Approach to WPS demonstrates the tenet upon which WPS is built. WPS should include all three elements to be sustainable and effective in providing support across all levels from individual experience to corporate culture. Support built upon awareness is relevant, resolute and fundamentally determined.

5.11 The Flagship Village Mentorship Program

The flagship product which provides a practical solution to point two, fills a gap where targeted one on one, face-to-face connection is offered as standard, by people

who have transitioned back into the workplace previously. It is an innovative mentoring program which facilitates a range of interactions and connections within Australian industry, combining an engaging software platform, training, and connections to facilitate face-to-face relationships between experienced mothers and new mothers before, during and after parental leave. The Village aim is that awareness, validation and transparency may be increased in the company, relationships between the company and parents are enriched, and so would the relationships between parents within the organisation. Village Mentors are allocated time within their role by the company to dedicate to the mentee, reducing pressure on management, and increasing accountability and consistency. By providing perspective on their experiences, women are more able to cope and feel confident with decisions they were making and experiences they were having, further, it was found that new mothers experienced less distress when the challenges they were experiencing were common to others (Hong Law et al., 2018). Further, women are less likely to make their needs known if they felt those around them were not able to provide the kind of support they needed (Negron et al., 2013). Scrandis (2005), also found that women who struggle were less likely to actively seek support, thus they may benefit from being involved in an opt-out program. The importance of face-to-face interactions is well documented in the work of Kerr et al. (2019), and is of the highest importance in sensitive situations such as PPDS to convey compassion, understanding and space for the emotive experiences which may be triggered by PPDS. Additionally, the company can layer in company-specific policies and parental leave protocol, competence training, addressing the knowledge gap that often exists in large organisations, leaving many parents at a loss when returning to work at a vulnerable and overwhelming time. The World Health Organisation (2019) recommends that all mental wellbeing interventions should cover prevention and

support; through engaging existing staff as either mentors or new parents for large corporations, government, health, and education sectors in a satisfying and rewarding way, it addresses two problems: for the individual it prevents isolation, loss of role identity, withdrawal and perinatal stress for parents combining work and family and for the organisation it reduces staff turnover and leave costs, while increasing productivity and wellbeing (Demirdjian, 2009; Taneja et al., 2012).

Within the current offering to the Australian market, there is no offer of a cloud-based platform for immediate connection nor a mentoring program. Parents at Work (PAW), industry leaders in the return to work arena, have seen the value in partnering with Village to deliver the mentoring and cloud-based software platform as they value the unique opportunity it brings to their clients, complementing what they have on offer. The Village Foundation's Flagship program has several unique offerings addressing workplace productivity, staff retention and engagement through issues arising during the postpartum and return to work phase.

1. Mentorship program using employees to support and assist each other during leave, returning to work and beyond.
2. Unique and secure enterprise platform for the employee community to be connected digitally yet develop and maintain face to face contact within each specific organisation.
3. Accessibility for partners and families to join the parenting community through a digital invitation issued by the company administration, which is inclusive and facilitates a village and community culture.
4. Is inclusive, with opt-out feature, digitizing and formalising the relationships that are often organically established within teams, leaving no one out.

5. Reporting tools, data on connections and wellbeing through a dashboard and qualitative and quantitative information around wellbeing and leave. Primarily data would be captured through qualitative data collection and analysis.
6. Training and Content can be managed administratively within the company and distributed through the technology platform meaning employees are getting information in a way which is more accessible and engaging.

The product combines technology and human support services; the software provides the platform for connection with experienced people who act as mentors within the organization. It creates a unique and secure enterprise platform for the employee community to be connected digitally yet develop and maintain face-to-face contact within each specific organisation. Partners and families can be invited to join the parenting community through a digital invitation issued by the company admin, which is inclusive and facilitates a village and community culture. It digitizes and formalises the relationships that are often organically established within teams, yet sporadically run, leaving no one out. The program provides reporting tools, data on connections and wellbeing through the dashboard and qualitative and quantitative information around wellbeing and leave. Training and Content can be managed by admin and distributed through the tech platform meaning employees are getting information in a way which is more accessible and engaging.

This is very different from a standard work-based mentoring platform, or from online forums and content portals. Firstly, it directly addresses the well documented point that new parents feel alone and isolated and will not talk about issues or ask for help, particularly with peers in the same situation as them i.e., other new parents. The Village Foundation is based on mentorship, as opposed to peer support, to leverage empowerment and promote compassionate leadership (Taneja et al., 2012). This is an important differentiation, as this is a time that can be competitive in

nature. The software platform is specifically designed to address this by being populated with people who are more experienced, and who, by being present, are saying, 'we know what it's like and it's ok to talk about it'. It also encourages face to face connection which addresses the significantly negative effect of some social media platforms on mental health which are forum, picture, and chat-based. The software is geographically based, addressing isolation at home during the parental leave period. Connections are unlimited, meaning people can create their own support village. Research clearly states that people will avoid seeking help; we have packaged Village to be accessible and available as standard to all parents, taking away the stigma of having to ask for support. We do not use a portal or online services which require more technology-based connections, rather, we facilitate peer to peer, casual and experienced, face to face connection. Village has the capacity to reach more parents and be a preventative solution than a reactive one, which has the potential to be more cost effective than identifying and treating PPDS (Sontag-Padilla, Schultz, Reynolds, Lovejoy, & Firth, 2013). Thus, its efficiency is incomparable. It is designed deliberately to appear unlike a support platform, where both men and women would be happy to connect and share without perpetuating PPDS stigma. The information provided on the software platform is collaborative, addressing a holistic approach to mental and physical wellbeing, by community members, experts and peers.

Benefits of Internal Mentorship

Helping others, personal satisfaction, and doing something worthwhile are the key reasons women choose to volunteer their time giving back to others (Volunteering Australia, 2015). The benefits of volunteering include increased happiness, health and sleep quality, positive effect on mood and mental health, and increased

longevity. Ninety five percent of volunteers claim that volunteering makes them feel happier and increases feelings of wellbeing. These claims are supported by Anderson et al. (2014), who found that volunteering later in life is associated with significant positive health outcomes, an increased sense of personal control and reduced severity of depressive symptoms.

One of the most common reasons people gave for not volunteering, was that "no one asked" (Volunteering Australia, 2015, p. 7). Furthermore, Culp (2009) claims the best way to recruit a volunteer is to ask them directly to be involved in an area they are aligned with and to frame it within a mentoring role. Moreover, the evidence suggests that the more meaningful the cause, the greater the biopsychosocial benefits to the volunteer (Anderson et al., 2014). The mentorship model supports research by Mitchell, Absler, and Humphreys (2015) and Law et al. (2020) who found that beyond the one on one relationship, there was a reduction in isolation, protective factors for the mother and improved outcomes for child development and, parenting confidence.

Strengths and Feasibility of The Village Program

The Total Addressable Market in Australia is comprised of 3,915 businesses with 200 or more employees. Other sectors which present an opportunity include:

- Government, Defence families: approximately one-half of families believe that the demands of ADF service have a negative impact on their families. This is particularly pronounced in geographically separated families.
- Refugee/Migrant Communities
- FIFO communities - there are close to 300,000 Australians working in mining. Many FIFO families experience stress and isolation.
- Health - Foster carers, Adoption. OOHC Carers - currently 47, 915 children living in OOHC.

The software platform is the first of its kind, dedicated to parents with an offering of both experienced and new parents. It hosts content specific to the parenting journey and encourages face to face connection via geographical mapping. The mentoring program is also a first in Australia and has strong support in terms of theoretical similarities with a program run through PwC US. It is an opt-out prevention tool for PPDS, disguised as a connection and well-being tool which is more likely to elicit users. It is backed with face-to-face and web training (in development) and utilizes a strengths-based approach with a company's existing employees. The product connects people through lived experience. It connects intergenerationally and invites both men and women to be involved, addressing isolation in both, and giving a sense of giving back to mentors. It creates an openness and transparency around the difficulties of parenting and working which, research tells us, is exactly what is needed. By employing a mentor approach, the competitive nature and potential associated distress of peer-to-peer programs is alleviated. It is designed to provide specific parenting villages within each organisation and is tailored to look on-brand for each company.

It addresses a clear need in the market and has the potential for rapid national and international scale-up and income generation. It creates employment opportunities and addresses labor market restraints. There are no exact offerings in the market, however, there are a number of return to work providers. The unique combination of software and mentorship that we have is unique. As a result, we are working WITH these providers, who are layering in what we have with what they offer, in a collaborative, co-branded nature. The Village Foundation addresses 6 of the seventeen goals; 3. Good Health and Wellbeing, 5. Gender Equality, 8. Decent Work and Economic Growth, 9. Industry, Innovation and Infrastructure, 10. Reduced Inequalities, and 16. Partnerships for the Goal. The World Economic Forum suggests

that interventions for mental health in the workplace should take a three pronged approach: reducing work-related risk factors, promoting positive aspects of the work environment and of employees, and addressing the problem through awareness and openness for adaptation, leaders taking action and support options being openly provided to employees (WHO, 2019); Village addresses all three, by way of the Triple A Approach to WPS. Village addresses the national and global recommendations for addressing workplace parental needs through technology, innovation and effective support (Australia, 2019; Work et al., 2019).

Weaknesses of the Product

As a new product, initial onboarding can be laborious. The pairing of mentors is a manual process at this stage of software development. There may be fear and stigma associated with any program regarding postpartum mental wellbeing, as it is being launched to drive cultural change; it is nevertheless being launched during a current cultural- paradigm of privacy and barriers to help seeking.

In summary

Despite research by Biggs et al. (2015) reporting positive experiences for callers to the Panda helpline for PPD, they suggest that participants expressed a desire for greater flexibility in availability, continuity with the same person offering support and the option of face to face contact. In the case of Biggs et al. (2015) research using peer support where the common factor is the incidence of PPD, this research proposes instead that the lived experience of motherhood as a more inclusive approach is the shared experience which intuitively lifts the focus from depression to all of the facets including strength based approaches which focus largely on the positive experience. Research by Small et al. (2011) into mentoring at risk lower socio-economic mothers was found to be beneficial. Offering mentoring to women

who might appear to 'have it all' but may be struggling and oppressed under societal pressures may also be beneficial to overall personal and community wellbeing (Hong Law et al., 2018).

Corporate mentorship programs tend to focus on career advice and work life balance, rather than on parenting and the emotional toll this can have on wellbeing and productivity. Demonstrating and celebrating the ways women can 'do it all' may add to the problem. Unlike parenting programs which provide work based coaching and generic educational tools, the Village software and program have been specifically developed, based on research, to address social isolation and increase supports. The training and mentoring has been designed based on current research (De Sousa Machado, Chur-Hansen and Due, 2019; Barkin et al. 2014; Darvill et al. 2010; Leahy-Warren et al. 2012; Letourneau et al. 2007; Negron et al. 2013; Ni and Lin, 2011; Razurel and Kaiser, 2015; Prevatt and Desmarais, 2018; Reid and Taylor, 2015) and market research as discussed with leading facilitators, Transitioning Well, and Parents at Work and addresses many of the concerns facing new parents in our culture. Unique to the Australian and global market, this product and service support the parent before during and after the leave period to facilitate a smooth transition back into the workforce and imparts lived experience and wisdom, skills, access to mentoring and coaching, and acknowledgment of the issues facing them in a way no other Australian firm is offering - through face to face, internal mentorship. The mentors are able to provide something peers cannot - a retrospective, invaluable testament to what they are going through and the ability to show that it is possible to come through it well.

The leading views of The Village Foundation centre on the belief that there is a necessity for an elevation of values and visibility around parenthood in the workplace. Village supports the assertion of Taneja et al., (2012, p. 46), that "it is imperative for organisational leaders to re-evaluate their strategies in an effort to retain female talent". The current reality is categorically lacking and the changes necessary are systemic in nature. Identifying the need and addressing the problem is on the Australian radar, with an increase in organisations offering support in the workplace, governments reviewing parental leave policy and standardisation that *something* be offered to align with appropriate Corporate Social Responsibility expectations. The views of The Village Foundation can be neatly described as a New Social Movement, comprising various other corporate, volunteer, and political stakeholders. The Village Foundation offering aims to steer the wave of societal expectations to make business productive, and to address parental, child and societal wellbeing.

Based on my research, my personal experience and the expressed view of hundreds of parents and leaders I have had the privilege of interviewing over the course of my research, it is clear that despite best intentions, many organisations are missing the mark when it comes to providing the most effective workplace parental support. I consider organisational best practice to be inclusive, flexible, opt-out, individualised, and compassionate. Women in paid employment in Australia report feeling torn, guilty, distressed, frustrated, and burdened with the notion of work/family balance, particularly in the early years, and the degree of emotional, mental and practical loads they carry still far outweighs that of their partners. Whilst it is my ardent belief that systemic cultural change is the panacea to an increasing problem, Village

provides valuable means for a company to support employees in this critical (and natural) time of transition and re-integration.

5.12 Village and Workplace Parental Support as a New Social Movement

The provision of support for parents in the workplace in Australian has developed from humble beginnings and continues to grow. Although the policies and formal practices remain inconsistent across workplaces and in government, this has not impeded the spread of knowledge and expertise in workplace parental support (WPS); it has taken hold in large corporate organisations, and is provided either in-house, or by small to large, for and not-for-profit providers in consultancy and psychological services across Australia (Australian Human Rights Commission, 2016). Furthermore, advocates of WPS including organisations such as, Parents at Work, Grace Papers and Families Australia have made strides to secure professional recognition of some elements of WPS as a 'must have' not simply a 'nice to have', based on the practical learning and applied research of a host of researchers and reports by, for example, Deloitte, PwC Australia, Fair Work Australia, The Australian Human Rights Commission and more. The growth of the service is evidence of wider community recognition of the special needs of those at the 'balancing stage' of combining work and family, and the impact this stage of life has on the parents, the infant, the extended family and Australian industry (PWC, 2019; Hertz, 2020; COPE 2014; Cheung & Halpern, 2010; Emslie & Hunt, 2009).

The growth of WPS in Australia, although slow, is one which has involved dedicated leaders and community-minded activists pushing tirelessly for equality, policy reform, and consistency. In the process an increasingly mobilized movement for WPS has also advocated collaboration with public agencies and private practice,

resulting in the creation of legislative frameworks and funding support from politicians and government, and has been incorporated – albeit fragmentedly - into professional HR, mental and public health education, and general acceptance in the wider community (Toohey, Colosimo & Boak, 2009). WPS usually aligns with the principles and practices of corporate social responsibility, employee wellbeing and shifting slowly away from the dominance of the patriarchal, more traditional workplace models (Du, Bhattacharya & Sen, 2010).

Neglected needs of working parents by a system driven to persist with traditional patriarchal management and workplace requirements, and an outdated roles-based home structure has provided the impetus to develop WPS services across Australian industry. New management, professionals, tertiary education providers, government and, not least, the many parents who work in full or part-time paid employment come together in the awareness that the direct and indirect benefits of such support is vital in today's culture. In more general sociocultural terms, the establishment of support services for parents in paid employment in Australia and elsewhere, could be seen to reflect the beginning of a change of collective mind, moving away from a work/family divide characterized by general silence of each where the other is present, consistent pressure to be dedicated solely to both and in stifling the struggles facing parents in the workplace, to one in which there is increasing awareness and acceptance of the inevitability of the contentious pressures and resulting mental distress facing parents as they balance family and work life. As people face parenthood, they inevitably shift to an altered perspective and value base both personally and professionally (DSS, 2001). Some parents may now find some comfort in the knowledge that when their time comes to return to work, appropriate WPS measures may be at hand to assist them manage the physical,

mental, and emotional needs of combining work with family. Combining specialist knowledge and organized care with honest qualities and compassionate values creates a valuable, supportive and nurturing experience for parents as they navigate a delicate and often turbulent phase of life – WPS of this type marks a step forward in achieving a humanistic, inclusive and civilised working culture (Hertz, 2020; Matias, Ferreira, Vieira, Cadima, Leal, & Mena Matos, 2017).

Workplace Support as A Social Movement

The WPS movement in Australia is largely focused on securing equality in parental leave, flexibility and balance in work and family for parents. It includes identification and definition of some basic workplace practices and policy frameworks to ensure the equal provisioning of leave for men and women; the establishment of good social and mental health policies and flexible procedures; the promotion of professional and career development and education; promoting support for research and publication; the advocacy of changes to the relevant legislation; and providing advice to other interested parties about WPS (Australian Human Rights Commission, 2016). In addition, the WPS movement raises awareness to complement and extend provision made by federal government. The WPS offered in Australia is distinguished by a high level of collaboration between public and private sector agencies, between professional and voluntary workers, and between metropolitan and rural service providers.

