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(Re)storying postpartum psychosis:

A Critical Narrative Analysis of women's stories of postnatal distress

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Tables and Figures

Abbreviations

CNA	Critical Narrative Analysis
MBU	Mother and Baby Unit
APP	Action on Postpartum Psychosis
APNI	The Association for Post-natal Illness
NICE	The National Institute for Health and Care Excellence
IPA	Interpretative Phenomenological Analysis
FDA	Foucauldian Discourse Analysis
ECT	Electroconvulsive therapy
PLEs	Psychotic-like experiences
PND	Postnatal depression
PPP	Postpartum Psychosis

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Abstract

Research indicates that postpartum psychosis is extremely rare, occurring in approximately one out of every 1000 births (Sit et al., 2006). Nevertheless, the postnatal period is considered a time in which women experience the greatest probability of psychosis, with research suggesting that women are 20-30 times more likely to be hospitalised after childbirth that at any other point in their lives (Twomey, 2009). Whilst there is a growing field of psychologically-informed research into postnatal distress more broadly, research into postpartum psychosis continues to be dominated by a biomedical framework. As a result, psychologically-informed understandings and interventions are markedly lacking, as reflected in the literature and in recommended guidelines for clinical practice (NICE, 2014). This research speaks to this gap in exploring the subjective experience of postpartum psychosis through women's narratives. Using a feminist social constructionist approach, it also intends to examine critically the role of broader discourses in shaping how women make sense of, and narrate, their experiences of postnatal distress.

In this research, five women told their stories of postpartum psychosis, conveying a rich and profound sense of the experience of postnatal distress. Participants' stories were analysed using Critical Narrative Analysis (Langdridge, 2007). The following identity constructions were proposed: 'a lost self'; 'a medicalised self'; 'a transformed self' and 'the good mother'. Tensions around agency and disempowerment were also explored in the context of identity work. Five main themes were noted across participants' narratives: 'explanatory frameworks'; 'power'; 'the multidimensional nature of family support'; 'stigma' and 'recovery'. Finally, a biomedical discourse of 'mental illness' and a canonical narrative of 'good' motherhood were problematised from a feminist perspective in a critical hermeneutic of suspicion, with the suggestion

that participants navigate discursive constructions of motherhood and mental health in restricted yet agentic ways.

This research builds upon a small body of literature that explores the subjective experience of postpartum psychosis. It is, to date, the only research that has considered the narrative construction of postpartum psychosis from a counselling psychology perspective. This research points to an unaddressed need for more considered and specific support for women experiencing this kind of postnatal distress, along with their partners and family members. It also raises important questions regarding the nature and timing of information provision for women experiencing these kinds of difficulties, and points to the importance of future research exploring women’s relationship with psychiatric diagnosis in the context of postpartum psychosis. Finally, this research underscores the importance of integrating discursive representations of motherhood in psychologically-informed interventions for postpartum psychosis, particularly if and when women’s experiences deviate from normative representations.

Chapter One

Introduction

1.0. Background to the research: Why postpartum psychosis?

My own connection to this topic partly arises from the impact of growing up with a mum who experienced psychological difficulties that, at times, took the form of what might be described as psychosis. The family narrative traced the origin of these difficulties to the early postpartum period after my older brother was born. Whilst as a child, I struggled to reconcile what felt like different versions of my mum, as an adult, I started to reflect upon the broader context in which women become mothers and developed a longstanding interest in the psychological transition to motherhood and in maternal distress. This left me reflecting upon motherhood as a psychological and relational context in which unresolved trauma may re-emerge in destabilising ways. I was struck that we, as a family, did not seem able to develop a coherent, meaningful, narrative that captured the complexity of what my mum, and the whole family system, experienced in those moments, instead relying on biomedical explanations that seemed to leave so much out of the picture. This left me wondering about how storytelling and sense making might be disrupted, or creatively negotiated in the context of maternal distress, and the role of broader discourses in shaping this process.

These questions have arisen in the context of a developing theoretical interest in the relationship between discourse and subjectivity, and more specifically, in the ways in which identity claims may be negotiated or reworked in the context of psychological distress. This research is thus a coming together of my own personal experiences and a related set of theoretical interests in questions of the maternal, encompassing subjectivity, language, memory and trauma.

1.1. Postnatal distress in the form of psychosis

This research inquires into the experiences and stories of women who have experienced psychological disturbance in early motherhood that corresponds with a presentation of postpartum psychosis. Postpartum psychosis falls within a broad category of maternal mood disturbance following childbirth, encompassing what has been described as maternity ‘blues’ and postpartum depression (Sharma & Sommerdyk, 2014). Within the psychiatric literature, it is conceptualised as taking three main presenting forms: mania, severe depression with accompanying delusions or confusion, or acute polymorphic psychosis (Brockington, 2004), with women usually demonstrating a combination of what has been described as mood changes, confused thinking, paranoia, delusions, and ‘grossly disorganised behaviour that represent a dramatic change from her previous functioning’ (Sit et al., 2006, p.354). Women may also experience derealisation, disorientation and depersonalisation (Bergink et al., 2016).

Research indicates that the phenomenon of postpartum psychosis is extremely rare: it occurs in approximately one to two of every 1000 births (Brockington, 2004; Sit et al., 2006), purportedly arising with a rapid onset in the first two to four weeks post-delivery (Sit et al., 2006). Despite its rare occurrence, psychosis in the postnatal period is approached as a serious and concerning disturbance in mental health, and with connotations of maternal suicide (Doucet et al., 2011) and infanticide (Spinelli, 2009), it is seen as a psychiatric emergency (Heron et al., 2012), often resulting in hospitalisation of the mother (Sharma & Sommerdyk, 2014).

A fuller exploration of the ways in which this form of postnatal distress has been conceptualised from psychiatric, psychological and feminist perspectives will be offered in a critical review of the literature in Chapter Two.

1.2. Some reflections on language

In using the term postpartum psychosis, I do not mean to suggest an uncritical adherence to a medical model and corresponding positivist epistemology. However, firstly, it felt important to use this particular descriptor when advertising my research as I was particularly interested in the stories of women who had experienced what is commonly described as psychosis in the postnatal period. Postpartum psychosis is a term that many women use to describe these kinds of experiences. The main campaigning and support organisations also use this term; for instance, the main national charity for women and families affected by these kinds of difficulties is called Action on Postpartum Psychosis (APP).

Secondly, this research is informed by a critical interest in how women use language to convey and make sense of their experiences. It, therefore, felt important to draw upon a broader psychiatric discourse that women themselves may use, bringing these diagnostic descriptors into conversations with research participants. However, in my writing, I have endeavoured to use alternative descriptions where possible, using the term postpartum psychosis alongside descriptors such as postnatal distress and early maternal distress.

Debates around diagnosis are explored more fully in subsequent sections but for now, I acknowledge the tensions between validating and pathologising what may be considered completely understandable reactions to adverse experiences (Ussher, 2011).

1.3. Research aims and rationale

The aim of this research was to explore the ways in which women made sense of their subjective experiences of early maternal distress through narrative. Part of my research interest also related to understanding the ways in which broader discursive constructions of mental health, femininity and motherhood may shape the ways in which women relate to, and narrate, their experiences. Finally, an important question that I held in mind throughout this research was how women can be supported in meaningful and helpful ways when experiencing distress in the postnatal period.

The postnatal period is the time in which women experience the greatest probability of psychosis: it has been estimated that the risk of experiencing psychosis in this period is 22% higher than in the two years preceding delivery (del Corral Serrano, 2015). Research also indicates that women are 20-30 times more likely to be hospitalised for an episode of psychosis in the first month after childbirth than at any other point in their lives (Twomey, 2009). These statistics underscore the critical importance of understanding women’s experiences in the postnatal period. However, as will be reflected in my review of the literature, research into postpartum psychosis continues to be dominated by a biomedical framework that pays little attention to women’s psychological experiences, as well as to psychosocial factors (Brown, 2021). It has also been argued that developing a more comprehensive, nuanced, understanding of psychosis in the postnatal period could also have a springboard effect to better understanding psychosis in general (del Corral Serrano, 2015), further underscoring the importance of research into this area.

1.4. Outline of thesis

The following chapter comprises a critical review of the literature, encompassing biomedical and psychologically-informed understandings of psychosis in the postnatal period, as well as feminist scholarship on maternal subjectivity and broader discursive constructions of motherhood. My review of the literature is followed by a methodology chapter, in which I outline the main methodological considerations of this research along with a detailed overview of the procedures that I followed in analysing the data. The following chapter comprises an analysis of the data using Critical Narrative Analysis (CNA). In this chapter, I present a brief overview of each participant’s narrative, including tone and rhetorical functioning. I then explore identity work across the narratives, as well as the main thematic priorities. The analysis chapter concludes with a critical hermeneutics of suspicion in which I interrogate the data using a feminist lens. A discussion chapter follows in which findings from this research are situated within broader research into maternal distress and psychosis. Suggested directions for future research and clinical implications are also discussed within this chapter. Questions concerning reflexivity are interwoven throughout; however, the final chapter of this thesis concerns final reflections on the research findings and the research process.

Chapter Two

Literature Review

2.0. Overview

This chapter comprises a critical review of the literature on postnatal distress in the form of psychosis, including discussion of psychiatric, psychological and feminist perspectives. This will also include a review of the ways in which female violence has been conceptualised, as well as maternal ambivalence. A review of the research into women's phenomenological experiences of postpartum psychosis will be offered, alongside consideration of research into women's stories of postnatal distress. Finally, this chapter will conclude by restating the rationale for this particular research in the context of wider literature.

It is worth noting that I encountered the literature as a divergent, fragmented body of research, comprising distinct discourses and conceptualisations of postnatal distress. This is reflected in the way that I have structured my literature review.

2.1. Conceptualising postpartum psychosis from a psychiatric viewpoint: Diagnostic classification and aetiological considerations

A review of the psychiatric literature on postpartum psychosis illustrates that the conceptualisation of this kind of presentation is fraught with contention and unresolved questions. One of the areas of contention concerns the diagnostic classification of postpartum psychosis: there is an ongoing debate within psychiatry concerning whether postpartum psychosis should be accorded a separate diagnostic category or be considered a manifestation of another psychiatric diagnosis (Sharma & Sommerdyk, 2014; Sit et al., 2006). These two theoretical positions trace back to the nineteenth century, with the latter being reflected in current diagnostic classification systems (del Corral Serrano, 2015). A seemingly central argument revolves around whether postpartum psychosis may be a manifestation of bipolar disorder: proponents of this argument draw upon research that indicates an increased risk of experiencing psychosis in the postnatal period in women with have previously been diagnosed with bipolar disorder (Di Florio et al., 2013; Jones et al., 2014; Lewis et al., 2016). However, postpartum psychosis has also been conceptualised as comprising two distinct presentations: an isolated affective psychosis in the postpartum period or a form of postpartum psychosis that reoccurs outside of this period and that may be conceptualised as a manifestation of a 'bipolar mood disorder' (Bergink et al., 2016).