Given the momentum for structural and workplace changes and the number of bodies dedicated to policy and change in Australian workplaces, one could refer to WPS as a "new social movement" (NSM). This involves a voluntary banding together of people concerned and is characterized by the efforts of senior managers,

policy makers, mental health advocates, practitioners, HR personnel, many of them parents, supported by the membership of very active voluntary associations, committed to the advancement of parental support more broadly (Eyerman & Jamison, 1991; Wilkinson, 1971; Elsey, 1998).

Intellectual and managerial leadership is typical rather than exceptional in NSMs. Whilst important to recognize that the traditions of voluntarism of new social movements increasingly rely upon intellectual leadership, reinforced by well-informed and motivated supporters. The intense involvement of high-status professional people in a voluntary movement poses a question about the character of that movement. In the WPS case, if professional groups get involved in a new social movement, does it shift away from altruism towards the goals of professionals with occupational interests? In that sense, does a voluntary social movement become a vehicle for some occupations to dominate an area of meeting human needs for their own professional advantage? If the main purpose is to address a perceived need to change society in some way - in this case, to successfully secure and improve the experience and wellbeing of parents in professional paid employment - does it matter if some members increase their professional and occupational advantages as a by-product?

In the case of the WPS movement many key leaders are already well-respected personalities, with considerable "inside" knowledge and experience of the workings of industry and government. Each new movement, like the WPS movement, still has to make its case for serious attention for funding and recognition within political and professional circles, but in this particular area of meeting human needs it appears to have started with definite strategic advantages in the process of managing change. It

is the assertion of this paper that the emergence of an effective WPS movement plays a significant part in clarifying the needs and interests of people in relation to the complex, sensitive task of combining parenting with paid work in our current culture.

Theories of Social Movements

To discuss whether WPS should be seriously regarded as a type of NSM, its leading ideas are set within the context of social movements. There are three main schools of thought on social movements; the Collective Behaviour (CB) approach, Resource Mobilization (RM), and the Particularist (P) school (Eyerman & Jamison, 1991; Wilkinson, 1971; Elsey, 1998). CB has value in the case of WPS, because it deals with grand narratives of social change and leans towards an extreme interpretation of collective behaviour. In addition, the CB school appreciates that social movements are often innovative and adaptive, breaking the mould of rigid social norms with fresh concepts and practices. The CB school would no doubt embrace the WPS movement as an example of such practices and outcomes. It is reasonable to argue that in the case of WPS the driving motivational force for its active membership is the collective commitment to make a comprehensive support service widely available. The RM approach concerns itself with the organisational effectiveness of social movements in achieving their goals and securing good outcomes. This involves an active role of leadership, strategic planning, deployment of resources, and other elements of successful change management. It is a pragmatic approach focused on returns on investment. Finally, the P school, which concerns itself with case studies focused on the needs and motivations of individuals and the details of organisational activities, goes beyond the generalities of the CB and differs from the RM school, by being more concerned with the external social forces that cause

people to band together and assert their collective will to bring about change. Overall, they share a common theme in taking their argument out into wider society and getting things done.

Characteristics of New Social Movements

Issue-focused social movements arise from outside an established order's usual vested powers, operational norms, and underpinning values, and challenge conventional wisdom and practices, usually seeking to change them (Eyerman & Jamison, 1991; Wilkinson, 1971; Elsey, 1998). Social movements usually achieve enduring change in the social order, and without exception, they have had to contest their alternative vision and agendas in a political process marked by conflicts of interest and a long struggle for recognition and acceptance (Cohen, 1985; Offe, 1985). WPS operates from a basis of persuasion, using examples, anecdotes, good leadership, professional competence, and informed advocacy and discussion, making a case for a comprehensive and quality-focused approach. This is the knowledge-based work referred to in the cognitive praxis model (Eyerman & Jamison, 1991; Elsey, 1998). WPS relates to the political domain of democratic and civil rights, principally through actions designed to formally define and further the interests of parents who are working together with ensuring the legal protection and equality of rights for both men and women in the workplace. On the other hand, there is equal interest in educating and informing those responsible for the design, implementation and administration of policies and practices within organisations.

The Cognitive Praxis Perspective and Its Relevance to Workplace Support

The above theoretical models provide general insights highlighting WPS as an NSM, however the Cognitive Praxis perspective takes the idea further. The model explains

the formation and conduct of social movements as a socially interactive process involving key thinkers as leaders who often have a double role as political activists (Eyerman & Jamison, 1991; Elsey, 1998). These key leaders communicate a vision for change based on clear human and/or worldview values and a foundation of specialised knowledge. Their impact is delivered through the unique expression of their individualised knowledge. Together leaders and supporters comprise a critical mass dedicated to making changes in the fabric of society. The cognitive praxis perspective is typically concerned with civil and human rights, aspects of gender and ethnic relations, minority and subcultural lifestyles, and broad matters of environmental management. The significance of these social movements is the new insights and understanding of human needs and conditions that they proffer, often leading to new theories of social relations, new social values and the active participation of new social identity groups in economy and culture. Into this frame of thinking the WPS movement clearly resides, representing one major aspect of human interest in the nature and quality of parental care and the politics of working parenthood in contemporary society.

The cognitive praxis model comprises four main elements; intellectual leadership, drive drawn from systematically acquired knowledge, the underpinning of human and social values, and vision for change within a wider political environment (Eyerman & Jamison, 1991; Elsey, 1998). As (Elsey, 1998) proposed, a theory of knowledge alone is not sufficient to explain how long-term social change is brought about. Hence his addition of a fifth element; the competence to mobilize human resources and voluntary organization effectively through the application of learned intelligence in the process of managing change.

The intellectual leadership of the WPS movement in Australia comprises professional, psychological and health care professionals, former and current members of parliament – many with first-hand experience in either the provision of lacking of WPS - and generally a strong following of other middle-class people as members of voluntary organizations, including lay people, also with firsthand experience of caring for those who are grappling with the new found reality of combining work and family. Often, they bear witness to personal experiences of adjusting and grieving. In cognitive praxis theory, attention is paid to intellectuals whose chief role is to lead the organisations they represent (Eyerman & Jamison, 1991). Such leadership must display enough personal appeal to meet with the critical approval of the movement's membership and to persuasively lead arguments to those with the political and institutional power to make laws and provide funding. Australian leaders in WPS combine their political and business skills with comprehensive knowledge, a critical mass of concerned public opinion, and often personal lived experience to further the arguments of the movement.

WPS provision is committed to the attainment of various standards of practice, or benchmarks. Nine standards of practice have been established by Parents at Work (PAW), in conjunction with various bodies dedicated to the area of parental support and equality. Each of these standards represents both a working philosophy and practical objectives intended to exemplify the distinct style of WPS. Each benchmark is underpinned by a combination of practical and theoretical knowledge which is typically acquired through continuous applied learning. Confidence in the knowledge base of WPS is further reflected in the attempt to inform and educate the general public about the process balancing work and family (APLEN & PAW, 2019). Thus, knowledge is understood in two ways: first as propositional knowledge, that

is, as an assertion of beliefs and values, and second as procedural knowledge in the sense of knowing how to do something. Various important contributions made by PAW, Deloitte, and The Australian Human Rights Commission, have been the compilation of evidence on the increasing incidence of mental distress and the linkage between a lack of WPS and wellbeing, productivity and staff retention (Toohey et al., 2009; AHRC, 2016). This supports the well-established claims that distress and depression in parents directly affects the short and long term health of the infant and other family members. Such empirical knowledge helps justify the argument that WPS provision should be developed so that special arrangements can be made for parents at each stage of their working cycle; before, during and after leave. Essentially the arguments pertain to individual rights and the onus of the workplace to provide a safe and nurturing environment (WHO, 2020).

Since WPS established the beginnings of a collective service in Australia, the quest for knowledge has continued. There is no doubt that WPS is well-founded upon a body of knowledge that informs practice and continues to advance provisions. This consists mainly of psychological, professional, and governmental knowledge and includes the valuable contribution made by volunteers in caring for parents who require additional support in the early years. Yet practical and empirical knowledge has been only part of the WPS development. It is likely that the documented history of WPS in Australia broadly reflects developments elsewhere. This history acknowledges the long tradition of the WPS movement, which has its origins in modern, industrialised nations where women are expected to work and contribute to the economy, as well as be predominantly responsible for child-rearing and household duties (Emslie & Hunt, 2009).

Genuine questions are posed about the limitations of the current model of family life, including the ethical and practical appropriateness of costly childcare, individualised living arrangements and dual income households (Emslie & Hunt, 2009). Questions arise around the dominant paradigm of the patriarchal workplace tradition, especially the authority of upper and middle management, evidenced by the neglect of the personal needs and rights of transitioning parents. WPS has developed within an historical sociocultural context in which people are becoming more open about the difficulties of living a fast-paced, individualised life where family and work compete for attention. Society has by no means reached the stage, however, where people are prepared to challenge the status quo and choose a less ambitious way of life to ease the daily struggle (Bolino & Turnley, 2005).

Synthesis could eventually be reached, accompanied by widely accepted and available options for parents in paid employment, or at least standardised WPS, in which people choose when and how they will work based on an understanding of the natural process of life transforming after the birth of a child. The core values that underpin the vision of comprehensive and quality-focused WPS services come together around the human empathetic ideal of compassion. Associated with compassionate values is the assumption that individuals have the right to both family and work. The concept of support is constructed to include the fiscal, practical, mental, and emotional aspects of a 'whole 'person's whole life. This implies for industry that their practical competence should be balanced by the capacity to meet the emotional human needs of personnel. More than that, society would ideally also shift towards one which values motherhood, compassion and human wellbeing over the selfish drives of a rampant individualism spurred by competitive economic materialism. Budig et al. (2012, p. 186) claims "cultural attitudes amplify, and even

change the nature of, associations between parental leave, publicly funded childcare, and maternal earnings". The WPS movement continues to articulate its vision of an equal and balanced parenting experience. This gives the movement both a long-term vision and a sense of purpose for achieving more immediate goals. On the Australian scene the WPS movement has successfully initiated a program of change in at least three ways: professionally, politically, and in public awareness.

Criteria for Success

One criterion of a successful NSM is the capacity to challenge received opinion and practices, often by arguing the case for new and unconventional ideas and practices (Elsey, 1988). Many organisations are for myriad reasons usually unable to provide and/or maintain the quality support required to make the holistic difference to a parents' experience . The contribution of WPS has been to affirm that support should be an integrated concept and system of provision. A second characteristic of success lies in being able to operate successfully, articulating special interests and political issues typically confined to the personal domain; In this case, the right to have a family and to work, that is to say, the right of parents to choose family and work without it impacting on their wellbeing and professional trajectory or standing (Supporting Working Parents). The WPS movement in Australia has made the most of its connections and professional respectability to become relevant in mainstream political decision making - Another dimension of success has been in attempting to shape public opinion and behaviour such that there is greater awareness of and demand for WPS. Nonetheless a definite start has been made in Australia.

The WPS movement comfortably meets with what constitutes a new social movement. It is likely that in the initial stages of the WPS movement, professionals,

entrepreneurs and volunteers saw themselves as missionary-like pioneers, as was the case with Emma Walsh of PAW. More than a decade later, the emphasis is on establishing WPS as a knowledge-based, standardised and policy driven discipline, with origins in feminism and equality. Professionals, politicians, and volunteers are all required for progression, cementing the movement even more firmly in its partnership with government. Moreover, the relationship between the voluntary spirit of altruism, the promotion of compassionate values, and occupational self-interest is clearly functional as well as inevitable in a NSM that depends upon experienced personal and professional knowledge, and its powers of advocacy. The cognitive praxis model has proved useful in outlining WPS as a new social movement, and the demonstration and application of experience of those who use their personal, humanistic proficiency in conjunction with professionalism to further personal, parental rights and this new social movement is ample testament to the power of Elsey's (1998) final element of human competence.

5.16 Strategic Intent

Validation for The Village Foundation sits within NSM theory research and is corroborated by personal experience and interviews with Australian corporate leaders. Village, as a substantial offering within a NSM can be deployed at all levels of Australian Industry; private, academic, public and governmental sectors. The product on a theoretical base, has received considerable support and corporate interest. Pilot roll outs for several large national Australian companies were planned and established for 2020, prior to COVID19 restrictions being enforced and thus work being carried out from the home.

Isolation and COVID19

In a culture already individualistic by nature, further disenfranchisement through social media and most recently COVID19, has increased isolation and loneliness for many. Sixty percent of co-workers pre COVID19 were feeling lonely at work, and thus in addition to postpartum stressors, the new challenge facing corporate Australia is how to create a less lonely experience in the workplace. COVID19 has presented an opportunity to reset and redesign the way we do work (Hertz, 2020), and Village provides a means to achieve connectivity for one of the most at risk cohorts, being new mothers. While we are facing a "social recession" due to COVID19 (Hertz, 2020, p. 21), mothers have been experiencing this for decades. COVID19 has simply increased and unveiled the suffering making it more comprehensive and understandable to many.

Resuming in 2021

When the project is resumed, it is the strategic intent of Village to validate the offering by recommencing the pilots, collecting quantitative and qualitative data and providing these case studies for the purpose of going to market with a strong evidence-based case of proven financial and health benefits, for a largely social cause. Specific pilot activities would include onsite training and development events, pairing mentors with mentees and initiating their program, conducting interviews with staff and performing analysis on those interviews. Online training will be available to all new staff who come onboard, minimizing costs and increasing consistency and availability of materials to all staff members, regardless of location; increasing the connection with remote users who are at an increased risk without the support available. Impact measurement and documentation of pilots will not only provide a strong indication of the value for companies and individuals but will also

provide information for Australian industry in terms of wellbeing, connections, and outcomes. Whilst the literature supports the offering, and whilst the concept is widely applauded, these pilots are important to validate the important distinction between Village and the current offerings.

Beyond the program offering of compassionate, individualised mentorship, Village aims to deliver education, awareness and practical approaches to corporate leaders, revolutionising the way we work, speak and behave in regard to parenting in the workplace. Village advocates for change within a paradoxical cultural reality concerning motherhood with an emphasis on the importance of face to face, experienced mentor support. Streamlining, then firmly positing effective WPS as a 'must have' establishing policies, visibility, and cultural change are the pillars on which Village was built.

5.17 Conclusion

It is the assessment of this research, that the crux of PPDS is as much cultural, as biomedical and that we live in a paradox and contradiction of theoretically idealised, yet realistically devalued, motherhood. The ideas, beliefs and values we embody and validate through our actions, which feed back into our culture idealise the working, achieving, 'balancing it all' mother. In our individualised, achievement based culture we have inadvertently devalued motherhood in and of itself. Culturally, we are unlikely to change the industrialised nature of the way we live and work; notions of freedom, independence, competition and self-reliance are deeply ingrained values (Hertz, 2020). To do this, would take conscious, deliberate, repeated effort and significant behavioural change from individuals, corporations, educational bodies and government. By adopting the biocultural approach to PPD

there exists an opportunity to widen the lens and enact this change in various cognitive and behavioural ways. Concurrently, the needs of mothers must be met presently, and met in the place where they are spending a majority of time by women with whom they share that time. It is the strong view of the researcher that parenting portals and informational supports miss the mark, and do not have the capabilities nor depth to address the real and individualised needs of mothers in paid employment, nor address and initiate the systemic change necessary for the validation and improvement of working mothers' experiences. This research posits the importance of face to face, shared experience in alleviating loneliness and PPDS. Human interaction skills such as empathy underpin inclusive society and moving towards these skills with face-to-face lived, authentic sharing between people drives towards a more humane, tolerant, society (Hertz, 2020).

We should not deny the biological bond of pregnancy, birth and breastfeeding. Nor can we ignore the socialisation of boys and girls from birth to think and act according to categorical roles or the unconscious cultural expectations that women will care for children and men will work. These biases exist in the very fibre of who we are, as per the Biocultural Model pictured (Diagram 1). As Participant 8 so poignantly states, "what we have to view, is that raising children and wanting to stay home with your children is not a bad thing. It doesn't make you a lesser person, it doesn't make your contribution to society any less…what we need to do is think of that as equally a valid contribution, and we don't." Culturally, ubiquitously, and subconsciously, we value career, status, and education over motherhood. We value career, home ownership, holidays, and private schooling, and as Participant 6 asks, "who's brave enough to break the mould? And how do we judge them when they do?"

Village is a work in progress, an enquiry and exploration into finding a better reality than we are currently experiencing which has the long term view of sustainable equality. It is a framework which seeks to take poor acceptance of motherhood and take it to a place of reverence through open discussion and sharing, without losing the value of paid work and increasing equality across parenting. Village is based on the premise that if you do not treat the whole person – mentally, physically, pragmatically and emotionally – you do not treat the whole problem. We do not function in part; if one part of the whole is not operating in alignment it affects overall wellbeing - whether we are talking about a person or a company, this holds true. The research undertaken herein validates the theoretical approach of Village and provides credence to the underpinnings of its offerings, as providing validations, visibility and integration through lived mentoring support and increased awareness within an organisation. The Village Foundation recognises that the future wellbeing – financial and individual – of Australia is underpinned by mental and emotional wellbeing, childhood development and parental health and productivity. We like to pretend we live in an equal, inclusive and balanced society. Village challenges that notion by bringing to light and questioning the cultural foundations upon which our society is built. In doing so, the unconscious becomes conscious and real change can take shape. The intended outcome of adopting The Village Foundation's Biocultural theory and recommendations for collectively reframing, formalising and streamlining all offerings of workplace support under one banner of WPS, including the introduction of the Village Mentorship program as standard practice has immediate implications for implementing and designing Corporate Best Practice, for informing government and industry policy and for the daily lived individual experience of mothers in paid employment.

We have seen the feminist movement increase significantly; policy and work culture and practices have improved with the implication of parental leave, flexible work conditions and increased visibility of work life demands, however they haven't kept pace with the rate of social progress and remain far behind what is needed. Underpinning this is generational cultural change which is decades behind. The aim of Village is the bring them into alignment.

The Village Foundation's Biocultural Theory and Triple A Approach to WPS provides the first steps to cohesively drawing together the learnings and work of many who join in the social movement of politicising and mobilising many of the issues contained herein. Village comes from something bigger. Addressing entrenched cultural, biomedical frameworks requires action. Significant change can come from having large corporate bodies enact innovative, voluntary measures. The Biocultural Theory is late to that game – with a 45% rate of immigration into Australia we have an opportunity to learn and change from the migration of people into Australia. We have a culture still reminiscent of the 1940s, 50s and 60s and it needs to be updated. We need further groundswell to take us to our desired state; innovative and transformational leadership rather than simply management of the status quo is key in shaping a society in which freedom of choice, equality and motherhood are understood from a biological *and* cultural level and women's needs are considered and met by all levels of society; governmental, educational, industrial and personal.

6

Conclusion

"You don't achieve good culture without constant attention, without an environment of safety, courage and vulnerability. These are hard skills, but they are teachable skills."

Ed Catmull

6.1 Summary of thesis arguments

This thesis portfolio has shown that lived experience, a widened lens and adaptive cultural values are key to understanding PPDS in a wider context, and the effects it can have on individuals and society. It has brought to light the shortcomings of current social support in Australia and provided best practice recommendations moving forward. These recommendations are based on informal methods and extend the responsibility of care from professionals to include experienced members of the community in a spirit of reciprocity. The importance of accurately identifying, labelling and providing relevant and individualised support is discussed, with implications for policy, design, individual wellbeing and state provided social support structures.

The premise that social support is key to a positive transition to motherhood is established as this research posits that emotional and appraisal based social supports for those suffering from PPDS are effective, missing, and sought after. Research undertaken in Sweden reveals that despite extensive, generous state provided social supports, rates of PPDS were still high, and systemic inequality and incongruences between notions of freedom and mandated compliance existed. Despite an abundance of biomedical and state provided supports, distress and internal conflict remained high in mothers. The research in Sweden supported the assertion that informally provided, trusted emotional and appraisal supports were sought and deemed beneficial, and allowed a space for silenced voices in mothers. Informal social supports are critical for good mental health, good parenting and the ability for new mothers to see that they do not have to fit an idealised persona, that we are complex and multifaceted and that by bringing a voice to their real experiences we unveil the reality of what many parents are experiencing, allowing for normalisation and a calling out of what is and has been unacceptably handled and denied for many years, across many cultures.

Creating business and policy avenues for implementing personal, authentic social support may seem trite and obvious, however it is becoming more necessary every day, compounded by COVID19, that human contact is imperative to wellbeing and mental and physical health (Hertz, 2020; Kerr et al., 2019; Uchino, 2009). Online forums, discussion boards, applications, conference calls, social media – all provide an element of support; however, these cannot replace human-to-human, candid, authentic conversation, compassion and physiological response. With the migration to online being our new cultural norm, it is essential that these experiences and

relationships are given the space, validation and reverence that they deserve (Hertz, 2020).

The potential contributions of this research extend beyond the aforementioned theoretical offerings, with five submissions situated within an applied business approach to addressing PPDS through prevention, awareness and support. Several studies have recommended the need for future interventions to focus on providing strong social support to mothers with the aim of reducing postpartum distress (Hanna et al., 2002; Negron et al., 2013). Drawing from lived experience, from the Narrative Review, and the findings from Sweden, The Village Foundation was formulated and establishes itself within the larger context of a New Social Movement. It comprises a theoretical foundation, The Biocultural Model of PPDS, a consolidation of the various workplace policy and support terms labelled Workplace Parental Support (WPS), a business and consultancy model designed to address cultural awareness and all aspects of WPS, the Triple A Approach to WPS, and a flagship product encompassing a Face-to-face Mentorship Program supported with an innovative Software Platform and App, for parents in paid employment. These practical steps can be applied across Australian industry immediately, creating consistency, inclusivity, and awareness. The business application sits upon the foundation of the Biocultural Model, whilst enacting the principles of the Cognitive Praxis Model of New Social Movement and striving for the pinnacle Aim of the Triple A Approach to WPS. Where private corporations lead, government may follow with targeted policy design and national education.

Despite the policy and the consistent narrative that men and women are equal, this research showed that women still experience an emotional conflict upon returning to

work and leaving their children in the care of others, even when the other, is the father. Whilst it can be contended that parenting is learned, we should not deny the biological aspects of birth: carrying, birthing, feeding. We also should not deny the social construction of gender norms in our culture. They are laden with expectations.

Rather than viewing the mother as deficient and perpetuating idealistic representations of motherhood, we can look further to understand the resistance to diagnoses, and the social needs of mothers (Mauthner, 2010) – PPDS "occurs when mothers cannot live up to the culturally devised but unrealistic standards, they set for themselves, and rather than let go of their standards, they try to change themselves to fit their ideals" (Mauthner, 2010, p. 13). This powerful statement encapsulates the essence of this research. I seek to make a small yet pivotal adjustment by examining the essence of the behaviour "they set for themselves" further: Given the embeddedness of cultural norms within each individual and in line with a determinist view, I question whether these standards are indeed set by the individual or are the result of a cultural collective. Either way, the point is made.

Proposing cultural change may not seem viable, however as we plan for future generations in industrialised societies, one may ask, what is the alternative? If each of us informs culture, then is it not probable, that by embracing the necessary cultural shifts to appropriately address PPDS and applying those internal shifts to the external expression of who we are in the workplace and in larger society, then positive social change may follow. This research challenges the notion of equality as being that each parent works and bears the responsibility of the children; it misses the point. Equality need not be two people undertaking the same fragmented role. Rather, true equality is embodied in equal recognition, praise, acknowledgment and

a sense of achievement and success regardless of the role one has chosen, whether that be full time parent, full time professional or a blend of both is equality. Policy cannot be the only key. Policy does not substantially lower the experiences of anxiety, or of internal pressure in women to be good in both paid work and as a parent. Raising the esteem bestowed on motherhood would no doubt address many of the aforementioned issues. Would it not also pay respect to, and perhaps honour, the biological and innate nature of motherhood rather than seek to minimise it by proffering it to either sex, despite the abundance of evidence to suggest that it can in fact be learned? These are contentious and precarious questions in today's climate, yet no harm can come from shifting the perspective of what it means to be truly equal, to have real freedom of choice where either a mother or father satisfied the cultural hallmarks of success and where either provided connection, a sense of self and worth? In our current culture the answer appears to be that this brand of equality requires equal mental load, equal home load, equal child leave. It is the assertion of this research that it is time for a more systemic cultural shift to support this.

This change will take decades, but it is the view of the author that questioning, and applying theory based, targeted, compassionate and practical solutions are the first steps towards systemic change. Perhaps one of the reasons women struggle to identify their symptoms as PPDS, or to accept a diagnosis of PPD, is that they know they are simply bearing the brunt of various environmental and cultural factors, and that this is not something with internal origins, that there is not something wrong with them. As I suspected with my own experience, it was not about deficiencies within – it was a "complex interplay" of various internal, external, and cultural factors which being so deeply rooted within were often interpreted as my own

(Mauthner, 2010, p. 6). By giving mothers appropriate support, they will fare better through personal transition, professional contributions and parenting. The alternative of pills, diagnosis, stigma, internalized blame and exceedingly high expectations falls drastically short in building sustainable equality and wellbeing for Australia and pays no homage to the lived experience of each woman.

6.2 Practical implications of findings

Benefits to Australia

The Village Foundation has the potential to be a successful, scalable, global business, consulting and advising corporations on increased productivity, employee engagement, and wellbeing. Commercialising this solution has the potential to provide an innovative solution to addressing the widespread experience and cost of stress and reduced wellbeing in the workplace. The implications of this solution, directly influence infant development, family wellbeing, costs to Australian business and health, so contributing towards The United Nations Sustainability goals 3, 5 and 8: Good Health and Wellbeing, Gender Equality and Decent Work and Economic Growth, respectively.

Strategic implications

The contributions made herein offer a sound theoretical base from which Health Care professionals can draw, advise and further knowledge. The practical contributions offer standardised, replicable structures upon which HR and People and Inclusivity strategy can be formed. The theoretical and practical contributions have the potential to inform workplace culture, popular culture and the individual experience within both. When the restrictions posed by COVID19 are removed and normal life resumes, the Village Foundation, as a response to PPDS in the workplace

and wider community would need to take stock of its future strategy. The simple way to approach this is to focus actions, or rather, strategic intentions, on a running order of *now, soon*, and *later*. For now, focusing on the advisory and consultation elements of The Village Foundation and how best to work with companies to effectively structure their support offerings is vastly important as the impact of COVID19 on families becomes increasingly evident. Using an Action Research approach, The Village Foundation will collaborate with Human Resource officers and organisations which will provide deeper insight into the current fragmentation of, and feasibility of, current workplace support solutions. At the time of this portfolio submission, The Village Foundation has been engaged to consult on a significant project with Sydney based company, Parents at Work, partnering with UNICEF, to develop Australian standards for Family Friendly Workplaces. The Village Foundation has also begun consultation for a major overview of family workplace standards within one large national Australian company. Soon, we will be placed to implement pilots using corporate Australian case studies which would provide credence to the theoretical offerings herein and engage assessment of the efficacy of the Village Foundation offerings, utilising companies such as The Social Impact Institute to measure effectiveness. Later, The Village Foundation aims to establish a second, not for profit arm, which would see the App and programs be delivered to the community – mothers, fathers, migrant groups, at-risk mothers and carers - to increase awareness, support and education, whilst reducing stigma.

6.3 Future research

As evidenced herein the experience of many mothers is one of loss, hardship and silenced grief; addressing postpartum distress as more common an experience than the exception to the rule creates an abundance of future directions in many areas.

In concluding on a future research note, the sole focus is on ensuring that The Village Foundation is 'fit for purpose' and taking actions that have useful impact and add value to its intended clients.

Further detailed research into the current industry offerings, guidelines and recommendations will commence forthwith, and a detailed evaluation of how they encapsulate and address what has been found within this thesis portfolio will ensue. In reality, this kind of thinking is a work in progress and requires further consideration with potential partners and therefore is left open for the present.

I will end how I began - on a personal note. I was recently asked, could I be a stay at home mum, to which I answered, no, not in this culture. I have a deep desire for community, for feedback and validation. I am still striving for equality, and seek recognition, validation and acknowledgment. Today, here and now, that is received in the workplace, and not as a mother. Having said that, as a mother I have had moments of community – of authentic, non-judgemental connection to other women, and I have found those moments more fulfilling and heartfelt than any workplace has ever given me.

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Appendices

APPENDIX A

Detailed account of Tiffany's Lived Experience

It was about 11am, on a weekday. I was walking down my street in Stirling. Most people were at work, so it was quiet. Faith was cuddled in close to me in her baby carrier, gripping my sides like a koala – I felt her little fingers pushing into my skin, and I kissed her sweet little face. The trees were beautiful; it was autumn, and the leaves were red and orange and yellow. Faith was looking up at them in absolute wonder as she did every morning on our walk. The sun was out although as is typical of the Adelaide Hills, it was cool and the breeze moved her soft, fine, hair. Her body against mine kept me warm. I was feeling nostalgic as I looked into each of the houses along the street thinking how much my mum would have loved it here. I often thought of her on mornings like this, when I felt particularly lonely.

My mum died 5 years earlier. It was sudden and she was 52. I had no conceptualisation of the fact she could die at that age. Even in the hospital I was oblivious to the possibility. Even in the quiet room with the doctors. Even when I lay next to her as she slipped away. I certainly had no idea the impact it would make on my life to come, as a mother.

When she died, it triggered a biological response in me, that I would carry for the next 3 years. The pain, guilt and grief I experienced manifested itself through the loss of blood. I would lose blood by the litre. I couldn't walk from one end of my house to the other without losing my breath. This psychosomatic response meant there was no way I could become pregnant, and there was no biomedical cure. For 3 years, through 18 blood transfusions and no hope in sight of getting better, I longed for and agonised about having a baby. It's all I could think about. I imagined it every day. I idealised it.

Four years later, after years of emotional and psychological healing and with the science of IVF, I was pregnant. I was completely overwhelmed with happiness and gratitude. I had dreamt of this moment and arranged to meet my husband so I could see the happiness on his face when I told him. But he wasn't excited or moved. He appeared anxious and agitated by the news. The first blow to my heart. I smoothed over it, I pretended it wasn't there, not to him but to me.

I absolutely loved being pregnant. After waiting so long I didn't complain at all about the queasiness, the discomfort, the indigestion. I embraced every sensation and every moment. I read every book, studied every aspect, played music to the unborn baby, meditated, cleansed, I am a perfectionist, a high achiever. I did it all. Craig and I would fight a lot during pregnancy. Blow number 2. I wanted him to join me, and be as excited as I was, but he was distant, and constantly warning me about the struggles of being a new mum, but I didn't hear them. Everything was going to be perfect. Looking back now, the naivety hurts, and I mourn for the innocence and fire that once had me alight with hope.

I knew it was over when Faith was 2 days old. I looked up, and saw it in his face, 'he's gone 'I thought as my heart sunk. Blow three. It took three years for the separation to come to fruition, as we fought to hold on – he to what we had, me to what could be. It is assumed that men's depression follows the woman's, however in my case Im going to say it was the opposite. Mine followed his. He really struggled to share me, to lose the life we had. To come back to the late nights and crying after having been through it with his first two children. He missed me, my income, our life. He missed the fairy tale we had, while I dreamed on the fairy tale we could make.

I experienced my own struggles too. I felt lonely and isolated, and we didn't have any family support. I always mourned the loss of my mum, of my freedom, my identity, my work. I was tired. I was trying to be everything – to sound good, to look good, to be good. I missed Craig and the connection we used to have. I missed being his priority as he disappeared more and more into work, running from this new reality, me constantly chasing. I missed being capable, and of receiving recognition and accolades for my work. I missed being easy going and fun. I was always tired and anxious and desperate for connection with literally anyone. There was so much going on – physically, mentally, emotionally, socially, culturally. I was devastated that my reality didn't look like the picture in my mind and denying it to myself became akin to trying to shove an inflated garbage bag into a small drawer – wherever I would push, it would spill out somewhere else. I kept lying. I kept smiling.

I remember the day I eventually succumbed. The day I gave in and admitted that my heart was broken. We walked down the path with our dogs as we always did. Craig

was distant, withdrawn. I broke down as he pulled away and yelled through a flood of tears "you're ruining this for me!"