In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013), postpartum psychosis is subsumed within other diagnostic classifications as the specifier, 'with peripartum onset', is applied to a number of different diagnoses, reflecting the view that postpartum psychosis constitutes a manifestation of another psychiatric disorder (del Corral Serrano, 2015; Sharma & Sommerdyk, 2014). Whilst in the ICD11, psychosis in the postpartum period is listed under the classification of mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, it lacks a clear outline of its specific features (del Corral Serrano, 2015).

Correspondingly, numerous studies from the field of psychiatry have examined the aetiology of postpartum psychosis, linking this to sleep deprivation (Bilszta et al., 2010; Lewis et al., 2016; Lewis et al. 2018; Sharma et al., 2004), hormonal fluctuations during pregnancy and childbirth (Sit et al., 2006), and immunological factors (Bergink et al. 2013; Bergink et al., 2014). Genetic factors have also been proposed, with research suggesting that women who have a family history of postpartum psychosis are at a greater risk of developing the condition (Jones & Craddock, 2011).

2.2. Recommended interventions

It has been argued that barriers to research, such as low incidence rates and high risks to mother and infant (Bergink et al. 2016), along with the rarity of the condition and lack of consensus regarding its diagnostic classification, have led to a relative paucity of evidence-based recommendations for the prevention and treatment of postpartum psychosis (Doucet et al., 2011). This is also reflected in the recommendations stated in the National Institute for Health and Clinical Excellence (NICE) (2014) guidance on antenatal and postnatal mental health. NICE recommendations for the treatment of psychosis in the postnatal period include psychotropic medication and interventions for the mother and baby relationship; however, the specific nature of these interventions is not specified (NICE, 2014). Whilst there is little focus on interventions specifically for postpartum psychosis, it is stated that any indication of severe psychological disturbance in the perinatal period, which would include postpartum psychosis, also requires a referral to specialist perinatal mental health services for immediate assessment and treatment (NICE, 2014). NICE guidelines state that specialist perinatal community services and inpatient Mother and Baby Units (MBUs) should be available to all mothers based on need. However, access varies considerably across localities (NICE, 2015), with Wales having just one MBU and Northern Ireland having none at all (Mongan et al., 2021).

NICE guidelines have also been critiqued for creating an unhelpful illusion of neatness (Court et al., 2017) and for subscribing to a predominantly medical model of treatment (Hemsley, 2013). Indeed, as indicated, this is reflected in the psychiatric literature, which mainly advocates psychopharmacological treatment interventions (Murray, 1990), hormone therapy (Ahokas et al., 2000; Huang et al., 2008) and electroconvulsive therapy for postpartum psychosis (Forray & Ostroff, 2007; Reed et al., 1999). Psychological interventions are markedly lacking. This is also reflected in the dearth of psychologically-informed explanations of postpartum psychosis, as discussed below.

2.3. Psychologically-informed explanations of postpartum psychosis

In contrast to research from a psychiatric approach, there is a notable lack of studies from the field of psychology that have explored the possible causes and presentation of postnatal distress in the form of psychosis. Indeed, it has been argued that the overriding emphasis on genetic and physiological factors under a dominant biological paradigm has contributed to a lack of attention to the potential role of psychological factors, such as trauma, in the development of these kinds of experiences (Kennedy & Tripodi, 2015).

However, whilst not specifically related to postpartum psychosis, there is a growing body of research that examines the relationship between trauma, psychosocial factors and psychosis (Bendall et al., 2008; Bendall et al., 2010; Johnstone, 2009; Morgan & Fisher, 2007; Read et al., 2005; Varese et al., 2012). Contemporary research has also started to explore interactions between psychosocial adversities and epigenetic processes in the development of psychosis, bringing diverse fields together (Read et al., 2009).

In the context of motherhood, there are a number of studies that have explored the potential implications of childhood abuse on women's experiences of pregnancy and parenting, and in the development of perinatal depression (Buist & Janson, 2001; Cohen, 1995; Fitzgerald et al., 2005; Leeners et al.,2006; Wosu et al., 2015). It has also been suggested that the bodily-based experiences of pregnancy and childbirth, potentially involving a loss of control and feelings of invasion, may pose particular challenges for women who have experienced childhood abuse, especially sexual abuse (Courtois & Riley, 1992; Jacobs, 1992; Johnston-Robledo & Barnack, 2004; Rhodes & Hutchinson, 1994). In their systematic review, Leeners et al. note that women with a history of childhood sexual abuse show a greater tendency towards stress, anxiety, suicidal ideation and dissociation during pregnancy, and that the somatic changes during pregnancy and childbirth may trigger memories of childhood sexual abuse (Leeners et al., 2006). Whilst far greater attention has been paid to the presentation of postnatal depression within the field of psychology, a study by Kennedy and Tripodi (2015) indicates a positive correlation between the severity of childhood abuse and the subsequent likelihood of developing psychosis in the postnatal period. The authors conclude that postpartum psychosis may represent an extreme, yet intelligible, response to the iterative bodily experience of reproduction, particularly for women who have experienced childhood sexual abuse (Kennedy & Tripodi, 2015). However, psychologically-informed considerations of the potential causes of early maternal distress in the form of psychosis continue to be lacking.

2.4. Psychoanalytic contributions

There is also a notable lack of contemporary research into postpartum psychosis from the field of psychoanalysis (Lucas, 2009). However, one recent contribution from a psychoanalytic perspective conceptualises postpartum psychosis as part of a spectrum of psychological disturbance after childbirth, as representing the most extreme cases of postnatal distress and as involving unconscious dynamics concerning a woman's relationship with her mother and self-representation (Lucas, 2018). This echoes psychoanalytic literature from a number of decades ago, which has theorised that unresolved unconscious fantasies and conflicts, internalised representations and a woman's own relationship to her mother, may all contribute to psychosis in the postpartum period (Markham, 1961; Rosberg & Karon, 1959; Sichel & Cepfer, 1974).

It has also been argued that whilst presentations of postpartum psychosis involving hospital admission are rare, incidents of what might be termed 'psychotic depression' in the postpartum period are much higher (Lucas, 2018). This has led to the suggestion that psychosis in the postnatal period may affect a greater number of women than currently recognised (Lucas, 2018), speaking to current debates regarding diagnostic classification of psychosis in the postnatal period and forms of intervention.

2.4.1. Intrapsychic processes in the transition to motherhood

Psychoanalytic contributions have paid greater attention to women's intrapsychic processes in the context of pregnancy and motherhood more broadly. For instance, this has been explored by Daniel Stern, who uses the term 'motherhood constellation' to describe what he conceptualises as a psychic reorganisation that takes place in response to the prospective reality of becoming a mother (Stern, 1998). This, he argues, centres around four main themes and corresponding tasks surrounding maternal capabilities: 'life-growth'; 'primary relatedness'; 'supporting matrix' and 'identity reorganisation' (Stern, 1998, pp.182-183). Stern proposes that several fears, wishes and feelings are connected to these tasks, such as a failure on the part of the mother to protect the infant, as well as fears around love for, and from, the infant (Stern, 1998). Stern's examination of the psychic reorganisation in pregnancy and early parenthood adds to psychoanalytic literature exploring the internal changes that women experience during pregnancy (Bibring et al., 1961), and that explore the implications of childhood experiences and internalised parental representations on the developing relationship between parent and infant (Fraiberg et al., 1975; Slade & Cohen, 1996).

More recently, Setterberg explored women's imaginings about their unborn child (Setterberg, 2017). A number of themes emerged in her interviews with mothers, including concerns around societal expectations of mothering and negative representations of the foetus, such as perceived aggression or devourment (Setterberg, 2017). Setterberg posits that women's reflective functioning and imaginings are shaped by their own childhood experiences of being cared for, thereby placing importance on early parent-infant relationships for women's intrapsychic processes during pregnancy (Setterberg, 2017). Culturally-specific defences, such as repression of affect, may, she argues, also increase the risk of psychological difficulties in the perinatal period due to corresponding difficulties with affect regulation (Setterberg, 2017). Setterberg also posits that the shift in family roles that women experience during this period, from being a child to becoming a parent, may induce a depressive state that comes through in expressions of maternal ambivalence and in an idealised or devalued relationships with the developing foetus (Setterberg, 2017). The conflicts that this may generate, such as rivalry between the mother and foetal representation, may, she suggests, induce feelings of guilt and shame in the mother, contributing to maternal distress (Setterberg, 2017).

2.4.2. Maternal ambivalence

Rozsika Parker also explores maternal guilt, conceptualising this as predominantly arising from difficulties in integrating the paradoxical and complicated feelings that arise in the experience of maternal ambivalence (Parker, 2005). Defining maternal ambivalence as ‘The experience shared variously by all mothers in which loving and hating feelings for their children exist side by side’ (Parker, 2005, p.1), she suggests that the cultural discomfort with these contradictory feelings hinders the creative potential of maternal ambivalence, as well as contributing to difficulties that women may experience in negotiating motherhood. Parker suggests that cultural representations of ‘good’ motherhood are not only becoming increasingly idealised concurrent with women’s increased mobility, but may also constitute a defence against the anxieties aroused by the idea of maternal ambivalence (Parker, 2005). This, she suggests, may also happen on an individual level as feelings of guilt may overwhelm a woman’s capacity to integrate the experience of maternal ambivalence, contributing to denial and undermining the creative potential inherent within these experiences (Parker, 2005). Thus, it is not maternal ambivalence in itself that is deemed problematic by Parker; rather, it is when this ambivalence feels unmanageable and needs to be disowned or denied (Parker, 2005).

Parker also argues that psychoanalytic representations of the maternal speak to a binary between the ‘containing’ mother and the mother that is at the mercy of unruly and destructive impulses (Parker, 2005). She argues that this reinforces problematic expectations and representations of motherhood (Parker, 2005). Deconstructing Winnicott’s notion of the ‘good mother’, she argues that in his appeals to a ‘natural’ maternal instinct, Winnicott has also contributed to a denial of maternal ambivalence (Parker, 2005), stating that: ‘The ‘natural’ is unnaturally associated with mother love not mother hate, so ambivalence will not be part of ‘natural’ mothering at all’ (Parker, 2005, p.69).

Drawing from her own experiences as a mother and from extensive clinical practice, Barbara Almond also examines maternal ambivalence, highlighting both the creative, constructive responses of women and those that may be considered destructive, such as feelings of self-hatred, helplessness and guilt (Almond, 2010). Maternal ambivalence, Almond argues, is inevitable and ubiquitous, yet deemed unacceptable, alarming and troublesome by wider culturally informed standards and expectations of what it means to be a ‘good mother’ (Almond, 2010). Almond suggests that concurrent with the growing idealisation of motherhood in Western society, changes to support networks and family constellations have added to the challenges of being a mother, again, with problematic implications for the experience and integration of maternal ambivalence (Almond, 2010).