The blows were too great to keep withstanding. I fell, and I fell hard. I no longer recognised myself.

Walking and yearning became my every day. I knew who lived in each house and I was hoping to see someone out in their garden so that I might go and chat. I looked across at Sues house. I could see her inside talking to her daughter in the kitchen and my stomach sunk as I thought of all the times I would spend in my mum's kitchen. I was envious of Mia that she could still take these moments for granted. I fought back tears although my mouth was pursed and started to do that involuntary downward turn, preparing to cry. "Please come out" I thought. I slowed down my walking and pretended to look at the flowers along the front of her garden. "Maybe they'll see me". After a minute or two I walked on, towards the stony path, knowing that if I stayed longer, I would look desperate. I was still trying to pretend to myself that I wasn't. I could hear the trucks rushing past on the freeway and the dogs barking inside the houses that I passed. The air was fresh, and the stony path was loud under my feet. I found myself on the walking path again, the 3rd time that day. I picked wild blackberries and as I ate them Faith stared at me, longingly. I fed her some and as her little lips tasted the sweet berries, I felt so close with her, so connected. It was apparent how important I was to her as I fed her from my fingers, juice dripping down my hand. "I love you so much" I said to her, my mouth moving downwards again, fighting. I looked up as I heard footsteps coming toward us and I smiled in anticipation "perhaps they'll stop and look at you" I thought. It was an older lady, wearing brownish pants, a knitted vest and hiking boots. Her grey hair bounced along covering the top of her face and she had a kind, weathered face. Her eyes seemed to smile. She was carrying a weaved basket full from the organic store at the end of the path. I made eye contact and said hello before she was even close to us… "slow down" I thought, "please". My mind was racing…"maybe she will stop and talk, perhaps she will want to hold you, I wonder if she has a family, if not, could she be mine?"

"Hello dear" she said as she got close. "hello how are you?" I replied. "Nice day!"

I pretended with everything in me that I was happy and together as I slowed down. She spoke to me as she walked past, looking back as she answered, "great day for a

walk with your lovely baby!" I stopped and turned to face her trying to keep the conversation going and as she turned and regained pace I felt so stupid. "Yes" I said, conceding that she wasn't going to stop. Inside I screamed. Shame rushed over me and I felt my stomach hollow and pulling. I found myself thinking, "god you're pathetic." I was so embarrassed for Faith, that I was her mother and I looked down at the stones and finally, cried. Faith stared at me with her big blue eyes, and I couldn't hide from her or myself. So alone and so embarrassed to be alive. The wind made my tears feel cold and as I tasted the saltiness on my lips, I wiped my eyes angrily with the palm of my hand. Blow 4. I kept walking. Maybe the next person will stop.

Eventually, I returned to 'work'; to university, as a mother of an 18 month old. It wasn't enough for me, but it was something which allowed me to be with Faith at home which I had committed to doing until she went to kindergarten, aged four. Theoretically I was welcome, and yet the whole structure, the whole experience simply highlighted that I was different, that it was harder. Was no one else a parent? Why was there no evidence of children in offices? In bathrooms? In existence?

One day I called my dad – we were 5 years estranged, and that was a hard call to make. He suggested that I had postpartum depression. I had been crying a lot, and I was desperately sad. I rejected the notion immediately, rolled my eyes and responded that I was just lonely, that this was just hard. As time went by, I began to wonder, maybe it *was* me?

I have worn the label every day since and I wear it alone. There is no mention of the part my husband played, the part society and culture played. There is no mention of the multifaceted snowballing descent into depression.

To me, depression was the conglomeration of so many varying factors; the end place. It wasn't the cause and what I know now is, it wasn't me. It was everything – not having a mum, not having my family, missing my work and study, feeling incompetent, being isolated from a community of people to share this with, financial stress, relationship pressure, societal expectations and values, lack of emotional support and ritual, loneliness, guilt, shame and external and internal expectations that I should be so happy and instinctively know what I was doing. It was my husband's own grief and despair, his own mismatch between dreams and reality, his external and internal pressure to be the breadwinner, the hands on dad and my emotional rock. Eventually it was the sheer depth of inequality around the roles in

the home – I was desperate to work again and rediscover my sense of identity, and yet I had my role cut out for me, by everyone. Despite seeking playgroups, counselling, and psychologists our experience ended in divorce, a broken home and a fourteen year life together, lost.

When I did work, I was still expected to do it as though I didn't have a child. I would feel ashamed and embarrassed when I couldn't remember something or put two words together or finish a sentence. I was so deeply angry at the incongruences of my workplaces, being openly and theoretically supportive and yet so practically inept. I was tired to the core of being, managing work and baby and home. It wasn't any one thing. And it certainly wasn't a personal deficit.

The shame and sense of failure I have felt over the years, and the longing and loss for what I had dreamed still haunt me today. My daughter, now nine years old is a bright, outgoing and gorgeous girl. She has debilitating anxiety and I carry the guilt of that every day as I wonder how free and self-assured, she may feel if I hadn't been so emotionally unstable.

Since, I have always wondered how many others are suffering and hiding behind smiles and happy pictures. How many parents are hiding or lying, or being lied to by other parents who are putting their brave faces on? How many parents are pretending their babies are sleeping? How many parents just need to hear the truth and be told that it will pass, that it isn't their fault, that what they are going through is normal? How many parents have their dreams shattered by life circumstance and wear the label of depression? I think about the excitement expectant parents have and whether they too will be shocked by the reality and feel as though they have nowhere to turn.

Fast-forward 7 years. I had my second child, Rumi. I took everything I learned from having Faith and planned well for this experience to be completely different. My partner had been well-prepared to be as hands on as I. I had my mother in law come and stay for 8 weeks months. I had friends and colleagues with children. I arranged for meals to be dropped to me for 2 months. I had lower expectations and more experience. I was much more relaxed about being perfect. And most importantly for me, I only took 3 months off before returning to full time work. There has been no sign of any kind of depression, or blues or distress, despite the reported 40% relapse rate of postpartum depression. Personally, I was well supported and well prepared. Professionally however, I noticed a similar trend to the first time around. Thrust back into corporate settings, into university life, and into the rat race of family and

work life I noticed that very little had changed. I still felt as though I had to hide the fact, I had children from my work environments. Workplaces seemed unprepared for women who had children; unwilling to accommodate the messiness of life in a meaningful way. In the past 7 years there has been an influx of Diversity and Inclusion Managers, of nursing and parent rooms, of flexible working from home conditions and of dads taking parental leave. These changes seem to skim the surface of what is needed, massively missing the point. There is still this invisibility of family in the workplace, and a lack of sharing and honesty between parents. The fight to be perfect and to manage it all is still being fought and no one is going to backdown.

APPENDIX B

Interview with Tiffany De Sousa Machado

I – interviewer (Marion Wands)

P – Participant (Tiffany De Sousa Machado)

I: Tiff, so the purpose of our session is to go through a series of questions in relation to The Village Foundation, in relation to why it was established, what was your thinking behind it, what have you learnt from the process, who's been involved, and if you could do it all again would you do anything different. And we'll also pull in some issues around theory that might helpful to understand the model that you've adopted. So, you're good with that?

P: Yes.

I: Lovely. And we have Barry with us – Dr. Barry Elsey and Dr. Wendy Lindsay will arrive soon and she'll join us as well.

Alright, could you just tell us why it's called 'The Village' - what did you have in mind when you actually created it? What was it about?

P: So, the name Village stems from the term 'it takes a village to raise a child' - it seemed to resonate a lot with a lot of people that I asked when I was toying with different names. But it really is around that concept of extended support that's necessary, especially in today's climate, I think, as people are, as parents are doing the role of full-time work plus full-time and they're largely doing it alone in our culture. What was the second part?

I: And so, what did you have in mind?

P: I had in mind bringing together community through friends, through retired people that could provide support through business mentoring, a whole range of people, but overall, I had this concept of connection and sharing of stories which would provide comfort and a sense of normality for those parents that were going through what they were going through without the competition that can sometimes be present.

I: So Tiff, could you just take me back to when you were talking about you made connections with people from business and community, was that part of your thinking in the establishment, or had you already reached out to them and sort checked the idea with them?

P: Look, no. The very original idea was just to present some way to connect within the community. So for lay people walking around the street. Parents, mums at home wanting desperately for that connection during the day, because that's where the idea came from. From my own personal experience. But having discussed that idea with a few business mentors, they suggested that it could actually be something that was utilised in corporate. So I actually took the idea to Westpac in Sydney and presented to a board of six and they all were extremely excited by the idea and the concept and were very much on board. And in my research, I actually found a very similar mentoring mums program which was named exactly the same and conceptually was exactly the same being run in America in one small office had then expanded nationally. So then, we had a conversation and it just kind of grew from community to corporate.

I: And were they delivering in corporate in America as well?

P: They were.

I: Did they start in community?

P: No, they started in corporate.

I: Wow. So the idea, when did it come to you to actually set this up and then when did you get to the board and do the presentation?

P: I think I… the idea came in 2017. I had, because I had post-natal distress, or depression, and so did my husband when I had my first daughter in 2011, I switched all of my focus during my psychology degree to looking at postpartum experience. And also, through the Anthropology subjects I did, I looked at it across the world. And what came up was this lack of support and this lack of facilitating the inevitable distress by being there. So, not preventing it, but enabling and allowing it a space. So, from 2012 onwards I had had this interest and focus through my studies. And then when I was awarded the 'Future Leaders Scholarship' I had the opportunity and the finance to be able to do something with it. So, that's when I came up with actually designing something that could be used for people because I had the financial support to do so.

I: So, the idea came from lived experience?

P: And research. So both.

I: Would you be comfortable to share that lived experience? Just so we can get that on the record, as long as it doesn't bring

P: It doesn't matter. So, when I had, before I even had my daughter, I had my mum who was the most maternal person in the world. She was the most loving, beautiful spirit and she had been asking me to have children since I was 18. And I had never wanted to have children. And when she died suddenly at 52, and I was 29, something in me shifted and I saw everything she saw. I saw all the importance of family, I saw all of that literally as I was sitting with her as she was dying. And I whispered in her ear, not that I know that she could hear me, that I promised– I was sorry that I didn't have children for her and that I promised I would do that. So, I actually became ill after she died; there was some psychosomatic stuff there, and I actually had developed a bleeding disorder for three years. I had to have 18 blood transfusions, I was on death's door, I nearly died that many times. So, for three years I worked through the emotional loss and the baggage of past abusive, and all this stuff. And cleared it all. And felt then that, you know, now that that was cleared and then that I was well, I then wanted to have a baby, but then I couldn't. Long story short, I had to have IVF. So, through the whole process I had Faith, and my husband at the time was 15 years older than me had already had two kids and as much as he wanted to give me the experience of being a mother, he really didn't want to be a dad again and he struggled with that when she was born. So I found myself very alone. He had emotionally checked out and was working interstate. I had no mum, no dad because we were estranged, and my husband's family lived interstate. None of my friends had kids. I was living in the hills far away from everybody and I was just isolated. I think had I not known the kind of nanna and support my mum would've been, it might not have been so difficult, but because I knew that so deeply that she would've been there every day that was even a greater loss. And, I kind of pretended that everything was fine for as long as I could. And I would find myself walking down the main street in Stirling, which is so beautiful, I was surrounded my beauty and gorgeous trees, and I'd walk down this little path to the main street every day about four times a day seeking someone to talk to. Just harassing old people on the street, lingering awkwardly in shops, desperately wanting someone else to hold her, checking to see if my neighbours were home. It was just really, I felt desperate and horrible. And then eventually I broke down and I admitted, and I yelled at my husband for ruining things for me. I felt like he was ruining the experience, because when we were together he wasn't there. And

so it was a whole mix of being isolated from my work, not feeling like I was using my brain which is very important to me. I'm like an achievement personality and I needed to be doing something with my brain. Missing my mum, knowing my marriage was over – we've been together for 11 years and knowing that that was now coming to a close, knowing he was depressed, then me becoming depressed, but I knew that there was nothing actually wrong with me. That had I had enough support, it would've been fine. So, that's kind of where it all came from. But it took me a long time to realise that what I was going through, and it wasn't until actually I went away to my husband's farm, his dad's farm and his younger brother who always thought I was the best chick, I heard him in the backyard talking to Craig, who had just left me inside with the baby. We couldn't go out because there were these poisonous things on the floor, anyway, he said to him, 'What happened to her? She used to be so cool, and now she's just a grump and a mess', and I knew then that I was just a completely different person and that it wasn't me, that all these different components had added up to me being depressed. And that it was a non-supportive environment, non-supportive culture, and the expectations were too high.

I: So what year was this happening?

P: That was 2013. 2012, 2013. Well, it was really from the time she was born, but I really didn't allow it to sink in until maybe she was about 10 months old.

I: So she was born 2011, and your mum died…

P: She died in 2006.

I: So, this is a lot of closed things happening, And then 2012, 2013.

P: That's when I – that's when we broke up and everything just clicked.

I: And then you had the idea, 'If this had happened it could've been so different'.

P: Well, just through the research. So then it was like bringing in my personal experience in and researching it at the same time and seeing there was just gap after gap after gap, and recommendation after recommendation that support needed to be personalised, and that there was cultural ramifications. And also, the biggest take away for me was in cultures where there was a collective, and where women surrounded a woman who'd just had a baby, the new mum didn't not experience distress, she did, but she got through it quickly because the support allowed it to be there. And also the support was reflective. It said, ''I've been here.

This is normal. It's OK. We'll look after you. You get through the distress of becoming a new mum, it's big. Your whole life has changed, of course it's going to take some adjustment'. So the support actually, it allowed the space. It didn't prevent, it just gave it room, and what happens with any emotional distress is if it's not given the room, it stays there for years and decades until it's given the space. And once it's integrated then it passes. And so that support from other women allowed the integration of that distress, and then it passed.

I: Lovely. In your mind then, when you think – what's in your when you think and talk about Village? What do you picture?

P: I picture parents getting up all night. I picture them then trying to get ready and look like they used to look in the morning. I picture them actually not loving their new life because there's so much pressure to go back to work and be who they used to be. And then I picture them going to work and not being given a space to actually say 'This is so hard'. And then, with Village, I picture them being greeted by someone who's been there before and being told 'How are you going? It's OK if you're not OK right now. Let's have a coffee. Let's take stock of how last night was. How's childcare drop off? Was it distressing? What can I do to support you? How can we work out how to make work for you? And, no one expects you to be exactly the way you used to be because you're not. 'And I picture this open, vulnerable and honest conversation between someone who has been there long before, and someone who's going through it now.

I: So, a sense that the conversation's based on the reality of what's actually happening.

P: Yeah. Not on what should be happening or not on the idealised version of what should be happening in terms of the new parents. And the amount of horror stories I've heard of new parents going back to work and not even being, not even having their desk there, not even having the same phone number, not knowing who their team members are, not being allowed any flexibility for breastfeeding, for pumping, for leaving early, for being upset that their kid had screamed as they left them at childcare. That's so difficult. And to then go in to a corporate Monday morning meeting, there's just so many horror stories where they've not been

acknowledged. But that aside, it's not celebrated either. Culturally, we don't celebrate motherhood, we don't. It's something that you're expected to do, and it's a pain, and if you choose to do it full-time, well, that's not very good. It's not, you don't have ambition and you're not a Super Mum and you're supposed to be a Super Mum. You're supposed to work and have your family and do it all. This just, and so to celebrate being a parent in the workplace, by acknowledging it and giving it a space and talking about it, it's actually all that's really necessary.

I: Tiff, I'm wondering, does that give you a sense in that the person can actually grow. Like motherhood presents a whole range of new experiences, but if it's closed down and you can't express, it's actually hard to grow through that experience, is that…

P: Yeah. Well, it's not honouring that new, it's a whole new existence. And when we don't allow expression of that, it's not honouring that existence and then we learn to resent motherhood and resent the duties of being a mother instead of embracing them. Still, it's difficult but if we know that everyone's going through it, or everyone's been through it, we can talk about it lightly as opposed to this heavy presence that we hide, and by hiding we don't honour. In some cultures, the more children you have, the higher on the hierarchy you sit because it does provide wisdom and it does give you a perspective and skillset that you'd never have otherwise. And yet in our culture, it's the opposite. The more children you have

I: It's frowned upon.

P: It's frowned upon. And the more ambitious you are, the higher you are corporately, then that's applauded. It's almost like there's a shame aspect to it as well.

I: And if I've heard you correctly, you said that it was people who've been through the experience of being a parent themselves, is that part of your model?

P: Absolutely. It has to be someone that's been there before, not peer to peer. The reason that – look, peer to peer has it's place, but in my experience and in much of the literature, there's a sense of competition that happens among new parents.

There's a sense of proving that they're doing it right. Of feeling as though they have to present best case, 'of course my baby's sleeping'. There's this comparative element to it, whereas when there's a gap between the lived experience and the new experience, there's a whole lot of wisdom in there, and hindsight. And there's also, this lack of needing to prove that they're doing it OK. So, in my own experience, the people that provided me the most comfort were mums of grown children who could laugh it off almost and say 'Oh, that's normal. Of course you hate your husband.' 'Oh, of course you're not sleeping! No one's expecting you to sleep for two years. 'Whereas, in a new mums 'circle there's this kind of, almost dishonest portrayal of what's happening because saving face and looking like you're achieving is…

I: Very important

P: important because no one knows that that's not real and the book say that your baby should be sleeping this amount of time. It's just not honest. And there's many cases where mothers groups do wonderful things for people, but there's just as many that say it was the most horrific time for a new mother. And that was definitely my personal experience.

I: So the person has to have grown children, they must've had children, is that important?

P: I guess it's not imperative, but for our model, it definitely is that you need to have children 5-ish plus. You know, you've been through the early years, they're at school now, you kind of can take stock, you're back into the swing and you know, through experience that there's a light at the end of the tunnel. It's not that school-aged children isn't difficult, but you're kind of a veteran then, you kind of doing it, and you're in the swing. Whereas, infant children or toddlers, it's a whole new… you still don't have your stride on.

I: Are there other qualities that you would expect of the mentor to have?

P: Yes – a big focus on sharing honestly and being open, non-judgement and empathetic. So, not giving advice or judging the new mum's choices because everyone's parenting choices are very personal. But hearing what's underneath

those choices and hearing that there might be some turmoil or some distress, and being a sounding board and someone who can listen without judgement or advice, which is the definition of being a mentor. It's to guide and to listen, not to lead and direct. And having the older children definitely helps. It doesn't need to be male or female. Two of my very, most important mentors for me were both male, and they gave me the best mentorship around new parenting. My boss, when I had Faith and was going through my divorce, so she was three, and I had quite a rough divorce; he was a 60 year old Italian man who didn't say two words most of the day, but would say the exact right two words over a short black and a cigarette and change my whole day. It would be something like, 'Tiff, do what works'. It's so simple but I was trying to make sure she was in bed and sleeping and at the right time and put this, and still had to do my Honours and all of this stuff, and he just said, 'Lie her on the couch next to you and let her go to sleep when she falls asleep', and it was just… break through but so simple, but you don't get that until you've done it the hard way.

I: And you mentioned there was a similar program occurring in America, but only in a small part of America

P: Yep. One firm.

I: And it started in as a corporate service, I'm wondering, are there other models like yours? How is it similar and different?

P: Well, the model that I designed is pretty identical to the one that was being done in this other firm. We had quite a joke about that when we chatted. But I haven't found anything else similar, and in the experience that I've had in connecting with various large groups that are providing in Australia, I haven't come across anything that provides parental support on an emotional level, on a mentorship level. It's definitely been suggested as needed and necessary and asked for, but to my knowledge, there's not a program running that offers the same. There are programs that offer coaching around flexibility in the workplace, parental leave negotiation, managing family and work, thriving with the balance, but there isn't something that connects to people face-to-face for honest and open emotional support discussion in that way.

I: Have you got in your model how many interactions are there, or it's open to what the individuals agree?

P: We structure the first 6 to 8 weeks, and then it's open. So there is a structure that needs to be followed for the program because in the initial control trial we left it open and people didn't connect. There's a lot of research, and everybody knows around mental health that people, especially new parents, will tend not to reach out and say they need help because they are trying to show that they're coping and everything. So, by forcing the interactions almost, and scheduling them, 1) it takes away that need to ask for help because it's there in front of you, and 2) it promotes that rapport building and the relationship development, and we offer a few suggestions for meetings so that it becomes more natural for the conversation to flow.

I: So, how do people nominate to be a part of the program? How have you instigated that enrolment?

P: So, we recruit mentors throughout the organisation. So we put out, sort of a call out for mentors, and there's normally, no shortage of people that want to do that for the reasons of wanting to give back, understanding what the pain was like, wishing they had one. And then, in terms of the new parents, what we do is initially we do a drive to get the one that are on leave, going on leave, or have just come back. But then, the program is implemented in a way where every single person then who registers as needing to go on leave is automatically recruited into the program and assigned a mentor. So that it again, there's no need to ask, or opt-in.

I: Can you opt out?

P: You can opt out, but then that takes away the need to ask for help and appear vulnerable, so it's standard.

I: That's great. The benefits then we've just gone through. Strong focus on mentorship, anything else you'd like to add about the mentor process? So if I've heard correctly, non-judgemental, open, honest communication, they've had a child themselves and that child must at least be at school. And it can be male or female.

P: The only other thing that we put as an option, for corporates to take into account is that often the mentors can be advocates for current policies within the

organisation. Because, if you're a new parent, the last thing you're doing is going on your website – your company's website – going 'What's available to me? How does leave work? What's flexi look like?' You're focused on giving birth, and then the first three months are pretty hectic, so that mentor then can, and the mentor's designed to be in touch before, during and after, and so that mentor can then facilitate some of those policy discussions, and be an advocate for higher management. So, we say, well, you know, 'How're you going? Do you think you're ready to come back four days? Or', and work out what's necessary and know the policies, but that's another level of education.

I: And if the person's having difficulty coming back, can they also arrange a meeting with that person's manager and say 'Would you like me to come with you and we can have that discussion?'

P: So that's right. So, the mentorship program is supposed to be before, during and after leave. So, they develop the relationship beforehand. They stay connected during leave, and then they reconnect when they come back into the organisation and facilitate meetings. Welcoming them back and be there on the first day back. Give them tips about coming back. Things like, obvious when you've had children, but when you're new, you don't think about things like meal planning. Have stuff in the freezer for the first four weeks of coming back to work. Have a cleaner booked for the first four weeks so that you can come home and connect with your child. Don't start childcare the day you start work. Do it two weeks before you go back to work so that you've got time to transition all those emotions. Don't come back to work on a Monday, come back to work mid-week, so that it's a soft transition. Those kind of little tips, and then being there to welcome back in. Have a coffee. Take them up. Introduce them to the team that may have changed. Show them where they're sitting. Introduce them to the new policies.

I: So you really must ensure then that the organisation is on board with this process because that volunteer mentor would need to, I'm sure they do a lot in their own time, but there would be things happening during work time, and they need to be allowed. And is that a part of your model or in discussion?

P: Yeah. So, the model is that this isn't a volunteering role on top of their original role because women already, particularly, do a lot of work for free. So the organisation needs to allow a certain amount of hours that this is part of their expected role. So as part of being a mentor and an ambassador of the company, they can undergo these activities within their already scheduled hours, not on top of.

I: It's good. We've had discussions in the past that you've been really keen to be authentic to your model that it was to be face-to-face. Why is that so important to you?

P: There's a lot of research by one of my favourite people, Dr. Fiona Kerr, and she and I are very aligned in that there's a lot that happens face-to-face that is impossible to happen over a Zoom call, or even over the phone. Eye-to-eye contact in terms of rapport building is key and also there's a physiological mirroring that can occur and that can, if a mentor is trained in, can actually use to speed up the rapport building program, so sitting the same way and leaning forward etc. But also, our brains process information and physiology differently when we're face-to-face. There's things like a twinkle of the eye, a slight nod, a leaning forward and touching of the arm that can say more than a thousand words. In many of my own personal experiences, you don't even want to talk. You might be emotional and you just want someone to sit next to you and kind of nod and look at you and know and express back to you that they know what you're going through. And that can be done in an instant face-to-face. Just the technology of Zoom, it is impossible to look into someone's eyes on Zoom. If one person's looking into the camera, the other person's looking at the screen, it just doesn't work. And our brains don't work in the same way, over a screen. I think phone calls are actually a better way to communicate an emotional connection than a Zoom call. There's research that suggests that all are effective but my personal preference is to use the phone, and you can hear, and there's more social cues that are picked up that are responded with, and face-to-face is obviously the gold standard way.

I: So, what's your thought though as a result of COVID? How do you need to pivot your program?

P: Obviously, any support is better than no support. So, in terms of COVID, the programs have been halted so that I can re-jig them. And I think the way that I will promote that is through potentially writing, or phone conversations. If there's a preference for Zoom, then that's the person's preference. But, the guidance that the program would be giving is to do it over the phone, yeah.

I: And have you done anything like that yet?

P: No. But we're about to in Spring. We're starting.

I: Have there been other difficulties you've faced with getting The Village up?

P: Yes. Unfortunately, a lot of corporate Australia still see parental support such as this as a nice to have and not a must have despite WHO recommendations that it is absolutely the role of the employer to take care of the employee. Despite the overwhelming data that suggests wellbeing directly results in productivity and low staff turnover, high staff retention, happiness etc, despite all of that, there is still this archaic thinking that it is nice to support parents, but it's not something that they have to do. Which I think is changing slowly but… yeah.

I: Do you think it's been different for men and women? Are women different to men in their thoughts about this? At senior levels.

P: That's a tricky one. I can only speak from my experience here and my experience is that it can go in extreme both ways. So there can, I've spoken and interviewed some women who, as a result of their own experience have implemented the most amazing support programs. And then there is the other extreme where women are striving so hard to be the hard, corporate Super Woman, that they actually go against that.

I: So, gender is not an issue here as to who's the best supporter.

P: No. Some of the best supporters of The Village Program have been men.

I: Are there difficulties that you've experienced?

P: Recruiting new parents. Getting them to be willing to be vulnerable and share. I think it's different once you're already in but saying 'Yes, I actually need support is difficult.'

I: Why do you think that is? Being difficult for people?

P: Well, I think culturally, we like to appear very strong and together, firstly, and even personally, I think once you open that door and say you're not OK can unleash a whole lot emotion that we're not quite ready for it. Certainly was the

case with me. I knew that as soon as I admitted that I wasn't OK, that the flood gates would open and that I would have to admit so much to myself, so much to my partner, and so much to those around me. Whereas, when I kept that façade, it was much, like I could still say everything was OK. And there's a lot attached to that. There's the idealisation of motherhood, there's the idealisation of how we are and how it's going to be, and if we start being honest, then those foundations can be [*dropped*], and then that's a whole new ball game.

I: So, what are the models that you've thought of to help shape your approach? Are there other theoretical models or frameworks that you've reviewed?

P: Most recently, the new social movement, that's very relevant because it does take into consideration the fact that there are so many different groups working to the same end. To normalise parenthood in the workplace. And they're coming from government, from private practice, from volunteers, from people within the organisations, from parents themselves, and from all of these different angles there is a growing expectation and need, and kind of knowing that this is really vital. But it's fragmented at the moment. So, there are a whole lot of different titles for what's being done in the workplace, and there isn't an overall umbrella kind of term, and policy. Everyone is doing it differently and people are doing it at different levels. Some employers are just going all out, and some are doing the bare minimum. And so there isn't a streamline approach. But it's growing. It's growing and growing every year to be something we're–now, we're seeing, 10 years ago, there wasn't really a role that was Diversity and Wellbeing, or Diversity and Inclusion, whereas now, it's such a big part of a corporate landscape. The People Manager. And their sole role is wellbeing and parents and what have you.

I: Is your approach different to others? Because often there's a policy directive so it's quite mechanised, like it's a mechanistic approach, where your program goes to the heart, literally, and at an emotional connection, and I've heard a lot of the discussion almost approaching it, culturally it's often seen as a deficit model, but your approach also tries to highlight, if I've got it right, the positive side and the growth that comes from being a parent. Is that a differentiator as well?

P: If I understand you right, I think that yes, I'm coming at it at an emotional level because as a mental health kind of expert, I understand the importance of

identifying and feeling and allowing the emotional expression. And we can hide it all we like but it manifests in other ways later down the track. So, it's not sexy and it's not corporate sounding, but it's actually hugely transformative and can benefit an entire organisation by allowing this generosity of who we are, as whole people, not just as corporate executives, or workers, or whatever, it's a really humanistic approach. But it's more than just identifying flexi-work, and needs, and pick-up, it's taking it to another level, a deeper level, which in my opinion, is absolutely necessary. If we're going to connect and grow as not just people but then as the organisation.

I: I have a picture in my mind that other policies or organisations approach it with like threads, but your approach actually provides the fabric into which the thread is woven.

P: That's a lovely way of putting it. Yes, I think so. I think if you have that, if you can be who you are at work, and then you take in all those other threads of the other policies that are there, and use what you need and add that to, sort of, the fabric of what's already there, then yeah, it grows. It's better. It's better for it. You know, you look after your people, you look after your business. And if we look after our people but not their emotions, then you're not looking after your people because that is the heart and soul of who we are and companies that do that thrive from the inside out.

I: Yes, and so, also, if I keep that analogy – the threads – are very contextually based according to the person. So the threads that are chosen is dependent upon the person's needs.

P: Yes, which is recommended over and over and over in the literature around parental wellbeing and wellbeing in general is that support needs to be individualised. I got very sick of reading all the recommendations, and then just reading more papers about the same recommendations. And for me, it was very apparent that some of those recommendations had to be put into practice and that's what Village is attempting.

I: I know your program isn't a specific mental health or certainly suicide prevention program, but we know that after giving birth, there is a higher risk of suicide for those individuals. And what you're describing actually aligns directly with the Australian Suicide Prevention Framework which is: 'It must be personal.

It must be contextualised. We all have different forms of coping, we must help the individual connect to others.' And the last one is: 'It must do no harm'. So, that's why peer-to-peer will actually do harm, but with a mentor who's also got those other qualities, so your approach is actually directly aligned with the Suicide Framework approach, and I'm wondering if that will be another in for you with corporates. Because corporates are very focused on mental health and suicide prevention, you actually have a program, because so many of them are mechanised, but yours actually tick all the boxes of best practice.

P: Definitely, the biggest cause of maternal death is suicide, and 1 in 5 women, and 1 in 10 men report post-natal depression, and there are hundreds of studies that report the implications for not only themselves but for their infant. For their infant's development. Not just short-term, but long-term. And then of course, that feeds into the community, and it feeds into the corporate as well. So, it's fundamental. In my opinion, it is absolutely fundamental. And it is about preventing mental health issues, but it comes to it from a normative approach where everybody gets the same opportunity. And then through connecting, and through conversation, and through personalising what they need, you're actually reducing the risk of it going further to being depression or distress or anxiety. Because you've addressed it early. It's not a treatment.

I: And the issue you've raised there the childhood experience, so adverse childhood experience is a main driver relating to mental health and suicide. So, I'm just wondering, I know this is questions for you, but I'm just thinking, how do you approach and sell this in the corporate world, and have you actually thought of these additional linkages to mental health and suicide prevention in the sales pitch.

P: I do touch on it. It's something that I haven't gone into, at the level that you're suggesting, mainly because suicide hasn't been my

I: Reason for being.

P: Yeah. And my ideas. My expertise, like yours. But definitely it's part of it. I have taken a different approach though. I have taken more of a 'this is for everyone' approach. And it's about just being open and honest as opposed to that really hard line mental health approach. But, I mean either could work. I think that when you start talking, in my experience, from talking about it like that, to

recruiting, there's a disconnect. So a new parent who's pregnant, or on leave and ready to give birth does not identify that they are at all at risk of depression, let alone suicide. There is such a gap between what they're expecting and the possible reality that even when I was displaying, from a psychology understanding, even when I was displaying every single indicator that I had post-natal depression, when it was suggested to me that I might have it, I was appalled. Of course I don't. That's not something that I would get. And that's really common. There's such a disconnect between the symptoms, what they look like, how severe they need to be, and that's why I've sort of taken it as like a normative, more of a normative approach. Because there's just no way, that as a pregnant woman or even as a new mum, I would've put myself anywhere near that kind of diagnosis.

I: So is there an education for the broader organisation to understand the risk associated with becoming a new parent, and the signs to look for? And is that a part of the program?