2.5. Conceptualising female violence

It has also been argued that prevailing normative representations of femininity and motherhood preclude full consideration of the potential for female violence, particularly when enacted by mothers. In her work on the psychology of female violence, Anna Motz argues that there is a profound social denial and resistance to acknowledging the possibility and extent of violence in women and mothers (Motz, 2008). One of the most extreme, and shocking, forms of maternal violence is that of infanticide, a risk that has been heavily associated with postpartum psychosis (Spinelli, 2004). In her book, Motz argues against conceptualising infanticide as evidence of an extreme disturbance of mind; rather, she makes the case for recognising the possibility of female violence more broadly, detaching this from ‘mental illness’, stating: ‘It is essential to recognise the possibility of female violence, and its manifestation in violence against children in women who are not mentally ill, as well as in those who are’ (Motz, 2008, p.135).

Drawing on psychoanalytic theory, Welldon also makes the case for greater recognition of maternal violence, which she refers to as ‘perversion in motherhood’ (Welldon, 2004), whilst Spinelli (2004) highlights the difficulties that women may face in sharing thoughts and feelings that do not correspond to normative representations of motherhood. This, she argues, compounds the potential for female violence in mothers (Spinelli, 2004).

Whilst this clearly constitutes an important area of research, care must be taken not to replicate binary constructions of the maternal as an idealised or denigrated figure, or to, once more, lose sight of the complexities of maternal subjectivity in foregrounding psychopathology (Vissing, 2016). Furthermore, there is clearly a balance to be struck between acknowledging the risk of infanticide in the context of early maternal distress, so as to maximise support for mothers, and not overestimating risk, thereby resulting in an excessive use of medication or unnecessary prevention strategies (Gilden, 2021).

2.6. Feminist scholarship

The aforementioned psychoanalytic literature links to a broader field of feminist scholarship that contextualises women’s intrapsychic internalisations and representations within contemporary Western social and political conditions of motherhood (Raphael-Leff, 2010; Takseva, 2017). From a feminist perspective, idealised representations of motherhood, along with discourses that foreground the needs of the infant and that eradicate the maternal subject in her own right, pathologise deviations from the ‘good mother’, as well as the emotions that may accompany the transition to motherhood, such as loss and grief (Chodorow & Contratto, 1982; Nicolson, 1998; Raphael-Leff, 2010; Stone, 2012). From this perspective, it has been argued that, even in psychoanalysis, in which much attention has been paid to the maternal, the complexity of women’s internal struggles in motherhood continues to be missed (Kraemer, 1996). Susan Kraemer states that, as a result: ‘The questions of how the mother feels about what she feels and what she does with how she feels are not addressed’ (Kraemer, 1996, p.765).

Whilst much has been written about the role of motherhood myths and broader societal discourses in shaping women’s expectations and experiences (Bilszta et al., 2010; Constantinou et al., 2021; Douglas & Michaels, 2004; Hager, 2011; Hays, 1996), there is, notably, an absence of contemporary feminist theorising on postpartum psychosis specifically (Brown, 2019). Writing on postpartum psychosis, Brown (2021) critiques the discursive construction of the female reproductive body as emotionally unstable and as at the mercy of unruly hormones. She argues that the prevailing hormonal hypothesis of postpartum psychosis not only reflects longstanding patriarchal representations of the female body but also detracts from consideration of the socio-political context in which women’s experiences as mothers arise, thereby negating psychological and social factors, such as gender-based oppression, sexual violence and systemic inequalities, in the development of psychosis (Brown, 2021). This builds upon feminist scholarship that critically examines the ways in which femininity has historically been equated with madness in English culture (Showalter, 1985) and has been pathologised within patriarchal biomedical discourse (Ussher, 2011; Ussher, 2018). This, argues Jane Ussher, results in women’s distress being cast as internal pathology rather than a reasonable and meaningful response to specific, oppressive, social and psychological conditions (Ussher, 2018).

Whilst feminist critiques of psychosis in the postnatal period are, overall, limited, there is a more established field of feminist literature that has critically examined the construction of postnatal depression. This literature argues that the biomedical construction of postnatal depression pathologises and internalises women's feelings and experiences, rather than examining the broader ideological context and structure in which these experiences arise (Mauthner, 1993; Nicolson, 1986; Oakley, 1980). Feminist critiques have also deconstructed the medical model of postnatal depression, arguing that it is deterministic and that it silences women's voices and experiences (Mauthner, 1993). Indeed, from a feminist perspective, the dearth of qualitative research into women's experiences of psychosis in the postnatal period is demonstrative of broader, problematic ideological structures in which women's voices and experiences are silenced or disregarded (Mauthner, 1993).

2.7. Women's experiences of postnatal distress

Whilst literature on psychosis in the postnatal period continues to be dominated by a quantitative, biomedical, approach, there is a growing body of research that explores women's subjective experiences of postnatal distress, some of which concerns the experience of postpartum psychosis (Chotai, 2016; Glover et al., 2014; Robertson & Lyons, 2003; Roxburgh et al., 2023).

Dolman, Jones and Howard (2013) conducted a systematic review and meta-analysis of qualitative research into pregnancy and motherhood experiences of women with a range of 'psychotic disorders' subsumed under the category 'severe mental illness'. They identified several themes from the literature, including 'guilt', ‘stigma’ and the ‘centrality of motherhood’ (Dolman et al., 2013). The complexities of combining a mothering identity with having mental health difficulties were noted under the theme ‘coping with dual identities’, highlighting tensions between societal notions of motherhood and psychological distress (Dolman et al., 2013). Whilst this brings a feminist analysis to research into women’s experiences of postnatal distress, this research lacked criticality in relation to the dominant biomedical model used to conceptualise postnatal distress, arguably, paradoxically reinforcing biomedical constructions that individualise and pathologise postnatal distress.

In their research into women’s experiences of ‘severe postnatal illness’, Edwards and Timmons (2005) highlighted internal and external stigmas around mothering. This included concerns that postnatal difficulties impaired mothering capacities, resulting in some women feeling like ‘a bad mother’ (Edwards & Timmons, 2005, p.477). Broader narratives around motherhood were understood to have compounded these negative feelings (Edwards & Timmons, 2005). This corroborates findings from Wardrop and Popadiuk’s research into postpartum anxiety, in which they noted that the discrepancy between women’s expectations and sense of competence in early motherhood may have contributed to feelings of anxiety and loneliness (Wardrop & Popadiuk, 2013). However, again, whilst Edwards and Timmons incorporated principles from feminist research, there is a striking lack of criticality towards the use of a biomedical framework in conceptualising these difficulties. There is some discussion of this under the theme ‘labels/diagnosis’, with a call for further research to explore the subjective experience of diagnosis; however, there is a broader lack of attention towards the ways in which women’s distress may be pathologised within a biomedical psychiatric framework (Ussher, 2018).

In their study, Engqvist and Nilsson (2013) collected accounts of the first days of postpartum psychosis from women and their next of kin. An overall theme of ‘shades of black with a ray of light’ was chosen to capture these experiences, with subthemes including ‘infanticidal ideation’ and ‘from a wanted baby to an unwanted baby’ (Engqvist & Nillson, 2013). Women expressed guilt for not wanting their babies after birth and one woman stated that she had been afraid of her child, worrying that he would eat her (Engqvist & Nillson, 2013). Whilst this study offers a valid contribution to understanding women’s subjective experiences of postpartum psychosis, it is lacking an exploration of the contextualised nature of women’s fears and anxieties. Situating these women’s concerns within broader dominant conceptions and normative ideals of motherhood would have deepened the analysis and added criticality. Instead, Engqvist and Nillson focus on the importance of next of kin and highlight a need for greater education of postpartum psychosis in antenatal settings, with little exploration of interventions aside from psychopharmacology (Engqvist & Nillson, 2013).

Finally, women’s experiences of postpartum psychosis are also explored in research by Robertson and Lyons (2003). In their study, they noted three main themes from women’s accounts: ‘puerperal psychosis as a separate form of mental illness’, ‘loss’ and ‘relationships and social roles’ (Robertson & Lyons, 2003). Additionally, two ‘higher-order’ concepts were developed to capture the changes in identity and the spectrum of emotions that women described during this time: ‘regaining and changing self’ and ‘living with emotions’ (Robertson & Lyons, 2003). In contrast to some of the qualitative research on this topic, Robertson and Lyons (2003) situate these women’s experiences within broader conceptualisations of motherhood in Western culture, integrating a feminist concern with the social conditions of motherhood. Robertson and Lyons posit that an inability to perform expected and valued social roles may contribute to feelings of loss, guilt and failure in motherhood (Robertson & Lyons, 2003). Citing Woollett and Phoenix (1996), they note that dominant ideals of what it means to be a ‘good mother’ often involve putting the baby first and parenting in a child-centred way, which the women in their study were not able to do (Robertson & Lyons, 2003).

There is, clearly, a growing body of qualitative research exploring women’s experiences of postnatal distress, with some studies employing the use of a feminist perspective in which women’s experiences are situated within the context of broader dominant societal conceptualisations of femininity and discursive constructions of what it means to be a ‘good mother’ (Choi et al., 2005; Taylor, 1995; Ussher, 2011). From this perspective, discrepancies between cultural representations of motherhood, as a time of universal fulfilment, and the reality of women’s experiences, including that of maternal ambivalence, are considered as contributing to identity dissonance, frustration and psychological distress (Kennedy & Tripodi, 2015; Lewis & Nicolson, 1998). However, despite this, there continues to be a worrying lack of integration of feminist scholarship into research exploring postpartum psychosis (Brown, 2021). Indeed, whilst there have been calls for developing a broader range of interventions for women experiencing postpartum psychosis beyond psychopharmacology (Doucet et al., 2011; Forde et al., 2019), the influence of gender in the development and expression of psychological difficulties is, arguably, still largely unexamined by mental health professionals (Saenz-Herrero, 2014). This had led to some researchers calling for a feminist re-conceptualisation of postpartum psychosis, which would include gender-oriented and trauma-focused psychotherapy as models of intervention, showing consideration of the ‘full environmental context' of women's lives, as well as offering the opportunity for women to explore the meaning of childhood experiences in the context of the transition to motherhood (Kennedy & Tripodi, 2015, p.12).

2.7.1. Autobiographical accounts of postnatal distress

Alongside a small but growing body of qualitative research into women's experiences of psychosis in the postnatal period, a small number of autobiographical accounts have been published by women themselves. In 1892, Charlotte Perkins Gilman famously published 'The Yellow Wallpaper', arguably a fictional rendition of her experience of medical treatment for depression and a feminist reading of patriarchal gender relations and female madness (Bauer, 1998; Gilman, 1973; Golden, 2004). More recently, Elaine Hanzak has chronicled her experience of postpartum psychosis in 'Eyes Without Sparkle: A journey through postnatal illness' (Hanzak, 2005). Her account covers themes related to loss of identity, medical authority, psychiatric treatment, as well as internalised normative ideals of motherhood (Hanzak, 2005).

In her memoir, 'Psychotic Mum', Brenda Froyen (2019) writes about her experience of psychiatric care in the context of postpartum psychosis after having her third child. She charts her experience of psychiatric care in the context of compulsory admission, describing her subjective experience during this time as disorientating and as involving a breach in communication with medical staff, echoing themes of medical authority and loss of identity (Froyen, 2019).

Autobiographical accounts of early maternal distress add rich depth to research that explores the subjective, lived experience of psychosis in the postnatal period. They also speak to a longstanding feminist concern regarding the representation of women’s voices and experiences in the construction of knowledge (Presser, 2005).

2.8. Women’s stories of postnatal distress

There are very few studies that have explored the ways in which women talk about their experiences of psychosis in the postnatal period. One study that has done so was conducted from a psychiatric nursing perspective, with researchers analysing women’s narratives from the internet (Engqvist et al., 2011). Women’s stories were conceptualised in terms of four overarching themes: ‘unfulfilled dreams’; ‘enveloped by darkness’; ‘disabling symptoms’ and ‘feeling abandoned’ (Engqvist et al., 2011). In this study, women also shared feelings of fear, disappointment and detachment (Engqvist et al., 2011). Some expressed feeling unable to care for their baby and to control impulses that may lead to harm, yet, worryingly, did not feel able to discuss their fears at the time due to concerns around social services involvement, thereby exacerbating feelings of anxiety (Engqvist et al., 2011).

Whilst it appears that no research to date has been conducted into how women narrate their experiences of postpartum psychosis from a counselling psychology perspective, some research has taken place from the field of clinical psychology. Using a discourse analytic approach grounded within a feminist perspective, Hunter explored how women construct their experiences of perinatal distress (Hunter, 2013). One of the discursive positions highlighted is that of a ‘fragmented self’, used to communicate the problematic nature of simultaneously being a mother and a mental health patient, two discursive positions that do not sit comfortably together in broader discourses (Hunter, 2013). Another discursive position was that of being a ‘survivor’, which the researcher argued enabled women to express a more hopeful, encouraging perspective against pathologising constructions of madness (Hunter, 2013). Hunter’s research highlights the creative, divergent, ways in which women use language to make sense of their experiences, and offers an insight into the ways in which the broader discursive context shapes this process (Hunter, 2013). Her research also demonstrates the potential that comes from integrating a feminist lens into research exploring postpartum psychosis.

2.9. Research rationale and concluding comments

As demonstrated in this literature review, there is an established body of biomedical, quantitative, research into postpartum psychosis alongside a developing field of qualitative research that explores the subjective, lived, experience of postnatal distress in the form of psychosis. Research that integrates a psychological framework has indicated that childhood adversity may contribute to psychological difficulties during pregnancy and motherhood, whilst feminist scholarship has drawn attention to the role of broader societal norms and expectations in shaping women’s experiences of motherhood and presentations of postnatal distress. From a psychoanalytic perspective, unconscious fantasy and conflict are understood as shaping maternal psychological disturbances in the perinatal period.

However, as reflected by this review, the theoretical and research field reads as fragmented and lacking, with little attention paid to the relationship between psychosocial and broader discursive factors in conceptualising maternal distress in the form of psychosis, as well as in researching women’s lived experiences. Furthermore, a large body of the research into women’s experiences of postpartum psychosis comes from the field of nursing, with relatively few studies from the field of psychology. Concurrently, suggestions for clinical practice tend to come from midwives, obstetricians and nurses, and predominantly focus on how to maximise support for women and widen resources, rather than further develop psychologically-informed understandings and interventions (Doucet et al., 2012; Johnston-Robledo & Barnack, 2004).

This study thus intends to address the gap in research into women's experiences of psychosis in the postpartum period from a psychologically-informed perspective. It also intends to include critical examination of the potential role that discursive constructions of motherhood may play in women's sense-making processes and narratives, integrating a feminist lens. The field of counselling psychology is particularly suited to explore how women talk about, and make sense of, problematic emotional states in motherhood given the discipline's historic positioning as an alternative to prevailing biomedical discourses of illness and its focus on the relationally situated nature of subjectivity (Strawbridge & Woolfe, 2010). Furthermore, with its humanistic value base, counselling psychology holds a strong focus on meaning-making and understanding, taking engagement in the subjective, inner experience of the other as central (Strawbridge & Woolfe, 2010). This makes research into women's experiences of psychological distress from the field of counselling psychology particularly fitting.

Chapter Three

Methodology

3.0. Overview

This chapter comprises two parts. In the first part, I will outline the main epistemological position underpinning this research, social constructionism, providing reflections on the application of this to this research. In this section, I will also include reflections on the relationship between qualitative research and the field counselling psychology before outlining the methodology chosen, CNA, alongside alternative methodologies considered.

The second part of this chapter concerns the procedures followed in the method, including participant recruitment, data collection and analysis. In this section, I will offer reflections concerning researcher reflexivity, as well as some of the main ethical considerations and challenges in undertaking this research. Finally, questions of quality and validity in the context of qualitative research will be explored, along with an outline of how these criteria may be evaluated in the context of this research.

3.1. Social constructionism

Whilst ontology concerns the nature of reality, epistemology asks how this reality can be known (Morrow, 2007). This research employs a social constructionist epistemological lens. Social constructionism explores the processes through which people make sense of the world, taking a critical stance vis-à-vis taken-for-granted assumptions and the production of knowledge (Burr, 2003; Gergen, 1985). Social constructionism is based on the premise that our ways of understanding the world are not only culturally and historically mediated but that knowledge itself is generated through social process (Burr, 2003). Social constructionism posits that commonly accepted understandings of the world arise from ‘historically situated interchanges between people’ (Gergen, 1985, p.267). These forms of knowledge are considered negotiated understandings, which, through discourse, enable and invite certain forms of social action and particular ways of conducting ourselves (Gergen, 1985). This brings relations of power to the fore, and, in doing so, moves away from a positivist-empiricist search for the ‘truth’ towards a critical examination of the production of knowledge through language and the interactive practices that constitute this (Burr, 2003; Gergen, 1985). This research acknowledges the ‘realism-relativism debate’ within social constructionism and is situated on the moderate end of the spectrum in its attention to extra-discursive process, such as embodiment, subjectivity and materiality (Cromby & Nightingale, 1999).

Willig argues for the starting point of qualitative research to be rooted within the underpinning epistemological and ontological assumptions (Willig, 2013). Concurrently, the decision to adopt a social constructionist position was informed by the guiding theoretical assumptions of this research: principally, that the narrative construction of postnatal distress not only takes place within an immediate relational context but also within a broader socio-political context abound with discursive representations of femininity, motherhood and ‘mental illness’. A social constructionist lens is thus coherent with a theoretical concern regarding the ways in which women engage with dominant discourses in narrativizing their experiences. Furthermore, the use of a social constructionist lens also enables consideration of participants’ use of language as a form of social action (Willig, 2013), making it possible to critically examine the discursive construction of the self. The links that are drawn between discourse, knowledge and power within social constructionism posit pertinent questions that I was keen to explore through this research; namely, the kinds of subject positions that are taken up or resisted through the use of discourse and the role of broader power relations in this process, such as social institutions and the psychological and medical professions (Burr, 2003; Rose, 1985). Social constructionism also pays heed to the influence of the subjectivity of the researcher, attending to the ways in which the researcher’s values, identity, life experiences and political positioning may shape the research process (Willig, 2013). These questions are examined in Stage 1 of the analytic process, in Chapter Three.

3.2. Qualitative research and counselling psychology

Qualitative research methodologies in psychology are concerned with meaning: they seek to explore the texture of lived experience and understand how we make sense of our experiences (Willig, 2013). This aligns with the historical roots and core values of the discipline of counselling psychology, in which the subjective experience of the individual is privileged, and in which multiple truths and the joint construction of meaning are acknowledged (Woolfe, 2016). The non-pathologising approach of counselling psychology also coheres with qualitative research in its focus on meaning-making and the incorporation of contextual factors in understanding people’s experiences (Morrow, 2007).

Woolfe draws upon the concept of the ‘reflective practitioner’ as a central feature of the identity of counselling psychology, highlighting the discipline’s orientation towards a reflexive awareness of the social and ethical context of the work (Woolfe, 2016). In doing so, counselling psychology makes its reflexive engagement with politics and values explicit, paralleling that of qualitative research in which the subjective engagement of the researcher and context of the research are considered fundamental to the joint construction of meaning and the research process (Morrow & Smith, 1994). Questions of researcher reflexivity are explored more fully below.

3.3. Researcher reflexivity

Researcher reflexivity concerns the myriad ways in which the researcher shapes the research process (Willig, 2013). This includes aspects of the design as well as the researcher's own subject position and social location (Langdridge, 2007). Researcher reflexivity takes on a different focus in qualitative research that is located within a postmodernist paradigm: here, the researcher is considered a co-producer in the knowledge generated, rather than a detached observer seeking to understand an objective 'truth' or form of knowledge (Langdridge, 2007). This has particular importance in that the researcher's existing knowledge, experience, creativity, intuition and personal history are all recognised as shaping the interpretive research process, as well as informing dimensions of power and professional responsibility (Haverkamp, 2005).

Scholars have attempted to delineate the different dimensions of reflexivity in the context of qualitative research. For instance, Willig (2013) distinguishes between 'personal reflexivity' and 'epistemological reflexivity'. Similarly, Wilkinson proposes three forms of reflexivity in feminist qualitative research: 'personal reflexivity', 'functional reflexivity' and 'disciplinary reflexivity' (Wilkinson, 1988). The former, 'personal reflexivity', refers to the researcher's personal identity and values, considered an integral part of postmodernist research, and even a resource, rather than a set of biases or obstacles to be eliminated (Wilkinson, 1988). This, Wilkinson argues, is particularly the case for feminist research in which personal experience is foregrounded and contextualised (Wilkinson, 1988). Inseparable from the realm of personal reflexivity, ‘functional reflexivity’ involves a continuous process of engaging critically with epistemological questions regarding not only the methods used but also the influence of the researcher’s values and assumptions, as well as those underlying the methodological frame of the research (Wilkinson, 1988). Beyond this, engaging in ‘disciplinary reflexivity’ entails critical reflection on the dominant research paradigm within which the research takes place, raising pertinent questions regarding the production of knowledge, power and legitimacy (Wilkinson, 1988). Indeed, there is a long history of foregrounding questions of power and subjectivity within feminist research given its concern with power asymmetries (Worell & Etaugh, 1994).