P: Yes, and we do that. As part of the mentor, so no one can be a mentor without the training. And in the training we talk about what it means to be a mentor; how to mentor; what the boundaries are; how to escalate because you're not a counsellor; where to escalate; what to look for without it being said overtly, so signs – physiological signs, verbal signs, and that's also covered in the training.

I: That's wonderful. There's a lot, you've thought through all the different elements and I think that's amazing what you've developed actually, yeah. So what supports have you been able to get with the development of this program? Because you've put a huge amount of thought, your own lived experience, which I expect at times has been heart-felt for you, and possibly brought up issues again for you, who's helped you along the way to create this?

P: Well, I had, I did the control trial with an organisation in Adelaide, and just simply by being willing to trial the control, which was no structure, no anything really, that taught me a lot. I've had support from local government. So I was given a grant to progress the program. I've also been given local investor support by someone who truly believes in the program and the work around it. I've been given a lot of support from a lot of business mentors in the community, plus the likes of Bank SA and Westpac who have been prepared to pilot the program

internally. Scotch College who are piloting the program internally, and they've been a huge support in terms of belief and connections and giving me whatever else I need. Unfortunately, please the program was designed face-to-face, COVID has stalled us. But the support is definitely there.

I: Have you ever gone away thinking 'If I knew I had this, or that, that would be really helpful?'

P: Yeah. If I had a bigger team, that would be really helpful.

I: Yes, but what would you want those team members to be doing? What skills?

P: I think having more people, so I do actually have a connection with a Sydney-based company who have been around for 12 years and they're very passionate around this space. They've been really supportive. But I think having someone to, more team members to work with/bounce things off, it can be really lonely starting a business on your own. But also, it can be demotivating not having that back and forth to come up with new creative ideas. I think having someone to help in terms of social media and marketing. That's probably the biggest need that I have that I lack time for, and the resources for, is that real knowledge around pushing forward. I have a PR agency that works really well and has done an amazing job promoting the services, but having a team to work with design, and with connections, and then just idea development is good. I also would ideally love a tech developer on board because obviously, that's a very expensive part of the program to have a third party tech developer for the app side of the business.

I: And you've got an app already, haven't you?

P: I do. Yep.

I: And that aligns with the program?

P: The app is available to both the public, but also aligns and is used with the corporate program to connect, and to create parental villages within an organisation. So, for example, Westpac will have their own parent village on the app and then mentors and mentees could connect and chat via the app. But also new parents would be able to connect with all other mentors that are on the app that might live close by that they might connect with in terms of their profile, and they could chat with others as well as who they've been assigned.

I: OK. Great. Is there an ambassador for you within Westpac who promotes your program to their business contacts?

P: Kind of. We have four ambassadors. We have Niki Vincent, Dr. Niki Vincent at The Equal Opportunity Commission. We have Ben Owen who is an executive at Bank SA/Westpac. We have Fiona Kerr who's our new ambassador. There's one more…

I: That's OK. I don't need to know their names. And what do they do for you?

P: They provide connections, they provide support. If I need something, they'd speak at events. So, when we had our launch, Niki Vincent hosted and spoke.

I: Have any of the members said, because Westpac is such a large organisation and they've obviously been very generous to create this scholarship program, do they actually say 'Hey, how about we'll give you 50 hours in a 6 month period to access our marketing team, and they'll actually help you as well develop your product'.

P: They haven't but I think that's because they're marketing team is very, I mean I could ask I suppose, but their marketing team is dedicated to, so the scholars ' network within Westpac is actually quite small. And they have, they run on a separate budget. They have their own CEO, and their marketing team is dedicated to promoting all 400 scholars and the work that they're doing. So to focus and to give me dedicated time, firstly, each department has their own marketing division, it's not a central marketing division, and so they don't have the resource to do that. They support me in many other ways though. So, I've actually been given access to a whole stream of support that a social change fellow would access, as opposed to a future leader would access because I sort of sit in-between. So that's a whole other scholarship essentially that I've been given access to.

I: Do they let you co-brand? Or can you sort of say this program is endorsed by Westpac as part of your

P: Susan Bannigan, who's the CEO of Westpac, has endorsed the program on my flyer. I can't use the logo until they are a client, but Susan has her photo and her recommendation there on the brochure. And also the program director has given me a testimonial for the website.

I: So I think about my own self in terms of the standards that I expect of myself, and I always want things to be, not so much now that I'm older, but a high level of quality and program fidelity. So you have got a flyer that with Westpac

endorsement, and a testimonial is gold, do you think there's any space to rethink through your model and accept, in this context, remember the thread and the fabric, the current fabric has been tarnished by COVID. So could your program cope with being a little tarnished, and do something face-to-face, so you can actually get the wheels to turn. What would be the consequence?

P: I guess I would have to let go of the face-to-face element, is that what you mean?

I: Yes. But forever?

P: Not forever. Just until we can safely do that again. I have been working on pivoting it to another type of awareness, education model.

I: At the moment, where do you have the OK to do it? Is it Adelaide-based?

P: No, nationally. Once – pre-COVID we had national approval.

I: And so, your participants were going to be from all across Australia.

P: From NT, Vic, New South Wales and South Australia.

I: So you've got some people ready to go in South Australia and we don't have, at the moment with COVID, we can actually do it face-to-face, now?

P: Yes.

I: So, could you have like a two-tier program operating, so a part of your model is you're actually going to be trialling, it's not ideal, but you've got your face-to-face happening here, and you've got some happening via phone and written. Is that a potential?

P: Yeah, I can do that. Definitely. That is part of the plan for Scotch. So, we were going to divide the team into face-to-face, and then some online or phone. It's only a small team there that were going to be… so maybe eight pairs. But you don't need a lot to prove the quality and the benefits of connecting.

I: What have you learnt to date from doing this?

P: I've learnt that large corporate is a very slow moving machine. I've learnt that there are leaders out there that are prepared to give everything they can to support their team, and there are other leaders that still don't see the value and that it still needs more education around the link between wellbeing and productivity. Even if they're going to take it straight off a business benefit approach, they can see the value in that. But more so, I've learnt that there is, that I have this fundamental understanding of how important it is to be a whole person and to acknowledge emotion and expression, there is such a great deal of misunderstanding around that. That there is still this vision that that is weak. That

that isn't being strong. And when I come across groups within organisations that have tapped into being open and vulnerable and seeing the benefits, that they are shocked and amazed at the benefit that it has, and yet still, there's a resistance within our culture to be that, and to show that, and to embrace that, I guess, side of us.

I: It's a fundamental cultural change that you're actually asking, and that's grounded into people's DNA almost,

P: I am!

I: and, is part of the learning it takes a long time to change a culture?

P: Yes. Absolutely. I haven't mentioned yet that I did three and a half months of research in Sweden where they're at least forty years ahead in terms of equality and parental wellbeing and flexibility in the workplace. And it is in their very fibre of being. That is an understanding that has taken decades to pass through. You know, I interviewed 60 year old men that were stay at home dads, and that that was completely normal. And that now their sons do it because their dad did it. And all it takes is, is the actual doing. Because in the doing, we inform our DNA on what's normal and what we actually need to change. And it changes. It's all connected. Like the biopsychosocial model of psychology, is very important to understand that. Each, the culture affects who we are, and who we are affects culture, and this cycle of being and doing does change beliefs. And beliefs change in our being and doing, and you can't separate them. So it takes strong leaders, and it takes strong parents and ambassadors to actually be vulnerable, and be open, which is one of the reasons I will have, I will never hold back my experience. I will always be honest with my experience because someone has to get the ball rolling. And I'm not the only one doing it. You've got famous people who have the guts to be able to say 'I experienced post-natal depression. This is what it looked like. This is how I got through it'. And they're the people that make hundreds of other people feel like it's OK to say it. But it needs to happen, not just from the famous people who are famous anyway and have it all together, normal every-day people need to stand up and say it. And so there was this group in PWC that actually, they did. They got their leaders to speak vulnerably, honestly

and openly, and the change within their team was huge. And that's what changes the culture.

I: So, if you could do anything differently, if you were to start over again, is there anything you might do differently?

P: I would create a structured program from the word 'Go'. I would provide a very, very strong financial case for each business pitch that I did. As opposed the emotional and people side, I would promote the financial side, because that is still where a lot of large business minds lie. At the end of the day, it has to be financially beneficial. And I would probably either not develop an app straight away. But given that I did, if I could go back I would secure enough funds to market that 'till the cows came home.

I: So, what now?

P: Now, I finish re-jigging for COVID. I see the outcomes from the Scotch College trial. And I'm currently in discussion with this large player in New South Wales around potentially integrating it in part of their standard offering. So, we see what happens.

I: And Westpac trial?

P: Westpac trial… well because that was largely interstate, and they're not returning to work until at least January next year, that is just on the back burner for now. They still are keen but it's just not a priority at the moment because they're utilising current programs at the moment rather than taking on something new. They've just got a lot, I guess, on their plate.

I: Yeah. Is there anything else that you'd like to add that we haven't covered?

P: There was. I think there's this need to work within the current framework of being ambitious and career driven and individualised. But there also needs to be a shift at the same time. So it's like 'This is what we have, let's work with that. But at the same time, over here, let's talk about changing what's normal and what's culturally acceptable by bringing it to light how important it is to honour the whole person. To actually have dads being just as involved as women. And by also acknowledging that this is only one way of doing life; this culture that we currently think is the only way. And that there are other cultures that see working with a small child as completely abhorrent. It's just not done and it's unacceptable. And that the focus is in those first five years should be the child, and I had one

woman, very child focused woman once say to me when I went to counselling with her and said, 'I just, I'm so stressed. I'm trying to do this study, and I've got this 2 year old, and I've got no support', and she actually, very directly said to me, 'Perhaps studying isn't the best thing to be doing while you have a 2 year old. ' And it hit me really hard because I am an achiever, and I do want to be in the corporate world, and I do want to be doing stuff outside of motherhood, but it was definitely a very strong other way of being. And, you know, I wonder, I often wonder would I strive for that if we had as much cultural importance placed on being a mother as we had on being successful. I wonder if what I strive for would actually be different. I wonder if I would put, I wonder if my value around being a stay at home other would shift if we placed value on it as a society. So, I just, I do want Village to provide a safe space for working parents because that's the current paradigm. But I also wonder if we could start thinking about a different paradigm and shifting the values based around what our culture is built on.

I: And/or your program actually provides the space to think through all the

P: Yeah. That's actually a part of it, is a values-based session where we talk about what is important to you, and what is important to society, and how can you marry the two. And which parts of this are most important? Can you take out some parts of it, that if you just did those ones, you would feel OK about being a mother. Or if you just did those ones, would you feel OK about working. You don't have to do all of the things that make up being a corporate person, or a working mother, or a mother at home. For example, for me, I must do school pick up. That's important to me. And I must be at assembly, if it's a once a month assembly. So I structure my work, so I that I can still be a working parent, but I can tick the boxes that are really important for me to be and feel like I value motherhood as well.

I: So, just to bring it to a close, you've done a huge amount of thinking, and development of the program based on lived experience, and research, and all your academic life in psychology that you've done. And you have a program that I believe, now, is even more important because of COVID will impact us in ways that we never thought of. And your ability to provide a safe space for people to share how they're going is paramount to their wellbeing. So I wish you every success because it's great what you've done. Fantastic! Well done.

APPENDIX C

The Village Foundation Corporate Brochure

THE PROBLEM

Billions of dollars are lost through reduced productivity, staff turnover and mental health issues each year in Australia and more than $500M is directly linked to perinatal health.

There can be a great loss of identity when a parent leaves their career for any length of time.

Returning to work with a completely new parental and professional landscape to navigate certainly has its challenges.

245,605
women experience postpartum distress per year.

16,762
are diagnosed with post partum depression.

40%
of the Australian workforce is made up by women. 40% return to work in the first year postpartum.

515 million
lost in productivity due to perinatal depression.

*Manicavasagar, V. 2012 & BeyondBlue, 2012

I knew my world would change,
I knew my role would change,
but I guess I thought my life would continue as it had,
just with an addition.

I was so wrong - I started to spiral.
I realised motherhood alone did not fill my cup.
I just had no one who I could talk to about that.

Jane, CEO, national not for profit organisation

THE SOLUTION

The solution is connection. Village, through the application of technology and a Suite of educational programs, facilitates the connection between mentors and new parents within a company before, during and after leave. Locally or away from home.

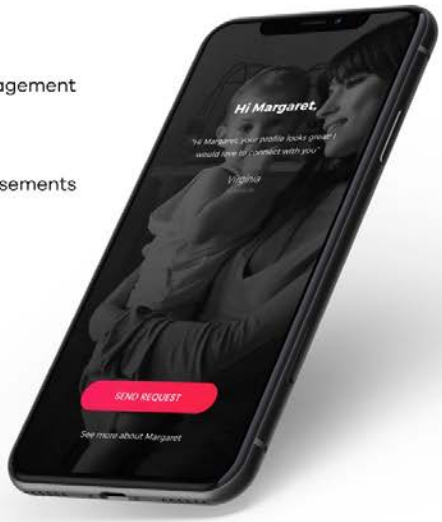
You already have the personnel and they already have the skills.

By leveraging the knowledge and wealth of experience these women and men have to offer, social supports are increased, productivity goes up, staff retention is improved.

Corporations have a social responsibility to provide healthy work environments and the Village App and Suite of programs helps to meet this responsibility by making it easy to deliver existing resource to those who will benefit most. Research has shown that "women won't ask", Village provides the connections, so that support occurs naturally.

THE FEATURES

- Multi-site administration allowing local and/or national management
- Geographical location services to find mentors nearby
- Monitor and track: Usage | Interactions | Connections | Endorsements
- Identify trained Mentors with verified status
- Availability status
- Automated regulation of users
- On-site training and educational workshops
- Podcasts



I'm inspired by the possibility for Village to assist men and women in their transition to parenthood and back into the workforce. As a parent of four and grandparent of nine, I have experienced the challenges of this transition both personally and with my sons and daughters. This unique and innovative initiative provides the opportunity for men and women to give and receive support for the benefit of all. It promotes equal opportunity in the workplace and is an excellent way to promote both mental wellbeing and productivity.

Dr **Niki Vincent**, Commissioner for Equal Opportunity (SA)

CUSTOMISED SOLUTIONS

Business
50-200 users

Executive
200-1000 users

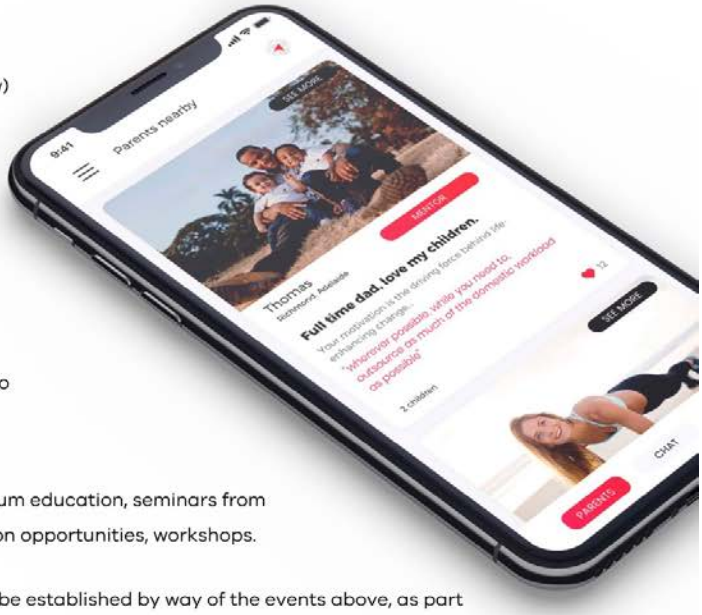
Corporate
1000+ users

- Multi-site admin access
- Management reporting
- Upgrades and new features
- Group training and coaching
- 4 x educational seminars online
- 4 x phone support sessions for mentors

THE APP

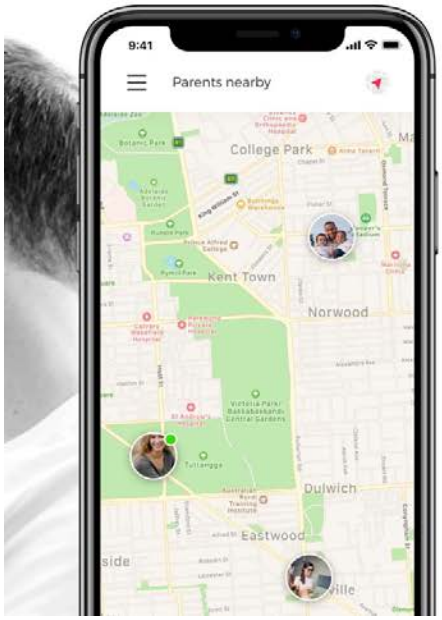
The app is available on both Android and iOS platforms. NEW PARENTS and MENTORS are able to:

- Create and personalise profiles
- View nearby parents / mentors (map view)
- Access mentor profiles
- Chat in real time
- Access safety contact information
- Access user reviews
- Receive push notifications
- Upgrade functionality to receive access to more mentors, products and information



Additional programs will address postpartum education, seminars from experts in the field, live and local connection opportunities, workshops.