Questions of ethics, power, and representation are especially pertinent in research that involves sensitive areas or vulnerabilities, and in which the researcher has not experienced the issue that is being explored (Langdridge, 2007). Indeed, Langdridge points to the risk of misrepresenting participant experiences, alongside risks of the researcher unwittingly imposing their own, outsider, position on to the data (Langdridge, 2007). In response to this, he makes a case for the researcher to interrogate the motivations they hold and to give due thought to the implications of pursuing the research (Langdridge, 2007). Traditional dichotomies between self/other and insider/outsider in the research process have also been challenged from a post-structuralist perspective, with scholars arguing for recognition of the multiple ways in which the researcher’s positionality shifts in relation to their multiple identities and the cultural ‘tones’ that emerge in the space between researcher-researched (Savvides et al., 2014).

Whilst holding the limits of my own reflexivity in mind (Mauthner & Doucet, 2008), I have endeavoured to reflect upon the impact of my own subjectivity on the research, alongside the epistemological and ontological assumptions that have informed my analysis of the data. Reflections on my own relationship with the topic of this research are offered in Chapter Four in which I interrogate my own subjectivity in the context of this research. Later, in Chapter Six, reflections on the research process are offered in the context of my analysis, bringing together considerations of personal, functional and disciplinary aspects of reflexivity (Wilkinson, 1988). I have also included excerpts from my research journal to illustrate my ongoing reflections during the research process, as found in the appendices. My research journal was used as an informal, spontaneous, method of recording thoughts, questions, doubts and emotional responses to the research process; however, I hope that it illustrates my continued reflexive engagement with this research.

3.4. Narrative research: An overview

The ‘narrative turn’ can be located within a broader ‘interpretive turn’ in the social sciences (Riessman, 1993), emerging in a context of critical questioning towards the application of positivist and realist assumptions for understanding the nature of human experience (Goodson & Gill, 2011; Riessman, 1993). Narrative research is based on the premise that we use stories to give meaning to our lives and to tolerate the complexities of what it means to be human (Clandinin & Connelly, 2000; Etherington, 2000). Accordingly, much has been written about the role of narrative in organising human experience (Bruner, 1987; Carr, 1986; Polkinghorne, 1988).

The main object of inquiry in narrative research is the ‘story itself’ (Riessman, 1993, p.8). Whilst stories of lived experience comprise the data, the researcher goes beyond the content of a story to ask questions of why and how the narrative is put together in this particular way, for the purposes of this particular audience and situated within this particular social-cultural context (Riessman, 2008). Narratives are interesting in what they do and in the functions that they perform, arguably, spanning sense-making to political action (Riessman, 2008). Bruner considers narratives as both diachronic and durative: events happen over time, and the significance of this time, 'human time', is related to the meanings that these events hold for us (Bruner, 1991; Polkinghorne, 1988; Ricoeur, 1988). He argues that all narrative necessitates interpretation and that narrativity rests upon a breach in the implicit canonical script: this, he posits, is what makes a story worth telling and what renders narrative a site for cultural negotiation (Bruner, 1991).

Despite a shared interest in storytelling and stories, narrative research is a varied field of inquiry (Squire et al., 2008). Originating in two divergent conceptual strands, that of humanism and poststructuralism, it is abound with theoretical tensions (Squire et al., 2008). This makes for a rich, yet contested, methodological field, with questions not only concerning how to obtain narrative accounts yet also regarding what actually counts as a narrative, as well as the nature of subjectivity, representation and temporality (Squire et al., 2008).

3.4.1. Narrative and identity

Questions of narrative, temporality and identity have been explored in great complexity by the French philosopher, Ricoeur. In his three volumes, *Time and Narrative* (Ricoeur, 1984; Ricoeur, 1985; Ricoeur, 1988), Ricoeur offers a narrative poetic to resolve what he calls the 'aporias of temporality', arguing that it is through narrative, interweaving history and fiction, that we can overcome the problematics of time (Ricoeur, 1988). He argues that by integrating the 'quasi-fictional' and the 'quasi-historical', 'human time' emerges, as narrative reconfigures temporal experience (Ricoeur, 1988). Drawing upon Gadamer and the hermeneutic tradition, Ricoeur posits a circular relationship between the world of the text and the world of the reader, suggesting that narrative reveals as much as transforms; he states: ‘A life examined in this way is a changed life, another life.’ (Ricoeur, 1988, p.160). From this, Ricoeur outlines his concept of narrative identity, which, he argues, is an identity that, crucially, allows for both continuity and change in selfhood in a circular process through the narration of the self (Ricoeur, 1988). Indeed, it is this reconfiguration of the self through narrative that, he posits, is fundamental to our subjective experience (Ricoeur, 1988). Ricoeur draws a parallel between this process and the psychoanalytic process of ‘working-through’, within which, he argues, one’s life becomes re-narrated and one’s life story becomes reconfigured and replaced with subsequent narratives, resulting in a ‘chain of refigurations’ (Ricoeur, 1988, p.250). Ricoeur thus locates narrative as central to the subjective human experience and the ongoing process of identity reformulation over time and place.

The concept of reconfiguration of the self through narrative connects to research that examines narrative as a discursive, interactive, activity; thereby moving away from positivist approaches that view narratives as internally located, coherent and stable, towards recognition of the situated construction of narrative identity (Brockmeier, 2000). In line with this, it has been argued that we say something about who we are through narrative, and we not only do this in immediate, interactive, contexts but also within a broader socio-political context that sets the frame for the kinds of identity claims that we might make or resist (Bamberg, 2004). Examining the situated narrative construction of the self brings to the fore questions of power and subjectivity, rendering narrative research a rich and meaningful area of inquiry that speaks to the political and that coheres with an emancipatory agenda of much contemporary narrative research (Bamberg, 2004).

3.5. Methodological choices

In deciding upon a research methodology, the value of a qualitative approach was evident in that my research was informed by an interest in the subjective experience of postnatal distress and the associated meanings that this held for my research participants, falling in line with a qualitative research framework (Bold, 2012). More specifically, my research was informed by the following aims:

- To explore how women make sense of their subjective experiences of maternal distress through narrative;
- To understand how discursive constructions of perinatal mental health, femininity and motherhood shape or interrelate with women's narratives;
- To understand how psychologically informed interventions may provide helpful and meaningful support to mothers experiencing psychological distress

3.5.1. Chosen methodology: Critical Narrative Analysis

Given my interest in exploring the lived experience of postnatal distress, as well as the broader discursive context in which these experiences take place, a narrative methodology seemed the best choice to fit my research questions. Narrative approaches in psychology constitute a broad methodological field (Hiles et al., 2017). This presented a challenge in my search for an appropriate method that aligned with my research questions. I gave some thought to a range of narrative methods, including that of Riessman's (1993), Labov's (1997) and Gee's (1991) approaches. However, guided by my research questions, I was looking for an approach that worked with both content and form, to enable me to explore meaning and lived experience, as well as to critically examine the social location of narrative within a relational and broader discursive context. CNA was the best fit in line with these research aims (Langdridge, 2007).

CNA, developed by Langdridge, is informed by the hermeneutic turn in phenomenology and grounded in the philosophical work of Gadamer and Ricoeur (Langdridge, 2007). This approach aims to explore subjective experience through a critical analysis of narrative accounts. Drawing heavily on Ricoeur, in CNA, Langdridge incorporates a *hermeneutic of empathy* to understanding meaning, alongside a *hermeneutic of suspicion* in which the data is subjected to an additional level of analysis using the lens of social theory (Langdridge, 2007). This, argues Langdridge, enables the researcher to go beyond that which is immediately apparent to explore 'what is hidden' beneath the surface (Langdridge, 2007, p.44). He suggests that this enables a *fusion of horizons*, in which knowledge is expanded as a result of a critical engagement with the other, thereby bringing together Ricoeur's dual focus on empathic engagement and suspicion (Langdridge, 2007). CNA comprised the most fitting analytic approach for this research as it enabled me to explore the lived experience of postnatal distress, whilst also problematising canonical narratives within the data to explore sense making and identity construction through the lens of a particular social theory (Langdridge, 2007).

In line with my research aims, I also considered using phenomenologically-informed approaches, such as Interpretative Phenomenological Analysis (Smith et al., 2021) as well as discourse analytic approaches. I will explore each of these in turn below.

3.5.2. Alternative methodologies

3.5.2.1. Interpretative Phenomenological Analysis

IPA, with its focus on subjective, lived, experience and meaning-making, would have, in many ways, been a fitting choice of methodology for this research (Smith et al., 2021). IPA aims to understand what it is like to undergo a particular experience, employing the use of a double hermeneutic as the researcher attempts to make sense of the participants' sense making (Smith et al., 2021). However, whilst this method offers an in-depth, qualitative, analysis, I was concerned that it would not have enabled me to explore, with as much criticality, the influence of wider socio-cultural discourses on women's narratives, nor the rhetorical function of language in identity positioning.

3.5.2.2. Discourse analytic approaches

Consideration was also given to the use of a discourse analytic approach (Potter & Wetherell, 1987). Approaches within discursive psychology are varied; however, the use of a discourse analytic approach would have enabled me to pay detailed attention to the action-oriented function of women's speech (Edwards & Potter, 1992), as well as to discursive subject-positioning (Goodman, 2017). This would have aligned with my research interests in the role of broader discourses in shaping women's narratives and identity claims.

I gave particular consideration to the use of Foucauldian Discourse Analysis (FDA) as a potential methodology. FDA coheres with a social constructionist epistemology and critical psychology research, examining questions of power and subjectification, as well as the construction of knowledge and the role of psychology, as a discipline, in this process (Arribas-Ayllon & Walkerdine, 2017). FDA would have fitted well with my interest in critically examining the ways in which the women talk about their experiences of postnatal distress in the context of a broader discursive frameworks in which motherhood and ‘mental illness’ are constructed. However, I was concerned that such a strong focus on discursive elements might obscure women’s stories as a whole, which remained of interest to me (Emerson & Frosh, 2004). I was also concerned that I might not be able to examine, with as much depth and texture, the subjective experience of postnatal distress.

3.6. Phenomenological approaches to research

CNA is situated within a broader field of phenomenologically informed approaches to narrative (Langdridge, 2008). Phenomenological psychology arose in the United States in the 1960s (Langdridge, 2008). Primarily influenced by Husserl, and later Heidegger, Sartre and Merleau-Ponty, this branch of psychology foregrounds the study of subjective lived experience and is concerned with the active construction of meaning and the ways in which individuals consciously experience their *lifeworld* (Langdridge, 2008). It is also based on the premise that when attempting to understand lived experience, we can only have direct access to the ways in which this lived experience is communicated, both verbally and non-verbally (Langdridge, 2008). Whilst research conducted from a phenomenological approach holds participant experience as central, focusing on generating rich descriptions, hermeneutically-informed approaches such as CNA, bring together both description and interpretation (Langdridge, 2008). This means that CNA may be located within the broader field of critical phenomenologically-informed social psychology (Langdridge, 2008). CNA is thus well positioned in attending to questions of power and politics, locating subjective lived experience within the broader socio-cultural context in which it arises (Langdridge, 2007; Langdridge, 2008).