Corporate Mentorship Program – this can be established by way of the events above, as part of the corporate bundle. The app allows staff members - past, present and on leave – to communicate through a secure and separate platform.



I have closely followed Tiffany's growth and development in the area of parental support, since she received a Westpac Future Leaders Scholarship in 2017. Tiffany recently presented her latest concept - The Village - to a group of key influencers within Westpac. We are really supportive of the direction Tiffany is now taking with her research, and when she is ready we're keen to pilot the program with a group of experienced and expecting mums in Westpac.

Susan Bannigan, CEO, Westpac Scholars Trust

THE WHY

The Founder of The Village Foundation, Tiffany De Sousa Machado has over 20 years' experience in executive management, training and facilitation and holds a Degree in Psychology (Honours). She is currently a PhD candidate in Psychology and is a Westpac Future Leaders Scholar. Most importantly, she has experienced postnatal depression personally and understands the challenges this presents and support systems required.

In February 2011, I experienced the overwhelming joy of giving birth to my first daughter, Faith. She was then and is now the absolute light of my life. In the months that followed however, things started to spiral. I had gone from successful, confident, and connected to someone I didn't recognise – isolated.
By May of the same year, I walked down my main street, for the 4th or 5th time that day, desperately seeking someone to talk to. I felt so ashamed, so embarrassed and my stomach sunk, at every passing stranger who smiled but didn't stop, for the little baby gripping my sides in her baby carrier as I felt myself slipping away.

It's easy to assume that people who look and sound confident are okay. However research tells us that we suffer alone – we don't ask for help. Up to 80% of women experience emotional distress postpartum.*
Like me, many new parents seek people who will understand.

This is why I created Village. Village is the tool I wish I'd had.

Connection through mentorship has the ability to increase overall wellbeing, increase productivity and staff retention, saving millions of dollars every year.

The Village Foundation was a finalist in the eChallenge, National finalist for Pitch@Palace, and is supported by an excellent team of industry professionals. We work with innovative and progressive companies who strive to change the landscape for mental health in industry, and the community.

Today our workplace is our village. As an increasing amount of us combine work and family, it's on all of us to take care of the foundations – then everyone wins. The cost of anything less is far more than monetary.

Tiffany

*Ussher, 2010.

PARENTS AT WORK

CODEFISH STUDIO
CONCEPT • DESIGN • DEVELOPMENT

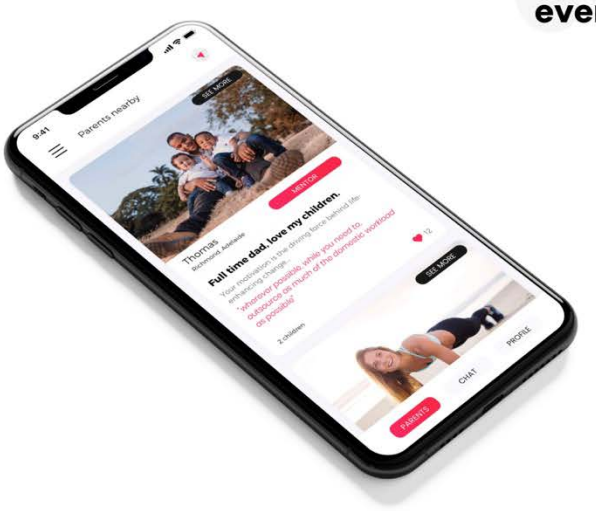
THE NEXT STEP

If your organisation is ready to create a supportive environment for parents and save thousands of dollars, then contact us today and we can arrange a time to discuss what you need, and how your people can best be supported. Like new parents returning to work, each organisation will have different needs and we deliver tailored programs to address those needs, so that you can deliver the same to your people.
We look forward to working with you.

It takes a village to raise a child and yet for many modern working parents that feeling of being connected to a community and workplace that supports them to raise a happy, healthy family is missing. The Village Foundation provides parents with an instant online connection to a mentor network that helps parents' return to work, that's why Parents At Work is proud to partner with Village.

Emma Walsh, CEO, Parents at work

By supporting the parent, everyone wins - the family, the infant, the company.



TIFFANY DE SOUSA MACHADO
Founder / CEO
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www.villagefoundationapp.com

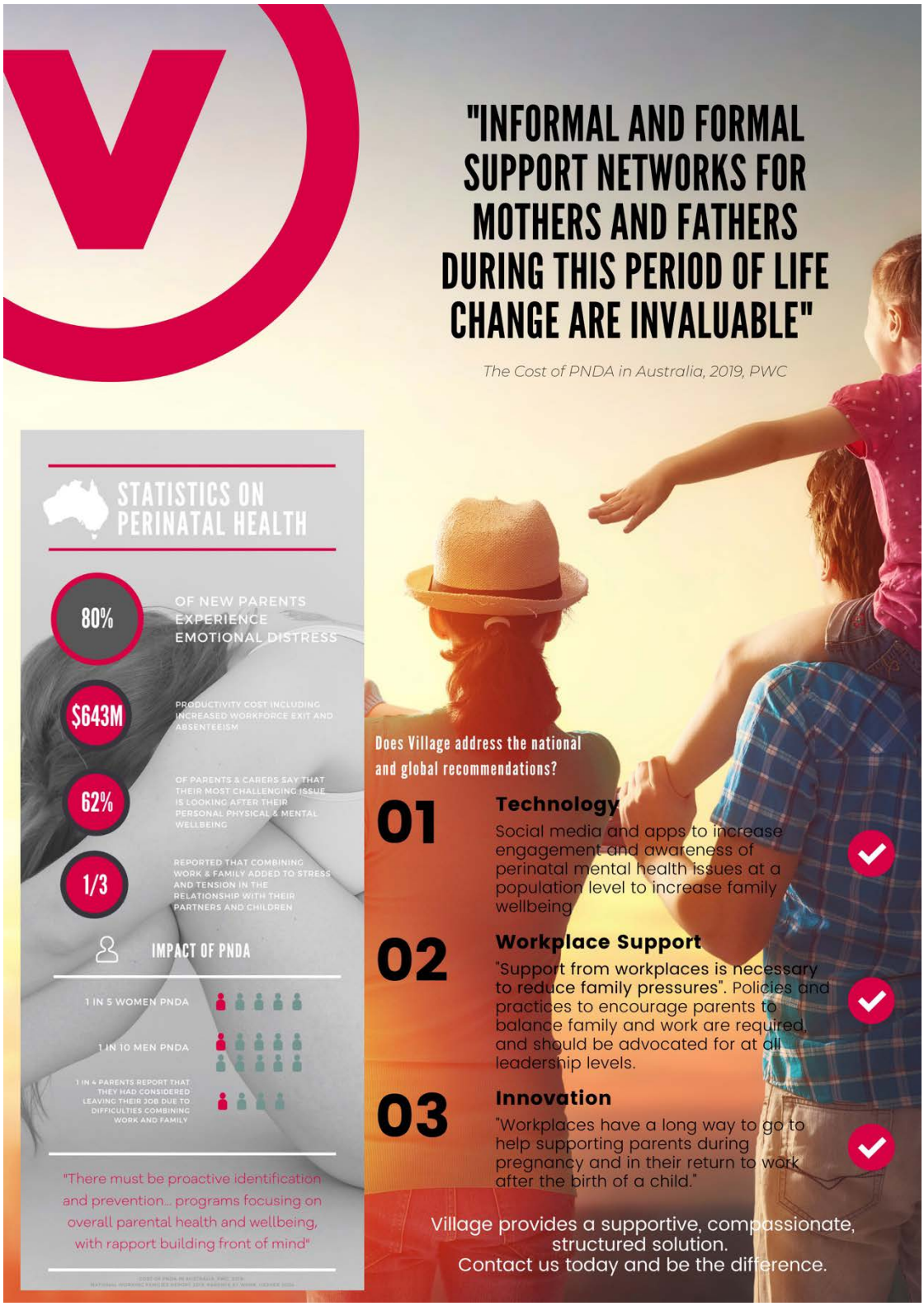
Village.

Download on the App Store

GET IT ON Google Play

www.villagefoundationapp.com

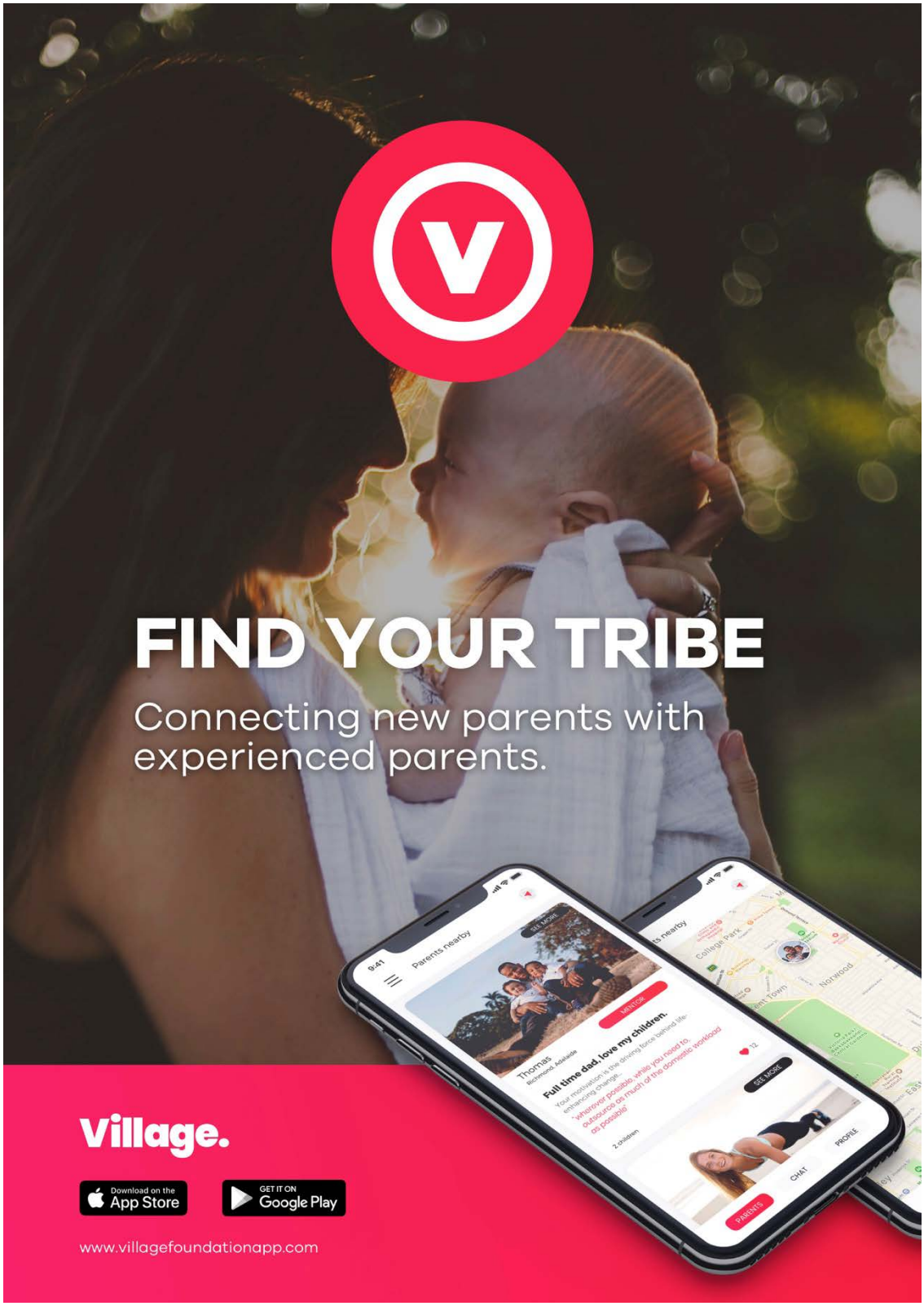
The Village Foundation Solution




Excerpts from the National Working Families Report 2019, and The Cost of Perinatal Depression and Anxiety in Australia Report 2019.
"Returning to work after a period of parental leave is a challenging and difficult time. Australians report feeling fatigued, stressed, anxious and depressed as a result of trying to balance work and family"
"There are barriers to men's access to paid parental leave & flexible work options, and social attitudes that make it challenging for men to ask for and take these support mechanisms."
"Women feel unsupported in returning to work and having access to the same opportunities as colleagues who have not been on parental leave"
"Parents and carers across Australia are finding it difficult to balance their work and family commitments and report their personal wellbeing and family relationships suffeer as a result"
"Employees want to work for organisations that recognise and support their outside of work responsibilities"
"When employees are adequately supported to meet these dual commitments their ability to thrive increases - this is good for families, business and society"
"Employers must be willing to confront and tackle stigma...associated with caring for children. This means a workplace that is inclusive and respectful of the fact employees have both work and family commitments"
36% of respondents said Role-models, Family- friendly champions and Leaders would help them balance work and home. Less than 20% of parents kept in touch with employers during leave.
"The future of women's wellbeing, career advancement and financial security remains at risk if we fail to invest in creating family friendly workplaces"
"Workplaces must make it more acceptable for men to lean in to caring by normalising men taking time to raise children"
"UNICEF is calling on all nations and organisations to invest in family-friendly policies and is urging government and business to take more action"
For the full reports visit www.parentsatwork.com.au and www.gidgetfoundation.org.au

APPENDIX D

The Village Foundation Poster



APPENDIX E

Examples of The Village Foundation Newsletter

Village

A Snapshot of Village Life

FOUNDER DINNER

The Founder Dinner was great. Village did really well in terms of voting. Such a fun evening with some very impressive presenters and guests! As the only female founder presenting in a room (almost) full of men, the feedback was fantastic!

VOGUE CODES

Attended the Vogue Codes women in STEM breakfast where we heard from some amazing panelists. Next week Tiffany will be included in Vogue Codes online STEM campaign. Link to come...

WESTPAC MEDIA

Last week Westpac released a national social media campaign featuring Village. https://youtu.be/gznH1TmW6bo

APPENDIX F

Example of Weekly Client Emails

Dear Mentors,

Tuesday 30th July is the **International Day of Friendship**. When I think back to having my daughter all those years ago, it was my friends who made all the difference to my day. Whether they brought me a meal or just popped by to check in on me, each and every visit was cherished. Some days it was the difference between tears of despair and tears of joy.

Research tells us that its these casual and light-hearted catch ups that can prevent a new parent from heading into despair.

This week, I encourage you to reach out to one new parent who you've connected with via Village and catch up for a coffee. Whether they are an exisiting friend or a friend waiting to be made, asking how they are and sharing a cup of tea will certainly add to their day, and yours.

Happy Friendship Day!

Remember to log on your Connect Calendar.

Tiffany x

P.S. You're always welcome to connect with me via the App

APPENDIX G

Media Coverage

SA Life magazine, 2021

Kids & Family

It takes a village

From postnatal depression to the empowerment of other parents, one Adelaide woman has taken the very worst time in her life and turned it into a lifeline for others.

Words Zoe Rice

It's a decade on, but Tiffany De Sousa Machado is still unashamedly emotional as she speaks about her struggles as a new mother.

Tiffany, now a mum of two, traversed some of the darkest times in her life, emerging with a light to shine for others on the same path she once walked.

She's told the story many times, but even now as she sits in the middle of a King William Road cafe, tears quickly build up and spill over as she recalls the feeling of utter desperation and isolation.

It was when Tiffany's daughter Faith was two-and-a-half years old that Tiffany experienced a moment that finally brought into focus the battle with postnatal depression she was waging – a battle she hadn't even admitted to herself.

"I was walking down the street and realised how desperate I was for someone to talk to me; I was lingering around hoping someone would," Tiffany says.