3.6.1. Epistemological challenges

Notwithstanding, there are notable differences in the epistemological and philosophical foundations of phenomenological and social constructionist approaches; namely, in the assumptions made regarding knowledge and language (Willig, 2013). This raises tensions in my adoption of a social constructionist epistemological framework and use of CNA, a phenomenologically grounded approach. However, previously noted, social constructionist approaches may be located on a continuum, with this research adopting more of a moderate constructionist approach (Harper, 2012; Willig, 2013). Furthermore, I would argue that the application of critical theory in Langdridge's approach, as a *hermeneutic of suspicion* (Ricoeur, 1970, in Langdridge, 2007), aligns CNA with a social constructionist concern in the location of subjective experience within a broader socio-political, cultural, context. Indeed, Langdridge himself makes a case for phenomenological social psychology to respond more fully to the 'turn to language' in the social sciences, and for critical engagement with the relationship between discourse and lived experience in phenomenological psychology (Langdridge, 2008). This can also be seen in the way in which CNA is positioned within a critical social psychology framework, and in the attention to both content and form in this methodology (Langdridge, 2008).

3.7. Research design

3.7.1. Recruitment and participants

I used purposive and homogenous sampling to recruit participants (Langdridge, 2007). I contacted several organisations and charities that offered support to women experiencing postnatal distress or engaged in awareness raising and campaigning on this topic. Having engaged in a series of conversations regarding my research with APP, the national UK charity for women and families affected by postpartum psychosis, my research was advertised through their Twitter page and their monthly newsletter. Alongside this, my research advert was shared with a group of women who were volunteers for the Association for Post-Natal Illness (APNI). These women were invited to contact me directly to express an interest in participation or for further questions regarding the research and participation.

I also shared my research advert through colleagues on my training programme, on social media, online forums, as well as on a local parents' WhatsApp group. As a result, early on during the recruitment phase, I was contacted by somebody who had previously been diagnosed with 'postnatal depression' and expressed an interest in participating in the research. As she did not meet the inclusion criteria, this was not possible; however, my exchange with her left me reflecting on the ethics of advertising my research to women in the local community, in which I occupied a dual-position as local mum and researcher. This also raised questions for me regarding my research focus, as well as my inclusion and exclusion criteria, as I was left reflecting on the spectrum of distress that may arise in the postnatal period, and the dangers of invalidating what might erroneously be consider milder forms of distress.

In my research advert, participants were invited to attend two successive interviews, both lasting for approximately one hour, to share their accounts of early motherhood in an open and exploratory exchange with me. To participate in the research, it was stipulated that women had experienced postnatal psychological distress that resulted in a diagnosis of postpartum psychosis and that participants were over the age of 18. In an attempt to mitigate the risk of re-traumatisation from recounting distressing experiences, it was also stipulated that at least two years had passed since the experience of postnatal distress, and that women were no longer receiving input from NHS secondary care services. Finally, it was asked that women had accessed some form of psychological intervention, such as talking therapy, connected to their experience.

I neither intentionally sought homogeneity nor variety in demographic characteristics for two main reasons: firstly, given the idiographic nature of critical narrative analysis, I was not looking to generalise my findings (Langdridge, 2007). Secondly, I was acutely aware of the challenges that I might encounter during the recruitment process due to the sensitive topic of this research and my specific inclusion criteria. I recruited a total of five participants for this research; three women contracted me though APNI whilst two women contacted me through APP. Basic demographic details of participants are outlined Table 1 below.

Table 1: Participant demographics

Name (pseudonym)	**Age bracket**	**Relationship Status**	**Number of children**	**Ethnicity**	**Occupation**
Emily	30s-40s	Married	2	White British	Human resources
Catherine	60s-70s	Married	2	White British	Retired Previous occupations: bookkeeper and solicitor
Rose	60s-70s	Divorced	2	British-Caribbean	Retired Previous occupation: health sector
Gwyneth	30s-40s	Married	1	Mixed White-Asian	Project management
Sophie	30s-40s	Cohabiting	2	White British	Agriculture

3.7.2. Data collection and analysis

Riessman reminds us that researchers participate in the generation of narratives as much as they find them (Riessman, 2008). I thereby approached each research interview as an active, co-participant (Riessman, 2008). In line with my research interest in exploring the lived experience of postnatal distress, I sought to use open-ended questions in my interviews (Langdridge, 2007). At the same time, given my interest in how women constructed their narrative accounts of postnatal distress, I decided to use an unstructured, conversational, approach for my interviews, allowing for spontaneity and flexibility in the dialogue (Kvale, 1994; Langdridge, 2007).

I opened each interview with an invitation for women to share their stories of postnatal distress, noting that they could start from wherever felt fitting for them. Whilst I created a loose interview guide, with a series of prompts on themes that I considered relevant, the immediacy of the dialogue, and the intensity of each relational encounter, meant that this schedule served more for me in terms of gathering my thoughts ahead of interviews than as an actual tool that I referred to during interviews.

Using my therapeutic skills of active listening and empathic attunement, I was mindful to remain attentive to the emotions arising in each relational encounter (Riessman, 2008). This felt particularly important given the distressing nature of the experiences shared. However, due to the Covid-19 pandemic, all of the interviews were conducted remotely; this meant that I felt myself working harder to sense the emotions arising in the ‘virtual room’ and to make judgements about allowing for silence, as well as naming and responding to emotions that came up during interviews. Finlay writes about the importance of connecting with the body in phenomenological research, outlining three layers in which we can attend reflexively to embodiment: *bodily empathy, embodied self-awareness* and *embodied intersubjectivity* (Finlay, 2006). Remote interviews posed particular challenges to working with embodiment. I found that my body often became rigid and static during interviews as all of my focus was directed towards engaging with my participants through the screen on my laptop and trying not to miss any of their story. This meant that I became very content-heavy in my engagement: I found it harder to notice my own embodiment, as well as to get a sense of the embodied intersubjectivity arsing in the relational encounter (Finlay, 2006).

Conducting interviews remotely also brought my own maternal subjectivity into the research encounter in more direct ways: holding remote interviews meant that the sounds of my toddler playing with my partner or her grandparents, or, at times, crying, would travel through to me and at points, to my research participants. At other times, I would feel the chaos of my own domesticity intruding into my thoughts and capacity to be present during interviews. In these moments, I was often confronted with my own maternal ambivalence and some of the losses and conflicts of my own motherhood experience. This, undoubtedly, entered the relational space of the interviews in an implicit sense.

After each interview, I held a debrief with participants in which we reflected on the interview process. This offered me an opportunity to check-in with participants, to gently enquire about the immediate emotional impact of the interview and to reflect upon how to transition from the online interview space. Often participants chose to go for a short walk or to make a cup of tea and give themselves time to drink it uninterrupted afterwards.

After the first interview, participants were invited to attend a follow-up interview with me. My hopes were that the follow-up interviews would offer participants a chance to expand upon their narrative accounts in the context of a developing dialogic relationship with me (Riessman, 2008). This felt particularly important given the sensitive nature of the topic being explored and the sense of trust and relational safety needed for women to share their stories (Dickson-Swift et al., 2007). Whilst I had initially intended for a gap of between 4-6 weeks between the first and second interviews, to allow time to aid reflections but to also keep a connection to the initial interview, it transpired that it was quite complicated to arrange second interviews and the gap between first and second interviews ranged from between 1-5 months across participants.

3.7.2.1. Reflections on the research process

Whilst I had anticipated that women would build upon their stories in the second research interview, this was generally not the case. Overall, second interviews were brief, and I sensed some difficulty or reluctance from participants to return fully to their experiences.

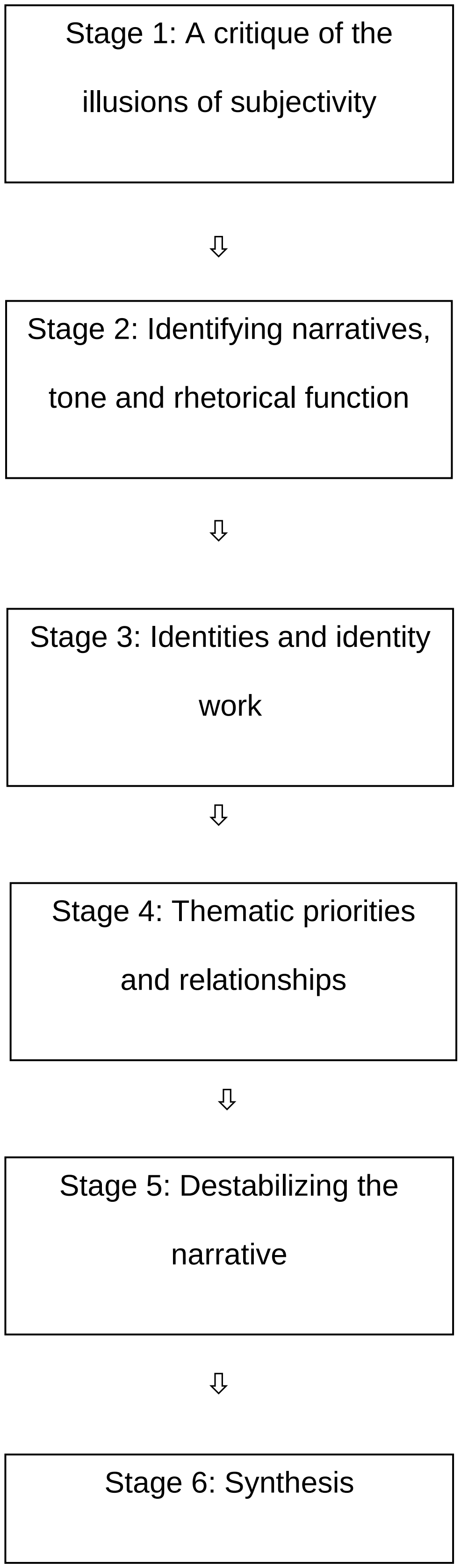
Before commencing recruitment and data collection, I made the decision to disclose my personal interest and connection to the research topic in relation to my developmental history. This decision was partly informed by an attempt to bring my own humanity to the research, beyond my ‘researcher self’ (Dickson-Swift et al., 2007; Haverkamp, 2005). I also felt concerned that the research might feel somewhat exploitative and that sharing the fact that my mum experienced psychosis in the postnatal period with me might level the ‘playing field’ a little bit (Dickson-Swift et al., 2007, p.332; Glesne & Peshkin, 1992). Whilst I briefly shared my own connection to the topic during the initial meeting with participants by way of explaining my interest in the topic, I noticed that this perhaps left me appearing vulnerable to research participants and one participant indicated that they were concerned about the impact of their story on me.

I also made the decision to share that I was a mother with research participants. This was partly based on conducting interviews remotely and anticipating that sounds of my toddler might travel through to participants. However, I also felt compelled to bring my own maternal subjectivity into the research more explicitly, as becoming a mother has deepened my interest in the realm of maternal, and plays an important part of my subjective engagement with this topic.

3.7.3. Transcription and analysis

I transcribed each interview by hand to capture the dialogue as accurately as possible (Langdridge, 2007). I chose to use a simple level of transcription to create a verbatim account of the research interview as I was predominantly interested in meaning, experience and identity work (Langdridge, 2007). I thus excluded features of the dialogue, such as syntactic elements of talk, that I might have transcribed had I used a discourse analytic approach or Labovian structural analysis. Subsequently, I followed the six stages of analysis involved in CNA for each set of research interviews (Langdridge, 2007). An outline of this process is illustrated in Figure 1 below.

Figure 1. The six stages of CNA (Langdridge, 2007)



Stage 1 involves a ‘critique of the illusions of the subject’: here, as the researcher, I subjected myself to a critique using my chosen hermeneutic of suspicion, feminism (Langdridge, 2007). This stage of the analysis involved reflexive engagement about the personal meaning and relevance of this topic for me, and the ways in which my own experiences and background may have shaped my involvement in the research process and the co-production of data (Langdridge, 2007). In this stage, I read and re-read each transcript multiple times to familiarise myself with the data and to appropriate meaning, allowing for a ‘fusion of horizons’ (Gadamer, 1975, as cited in Langdridge, 2007). Following this, I used a feminist lens to reflect further on the preconceptions and assumptions that I might be bring to the research (Langdridge, 2007). Reflections from this stage can be found in Chapter Four.

In Stage 2, I sought to identity narratives within the interviews (Langdridge, 2007). For each interview, this involved reading and re-reading the transcript, searching for ‘distinct and identifiable stories in the text’ (Langdridge, 2007, p. 137). This process resulted in a cluster of narratives for each interview (Langdridge, 2007). Following this, I worked to identity narrative tone, paying attention to shifts in tone and rhetorical function throughout the interviews (Langdridge, 2007). Subsequently, I reflected upon the potential function of the narrative, asking myself what kind of story was being told and what this story was doing (Langdridge, 2007). Initial notes made during this stage of the analytic process can be found in the appendices.

In Stage 3, I considered the narrative construction of identity (Langdridge, 2007). This involved returning to the transcript and asking myself: ‘What kind of person does this particular narrative construct and how does this relate to what we know of the person’ (Langdridge, 2007, p.138). As Langdridge notes, there is considerable overlap between Stages 2 and 3 and I found myself going back to my reflections from Stage 2 to wonder about the links between identity, tone and narrative function (Langdridge, 2007).

Stage 4 involved identifying thematic priorities in the narratives and considering the relationships between them (Langdridge, 2007). Here, I read through each transcript again, systematically, to identity key themes (Langdridge, 2007). I noted these themes down initially on each transcript before bringing my notes together, ultimately organising these themes into main themes and sub-themes (Langdridge, 2007). An example of my engagement with this process can be seen in the appendices.

I then moved on to Stage 5, which Langdridge describes as ‘destabilising the narrative’ (Langdridge, 2007, p.139). This stage involved using my chosen hermeneutic, feminism, to engage critically with the text (Langdridge, 2007). My choice of feminism as a hermeneutic was informed by the topic under investigation, psychological distress in early motherhood, as well as my research interest in exploring women’s engagement with broader discourses of motherhood.

Given the format in which the participants’ narratives are presented in this research, the sixth stage of CNA, which comprises a synthesis of the findings (Langdridge, 2007) is integrated into the presentation of participants’ narratives, identity work and thematic priorities.

Riessman notes that the process of interpretation begins at the point of interview: in the orientation of the researcher, in the questions asked, and in the intersubjective dialogue that emerges (Riessman, 2008). As such, I kept a research journal throughout, which I used to note down reflections coming up for me during the research process; I found this extremely helpful in my engagement with the messy, complicated, parts of the process, which I might have otherwise felt tempted to dismiss.

3.7.4. Ethical considerations

This research project received full ethical approval by the Metanoia Research Ethics Committee on 15 January 2020 (See Appendix 1). Throughout the research, I have followed the British Psychological Society's Code of Human Research Ethics (British Psychological Society, 2021) and Code of Ethics and Conduct (British Psychological Society, 2021). I adhered to the General Data Protection Regulation (Data Protection Act, 2018) for handling all personal data related to this research. Participants were informed as to how their data would be handled and stored, and given the opportunity to ask any questions related to this. All written data was stored in a locked cabinet and audio files were stored on an encrypted file on a password protected personal computer. Additionally, interview recordings and data analyses were saved in separate files to consent forms and demographic details of participants. To protect anonymity, identifying details were changed or omitted from the write up and participants were invited to choose their own pseudonyms. These decisions were made in collaboration with research participants, and any concerns regarding anonymity were worked through in an ongoing dialogue.

Prospective participants were provided with a copy of the Participant Information Sheet (See Appendix 7), which outlined the aims of the research and the nature of participation. Written consent was obtained before both research interviews with all participants; additionally, verbal consent was re-obtained before and after each interview. Participants were provided with the name and contact details of my research supervisor and informed that they could contact them should any concerns arise that they wished to discuss privately. Participants were also informed that their participation was entirely voluntary and were given the right to withdraw from the research up to three months after the second research interview, after having had an opportunity to review the initial analysis.

Due to the sensitive nature of the topic being explored and the risk of re-traumatisation (Fujii, 2012), much consideration was given to the emotional and psychological implications of participation. I implemented several measures to mitigate these risks as much as possible. For instance, I met with each prospective participant for an initial conversation to explain the aims of the research and to outline what participation would involve; this also provided an opportunity for prospective participants to ask me questions or voice concerns. Due to the impact of the Covid-19 pandemic, these initial meetings all took place remotely via Zoom and MS Teams. This initial meeting also served as a means of thinking more carefully, with each prospective participant, about the potential emotional implications involved in telling their stories to me and of revisiting their experiences of postnatal distress. I created and used a screening tool as an aid to these conversations, although I kept the interaction as conversational as possible. This screening tool was adapted from Draucker, Martsolf and Poole's (2009) protocol (See Appendix 2). Decisions regarding each participant's suitability were then discussed with my Research Supervisor. All the women whom I met for this initial conversation went on to participate in this research.

I endeavoured to create an unhurried pace for the research interviews. Before interviews, I reminded participants of the potentially distressing nature of the interviews and gently enquired about any concerns they held regarding their participation at this point in time, exploring the option of rescheduling or withdrawing if needed. One participant was experiencing ongoing fluctuations in mood. In light of this, we agreed to communicate via email a few days ahead of her first research interview to explore any concerns in meeting for an interview at that point in time. It was also arranged that I would ‘check-in’ with this participant the day after her research interview to offer space for her to voice any concerns around the emotional impact of telling her story to me. This decision was developed with the guidance of my research supervisor and created collaboratively with this participant.

All participants were informed that they did not need to answer any question that they did want to answer during interviews and that the interview could be paused or stopped at any point. During interviews, I used my therapeutic skills to offer an emotionally attuned, containing, relational dialogue; as to be expected, some of the participants did express strong emotions during the interviews and I offered to pause the tape or stop the interviews at these times. I also developed and used a distress protocol to act as a guide for responding to participants’ distress during and following the research interviews, as well as for responding to safety concerns (See Appendix 3). This was individually tailored to each participant: during initial meetings, we explored the diverse ways in which participants anticipated that they might be impacted emotionally, and we reflected together on how I might know that they were experiencing distress during interviews and how best I could respond to this. The fact that interviews were taking place remotely was also taken into consideration here as I was mindful that I might not be able to sense participants’ distress quite as easily. I provided an opportunity to debrief after each interview and all participants were provided with a list of support services (See Appendix 8).

I also put a lot of thought into how I imagined I might be impacted by this research, particularly given my developmental history. During the research process, I used personal therapy, as well as my research journal, to reflect on what was coming up for me. I endeavoured to bracket time around research interviews to decompress. At times, however, this was simply not possible as I was juggling this research with looking after my own young daughter who was two years old at the time of interviews. As a result, much of my processing immediately after interviews involved quietly reflecting on the experience whilst simultaneously breastfeeding my toddler and drinking tea that my parents or partner kindly provided me with. I took snatches of time to check in with myself where I could and found time away from the research process invaluable in remembering to laugh or be silly, as well as to have more ‘intellectual’, thought-provoking, conversations with close friends. All of this got me though and helped me to navigate my own emotional responses to the research process.

An additional challenge that I had not anticipated arose whilst I was in the midst of conducting research interviews: in April 2022 my mum was diagnosed breast cancer. This completely blindsided me and the rest of my family, and I stepped back from the research and a number of other professional commitments until September 2022 when my mum had completed the majority of her treatment.

3.7.4.1. Ethically important moments

There were several ‘ethically important moments’ that arose during the research process (Guillemin & Gillam, 2004, p. 262). Of course, moments in which the researcher is required to reflect upon ethical considerations arise frequently over the course of psychological research. However, there were a few occasions in which I found myself struggling with making a decision that connected to ethical concerns, or feeling confronted with a relational encounter that brought ethical questions to my mind.

One such moment arose in the context of my research interviews with Sophie. After meeting Sophie for the initial screening interview, I met with my research supervisor to discuss her participation in the research given that she had shared experiencing suicidal thoughts at times, as well as navigating ongoing difficulties. When considering the potential psychological risks of Sophie participating in the research, we considered the fact that Sophie seemed to know herself well and reached out to her support network when needed. I also had a dialogue about this with Sophie and we agreed that I would contact her the day after her first interview to have a brief telephone conversation and to see how she was feeling. Then, at the start of her second interview, she told me that her mood had dipped since her first interview and that her GP had increased her dosage of medication. I explored her thoughts about continuing and proceeded with the interview in line with Sophie’s wishes. This decision was also informed by my previous conversations with my research supervisor regarding the importance of balancing a need to protect participants from psychological harm and also respect their agency (British Psychological Society, 2014).

However, at one point during Sophie’s second interview, I noticed that I was struggling to hold a boundary between my practitioner self and my researcher self (Haverkamp, 2005), and I found myself taking up more of a ‘rescuer’ position in exploring psychological services Sophie might be able to access (Karpman, 1968). Afterwards, I reflected on this and noticed that I had perhaps felt some discomfort in engaging with Sophie’s experience of postnatal distress whilst this distress continued into the present; the interview felt exploitative in the context of the powerlessness that I heard in her account. My practitioner self also felt a responsibility to explore services available, whilst my researcher self was curious about this experience and how it connected to the narratives within her account. Perhaps the powerlessness that I heard in Sophie's account at this point might also have reminded me of the overwhelming feelings that I experienced when my mum was experiencing psychological difficulties, leaving me feeling compelled to help. After Sophie's second interview, I took these reflections to personal therapy and research supervision, reflecting on the challenges of balancing care, responsibility, reciprocity and professional boundaries in emotionally engaged qualitative research (Cotterill, 1992; Ribbens & Edwards, 1998).