"That feeling of being really pathetic still really gets me after all these years – Faith's now 10.

"If I'm really honest, the hardest part was feeling like a fool because I thought people would step up and help me and, when they didn't, I felt rejected – but through no fault of theirs."

Suffering from a bleeding disorder, Tiffany's chances of conceiving were low. After four years of yearning, Faith was her miracle baby.

"I was bleeding pretty much every day for three years, to the point where I'd spend a few days every month getting blood and iron transfusions. In that time, even though I desperately wanted a child, I physically couldn't have one. During those three years, I had built up the expectation of what it would mean to be a mother, more so than normal because it was so out of reach and so desperately wanted it," she says.

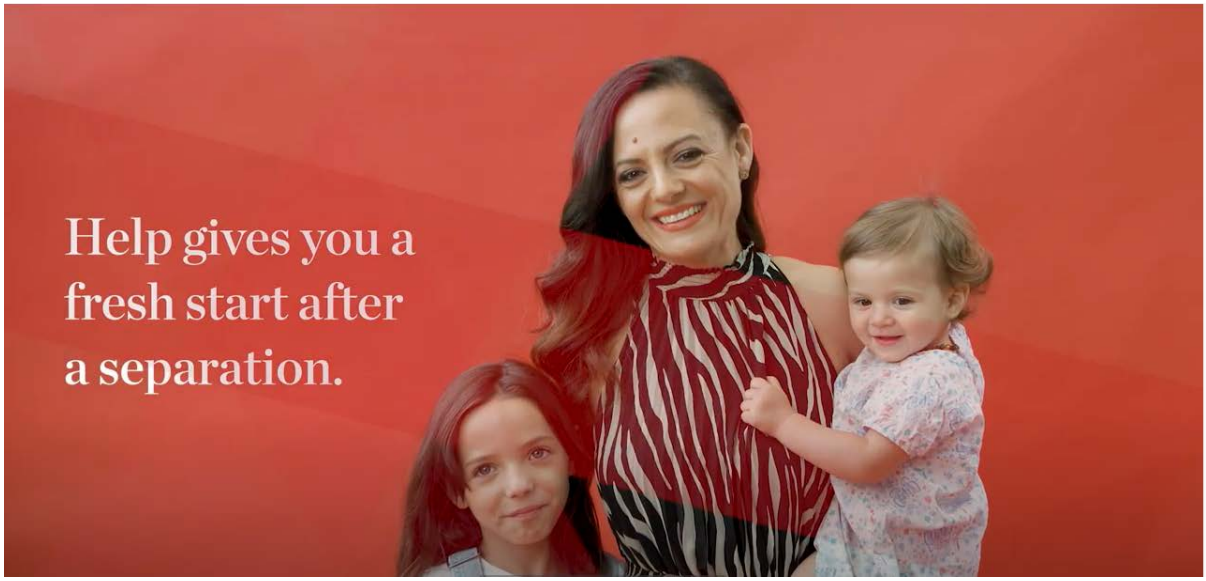
On top of that, the pressure was heightened because Tiffany had promised her mother, on her deathbed, that she would have the children her mother had always wanted her to have.

"It meant so much to me in terms of my mum and there was a of this added emotional burden on it, which is really dangerous, and I definitely own that part of my postnatal depression – all of that expectation versus reality."

Once Faith came along, it was difficult for Tiffany to find the soci support needed to cope. She lived on a farm, had few friends in the same position and found mother's group to be horribly unhelpful, to the point of leaving in tears each time, but still going every week because it was the only company she had. Tiffany didn't realise she could have postnatal depression until her father suggested it.

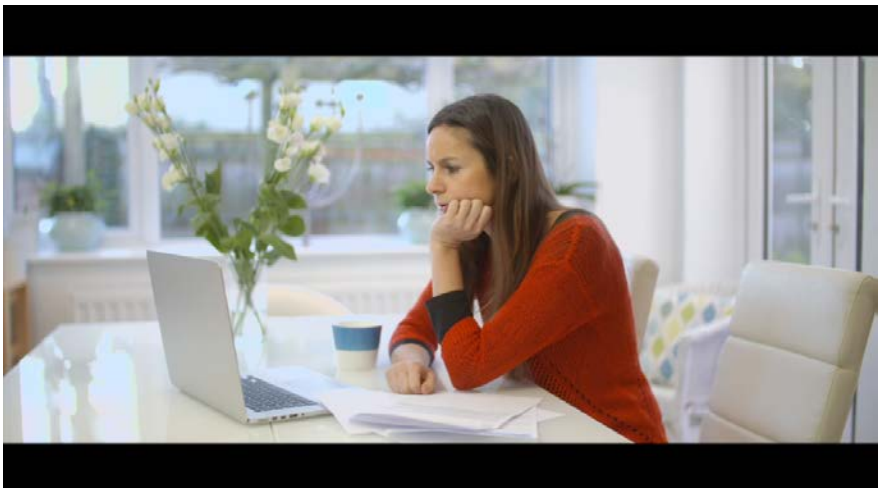
"I was appalled! I thought, 'I'm not that person'," Tiffany says.

Westpac Social Media Campaign



Vogue Codes

Appearance on Ticker TV



Podcast Interview

Other Media

WESTPAC BIOGRAPHY *'Find out more about Tiffany as Westpac Future Leader'*

WESTPAC STORY *'The signs were everywhere, but I didn't see them'*

THE ADVERTISER *'App lets parents share the joy, pain'*

RUBY CONNECTION *'Postpartum Distress: Westpac Scholar Explores New Themes'*

THE ADVERTISER *'SA Future Leader has used her experience of PPD to educate others'*

MAMAMIA' *Life After PPD'*

LUMEN *'Challenging Cultural Norms'*

RUBY CONNECTION *'Future Leader tackles PPD in the community'*

APPENDIX H

Keynote Speech for International Women's Day #BalanceforBetter

Good afternoon everyone, I would like to Acknowledge that the land we meet on today is the traditional lands for the Kaurna people and pay my respects to their spiritual relationship with their Country. I also acknowledge the Kaurna people as the traditional custodians of the Adelaide region and today I would especially like to acknowledge the women of the Kaurna people, and pay my respects to them for their wisdom and spiritual connections to the land and each other.

It is an honour and my absolute pleasure to be speaking with you today for International Women's Day, as we focus on this year's theme, #Balanceforbetter. As a PHD candidate and student, as a new business owner, as a partner, as a workshop facilitator and as a mother, I feel that balance, is certainly worthy of our attention.

Its easy to talk about balance and how important it is conceptually, but Id like to share a personal story about balance, or rather a lack of balance. 8 years ago, on the 11th of February – I gave birth to my beautiful first daughter, Faith. In that moment, in her utter perfection when I looked down at her, and as I breathed in her scent and kissed her head, I knew I was never going to be the same. A perfectionist by nature I had read everything. I had studied it all and I had plans for this to be perfect. I held her every moment of the day. I wore her like a little koala and as she clung to my sides in her carrier, she would look up at me with big blue eyes and I would sing to her as we walked our gorgeous treelined streets. I played her beautiful music, I ate the right foods, I responded to each cry and was more than hesitant to leave her with anyone, including her dad. I was trying to be the perfect mother. I thought it was my role alone to be her everything.

Fast forward 6 months. Im walking down my main street as I did every day. It was now winter, I could hear and feel the leaves under my boots and the cold air biting at my face. As I held her little feet in my hands I could see someone coming towards us. It was an older woman, she was wearing a knitted beanie and carrying a bag from the local organic market where I was headed. I noticed my heart start to race and I heard myself inside my mind desperately cry out, 'please stop'. Please stop and hold my baby. Please stop and talk to me. Spend time with me. I need a break, I need some connection, I need to use my brain.

My heart sank as the stranger smiled, but didn't stop, and I looked down at Faith staring at me and the tears welled up as I realised that I, and my life, were slipping

away. I was filled with shame that I couldn't escape and I realised I had given so much of me – every moment, every thought, every piece of energy to this beautiful baby trying to be perfect that I had lost everything. My relationship, my self-identity, my work, my body, my freedom, and my mind.

My lack of balance had effected not only my mental health but my husbands and my daughters. All she wanted was a happy healthy mum. I thought by giving her all of me, that I was giving her everything. What I lacked was balance. My lack of balance would have an effect on my workplace as I re-entered after leave. It would affect my focus, my performance, my productivity. How could it not? And I was quick to blame those around me for how I was feeling – for the way our culture was set up – for not having any support. I looked outside of myself for all the answers to how this could've happened.

This week will bring a lot of focus around the pay gap, around gender equality in the workplace, discrimination, parental leave. Women roles and rights and have come a long way from a very imbalanced place, and the pendulum has begun to swing. In my research and in my business Im seeing the strong push and acceptance of shared parental leave, of flexible working arrangements, of family focused policy. We have incredible CEOs like Brian Hartzer who see imbalance and say "fix it". We have worldwide movements standing for the voice of women, and all these things are moving in the right direction. But maybe there's something each of us can do, to hasten this shift. Maybe there was something I could've done. Last night I facilitated an event for women around empowerment and one of the topics was about personal responsibility, and how for real change to occur, we need to focus on ourselves. That change, starts from within. We have all heard the expression, be the change you wish to see in the world. Mother Teresa put it slightly differently saying if you want to change the world, go home and love your family…the essence of these quotes is the same. For anything real to change for us out here, in the workplace and in the world, we need to start from within. For a more balanced world, we need more balanced selves. We need to demonstrate a willingness and acceptance of all aspects of who we are. For me, 8 years ago, I needed to understand that I was enough for my baby, just the way I was. I also needed to acknowledge the things that I needed, in order to stay healthy.

As women many of us have learned to fight, to hang on, to grip tighter, – to strive to have and be it all. The literature in psychology certainly supports this. Rather than

asking for help or stepping back women simply try harder. The research I conducted in Sweden for my PhD centred around parental support structures and policies and as I was immersed into their culture I learned many things and saw different ways of being and understanding how to balance parenthood and work. I learned about how critical social support is in all areas and how the culture focuses on the real integration of family into work-life. All of these policies were in place to support this. But the real difference was in the men and women and their individual expression and expectations. The biggest lesson, was that as mothers, we need to learn to let go. Let go of control, let go of the details, let go of the belief that parenting is primarily women's work, that we know how to do it better. 95% of primary parental leave (outside of the public-sector) is taken by women and women spend almost three times as much time taking care of children each day, compared to men. While there are complex reasons and policies around this statistic, if we come back to the inner expression of this and how we might effect change from within, as women we need let go of the idea that maternal instincts magically kick in or even dare I say, exist. If like the Swedes, we embrace the idea that parenthood is a learned, shared, skill and that as such, our partners, our community and our workplaces can learn it and shape how we combine our lives, then we open up the possibilities. We can let go of control and perfectionism in the workplace by sharing the experience of being human and having to balance our hearts and minds with each other, we can negotiate the details we need for balance, we can be open and safe to express our needs, our experiences. We let go of the need to be perfect, to be hard and tough and able all the time to handle the entire load that is to a large degree not only expected by society but ourselves – we make up society. When we change our internal expectations we change what is expected out there. With a balanced approach to ourselves – with strength and softness, with a desire to combine success with the skills to stop and take time for self-care, for delegation, then we are balanced in how we present ourselves to the world. We are honest, authentic… we know we have strength – we have resolve, it's how we have come so far and achieve so much. The challenge is in presenting the softness, the vulnerability, the sorrow at the lengths we are going to to have and be it all. To share the good but also be open in the cost it can have on us.

A more balanced individual equals a more balanced home. And this is better for individual mental health, for infant and child development and the mental wellbeing of our loved ones.

A more balanced home equals a more balanced workplace. And this is better for performance, for team cohesion, for productivity.
A more balanced workplace equals a more balanced society. And this is better for policy and structural design of the way we shape our future.
As women we are the role models for the little girls who look to us for their ways of being in this world. We are their inner voice which shapes their future voice. When we present a balanced self, a woman with boundaries around what is acceptable and normal in the home and in the workplace, around the time we allocate for self-care and the expectations we place on ourselves, we not only provide ourselves with choice and freedom, but we give them this gift also. We teach them, in the most powerful way, by demonstration, that they matter. That they are worthy of balance in all areas of their lives. and that they can create that. And what a gift to give the strong, capable perfectly imperfect women of the future, to teach them that indeed, for all these reasons and so many more, that balance is better.
My company Village is about creating connections so that within our workplaces we find a balance between our working selves and our family selves. When I blend what I have learned from my research, from starting a business, from having a 1 year old and an 8 year old, I can attest that balance for better, works.
I came home from Sweden and said to my partner, "I can't un-see what I've seen, so strap yourself in". I then set about letting go…. This is a very tough thing to do for a micromanaging control freak.
Today, in what is a vastly differently experience to my first time as a mum, I really share parenting, I trust that my partner is just as capable and able to do what I do, I trust that this balance and the positive effect this has on me, flows through to my daughter, Rumi so that these habits become ingrained in her. I watch the increased bond between him and her and see how each of them are gaining from me having stepped back and let them work it out. I allow myself the time to work, to workout, to explore my mind and do the things that empower me, so that the time I do spend with hr, I am giving from a full cup. The time is less, but it is richer and fuller. This is what I need. It's not for everyone, but there-in lies the challenge – what do you need?
The time of a one size fits all approach is gone. It's time to co-create – with our family, our community and our workplaces - the life we need to be able to do the things we have to do, we choose to do.

With Village I hope to demonstrate through education, through connecting parents, through lived experience, and by putting into practise these ideas, that for me, my family, for my business and for all of our futures as women, that support and openness does not signify weakness but strength. That by standing for our needs as parents, and the needs of our families we are demonstrating strong boundaries and saying that rather than doing more, what is often needed, is in fact to do less, to let go. We need to be honest about how exhausting it can be combining two roles into the time allocation of one. Today our workplace is our village, and we need to be able to work collaboratively, to be supported in being healthy, productive and happy.

When we as women stand together and embody these principles we are declaring that balance for better, is not only crucial for individual and societal wellbeing, but the only mentally and emotionally sustainable way forward.

APPENDIX I

Poster - Health Psychology Conference

THE NEED FOR INDIVIDUALISED SUPPORT: A NARRATIVE REVIEW OF MOTHERS' PERCEPTIONS OF POSTPARTUM CARE

Tiffany De Sousa Machado*, Anna Chur-Hansen, Clemence Due
School of Psychology, Faculty of Health and Medical Sciences, University of Adelaide
*Corresponding Author: tiffany.desousamachado@adelaide.edu.au

THE UNIVERSITY of ADELAIDE

BACKGROUND

- Perinatal Anxiety and Depression (PND) includes depressive and anxiety disorders which occur during the perinatal period, the more severe of which can affect approximately 20% of women
- The review question is: what are first time mothers' perceptions of social support and what barriers do they face in gaining that support?
- Social support promotes well-being in the postnatal period
- Social support may be provided by partners, family, peers, colleagues, and others from within the community
- Support is offered in myriad ways, from various sources (see diagram 1)

"You want a mum, but not your mum"

LETOURNEAU ET AL., 2007, P. 445

METHOD

- Literature search across PsychInfo, Pubmed, Embase, Scopus and Google Scholar for terms related to postpartum social support.
- 31 studies were located utilising quantitative, qualitative and systematic review methodologies.
- Themes were identified

FINDINGS

- Themes were identified including 1) The Need for Informal Support and 2) Inadequate Professional Care
- These themes spoke to the insufficiencies and dissatisfaction some women found with various aspects of social support.
- Women frequently express dissatisfaction with both formal and informal supports in the postpartum period
- Women refrain from help-seeking due to personal and societal pressures to be seen as capable and coping.
- Current support offerings are not addressing individualised needs and circumstances.

RECOMMENDATIONS

- Empathetic listening by health professionals,
- Increased home-based services,
- Individualised care and providing community resources
- Informal, experienced support

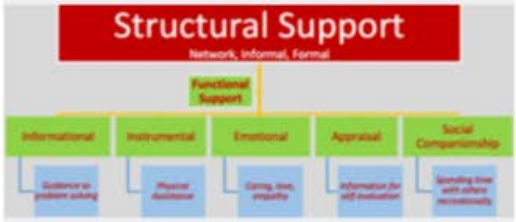


Diagram 1

CONCLUSION

- Each new mother faces different challenges, has differing needs and requires customised, individual support from various sources of social support.