3.7.5. Quality and validity in qualitative research

In terms of assessing quality and validity, Morrow calls for qualitative research to generate its own set of standards from within the methodological field, rather than apply standards from quantitative research (Morrow, 2007). She cites 'thick description' (Geertz, 1973), researcher reflexivity, the quality of the analysis and consideration of the context of the research and of participants' lives as some of the many criteria that may be used when evaluating quality in qualitative research (Morrow, 2007). Similarly, whilst cautioning against the use of a checklist, Riessman (2008) outlines four areas in which validity may be considered within a qualitative research paradigm. These will be considered below in line with this research.

Historical truth and correspondence

Riessman distinguishes between the validity of the story, as told by the participant, and the validity of the analysis, 'the story told by the researcher' (Riessman, 2008, p. 195). She suggests that the latter can be subject to scrutiny through the methods used, choices made and the audit trail of the research process. I have endeavoured to make the choices made and process guiding this research explicit to readers. An audit trail of the research process can also be found in the appendices, along with reflections on my engagement with the research process as evidenced in my research journal.

Coherence, persuasion and presentation

It is pertinent for the researcher to bring the data together in a way that is persuasive and coherent (Riessman, 2008). I hope to have provided a coherent, persuasive, account of these women's stories in my analysis, not only highlighting points of convergence and divergence (Riessman, 2008) but also integrating the tensions and complexities of their narrative accounts. My use of excerpts from these women's accounts supports the plausibility of the story that I tell of their experiences and adds support to the analytic claims that I am making (Riessman, 2008). I have also included primary data from interviews in the appendices to demonstrate my reflexive engagement with the data and to enable the reader to understand my particular use of the analytic method, and the conclusions that I have drawn in the process. **Pragmatic use** can also be demonstrated in making the research process as transparent as possible, as noted above.

In evaluating validity, Riessman includes the extent to which the data serves a **political and ethical use** (Riessman, 2008**)**. This research forms part of a broader appraisal of the discursive context of motherhood, using a critical lens to examine the relationships between subjective experience, narrative, and social discourse. On an ethical level, I have given much thought as to how to work with the data in collaboration with my research participants. I shared a first draft of the analysis with each research participant, with an opportunity to feed back thoughts and reflections via email or in a meeting with me. Copies of the transcript were also offered to all participants. This involved a complicated set of decisions regarding exactly what and how much of my analysis to share, as well as how to navigate potential differences in interpretations. Conversations with my research supervisor helped me to reflect upon this process and I made the decision to share a summary of each participant's narrative account, including tone and rhetorical function. This excluded reflections on identity work and the application of a feminist lens as a critical hermeneutics of suspicion (Langdridge, 2007). This decision was informed by my primary aim: to ensure that I had captured the essence of participants' narratives as accurately as possible, and not excluded anything meaningful. However, alongside this, I was also concerned that participants may not be able to recognise themselves as easily in the other sections (Langdridge, 2007) and that we might enter a complicated theoretical dialogue regarding identity work and broader feminist conceptualisations. This, of course, should not be a reason to avoid engaging in the process; however, the constraints of this research project and of my own resources played a role in making this decision. I hope that this way, participants still benefitted from being given the opportunity to review my representation of their narratives.

Riessman also points to the epistemological difficulties in using the concept of 'trustworthiness' in qualitative research, which, generally, looks to explore meaning rather than establish facts (Riessman, 2008). Similarly, Bruner explores some of these dilemmas in relation to hermeneutic analysis in qualitative research: he argues that the researcher's reading of the text can only be judged against other readings (Bruner, 1991). There is no objective 'truth' that can act as a benchmark (Bruner, 1991). This, he argues, constitutes the dilemma of the hermeneutic circle (Bruner, 1991). Narrative truth, then, becomes about coherence between the parts and the whole; he states: 'In effect, the best hope of hermeneutic analysis is to provide an intuitively convincing account of the meaning of the text as a whole in the light of the constituent parts that make it up’ (Bruner, 1991, p.7). I hope to have offered this in my analysis, as found in Chapter Four below.

Chapter Four

Analysis

4.0. Chapter overview

This chapter begins with the first stage of the analytic method of CNA: a critique of the illusions of my own subjectivity using my chosen hermeneutic, feminist theory (Langdridge, 2007). This is followed by a narrative overview of each participant's account, including reflections on tone and rhetorical function. Subsequently, I offer a critical examination of identity work within participants' narratives, followed by an exploration of the main themes across the narratives. Finally, I will offer reflections from Stage 5 of the analytic process, in which I subject the data to a critical hermeneutic of suspicion in the form of feminist theory to destabilise the narratives.

4.1. Stage one: A critique of the illusions of the subject

In stage one, I subjected myself to a critique using my chosen hermeneutic of suspicion, feminism, to reflect upon the assumptions and beliefs that I hold regarding early maternal distress, and the ways in which this may shape my engagement with the data (Langdridge, 2007). In this stage, I also reflected upon the personal meaning of this topic for me (Langdridge, 2007).

Many of the beliefs and assumptions that I hold regarding postpartum psychosis originate from salient experiences from my own developmental history. Having witnessed my mum struggle with debilitating anxiety and, at times, paranoia, which started in the postpartum period with my older brother, I have a strong emotional connection to this research. I feel passionate about taking women's experiences seriously, as well as giving voice to them. In my reflections, I have wondered if this may constitute an attempt to balance what felt like my own mum's voice being silenced in relation to the psychiatrists and other health professionals involved in her care, as I witnessed her confusion and dependence on others to navigate her way through in moments of distress. As a family member, I was also looking for a way to make sense of what happened in these moments, and the dominant biomedical paradigm, which traced the cause of her difficulties to chemical imbalances in the brain, seemed limited and lacking to me.

Undoubtably, the emotional legacy of my own developmental experiences has been present for me on multiple levels in my engagement with this research and has informed the lens through which I have interpreted participants’ experiences. I have reflected on how the part of me that was looking for some kind of clarity in this research, to perhaps speak to the confusion I felt as a child, might have failed to engage fully with the messier aspects of participants’ stories. I was also mindful that this could translate into a rushed analytic process, prematurely coding the data rather than staying with analytic disorder and not knowing.

In regards to psychosis, my theoretical leanings have been influenced by the notion that experiences that might be commonly be referred to as psychosis constitute attempts to make sense of distressing, stressful or traumatic life experiences (Cooke et al., 2014; Seikkula et al., 2001; Harper, 2011). I acknowledge the debates surrounding biomedical explanatory frameworks (Cooke et al., 2014); however, in my practice as an integrative psychotherapist and trainee counselling psychologist, I am predominantly aligned with theories that foreground the relational and social contexts in which experiences of psychosis arise, including contexts of social inequality (Cooke et al., 2014; Cromby & Harper, 2009). In my professional view, meaning and selfhood are central to the experience of psychosis (Ogden, 1980). This is a particular lens through which I have co-created and interpreted these women’s stories.

An awareness of gender and power dynamics in the context of psychological distress has for me, underscored the importance of bringing a feminist lens to this research (Burns & Walker, 2005). In line with this, I have endeavoured to give voice to the women who participated in this research and yet, I have felt this to be in tension with the need to engage critically with their stories as part of the analytic process of CNA (Langdridge, 2007). This critical engagement has felt like a betrayal at times, and I have been mindful of the complex set of power dynamics inherent in representing participants’ stories, and in my position as a researcher and a psychologist in training. In line with questions of power and representation, I have reflected on social differences within the context of this research using the social GGRRAAACCEEESSS (Burnham, 1992; Burnham, 2012). I am aware that my social location, as a white, middle-class, heterosexual, educated and able-bodied mother not only affords me privilege but also shapes the lens through which I hear and interpret these women’s experiences. This includes, but is not limited to, the process of identifying what I may consider to be salient aspects of their stories, as well as my analytic interpretation of identity claims and themes across the narratives. I have also reflected on how social difference will have shaped the narratives that have been co-constructed in this research, as participants may have foregrounded or sidelined parts of their experiences not only in response to my active engagement but also visible or voiced aspects of difference arising in the research encounter (Burnham, 2012).

In my reflections, I have also noticed tensions in my engagement with the topic of motherhood on personal and professional levels. For instance, whilst I draw from attachment theory in my professional thinking (Bowlby, 1969), on a personal level, I am also influenced by feminist approaches, which have critiqued attachment theory for negating the importance of the social context of motherhood (Orbach, 1999) and have highlighted the particular historical and political context in which Bowlby developed his ideas (Franzblau, 1999; Vicedo, 2011). Tensions between attachment theory and feminist values have also arisen in my own experience of becoming a mother. I acknowledge having internalised societal discourses of the ‘good’ mother and that I do, at times, judge myself against these ideals. This has left me feeling proud for some of my parenting practices that hold cultural currency; for instance, for having a ‘natural’ delivery and for exclusively breastfeeding.

In my reflections, I also noticed some of these feelings arising for me during my engagement with this research, which left me feeling uncomfortable, yet also curious. From a feminist perspective, this speaks to the pervasive nature of societal discourses and underscores the difficult feelings that can mark women’s relationships as situated within broader societal structures and discursive frameworks (Orbach & Eichenbaum, 1994). It also speaks to the power dynamics at play in this research. Indeed, I am mindful that I am well-resourced to take up the role of the ‘good’ mother: I have financial means, social support and extensive psychological training that has afforded me the ability to engage in my own therapeutic process and to reflect on different dimensions of my experiences. I am also aware of the resources I hold to reformulate aspects of my own story, and to draw upon a range of interpretive devices in my own narratives.

Finally, whilst my mum experienced postnatal distress after having me and my brother, as well as ongoing psychological difficulties throughout my childhood, I did not experience any kind of postpartum distress after having my daughter. In fact, I found the first few months of motherhood to be a blissful interruption of my hitherto busy life, abound with multiple, demanding, commitments. At times, this left me straddling an insider/outsider position in relation to the topic explored (Braun & Clarke, 2013).

4.2. Overview of narratives

In the section that follows, I will provide a brief descriptive overview of each participant's narrative, including reflections on tone and rhetorical function. Women's narratives are presented in the order in which interviews took place.

4.2.1. Emily: *That's not how it should have been*

Emily is a 38-year-old married woman. She has two children and was diagnosed with postpartum depression 'with psychotic features' after the birth of her first child 9 years ago. Emily was initially admitted to hospital and treated for an infection, as this was believed to have been the cause of her symptoms. She was subsequently admitted to a psychiatric ward and separated from her baby, before being transferred to a MBU, where she stayed for approximately 3 months under section. Emily received Electroconvulsive Therapy (ECT) whilst at the MBU, and was prescribed antidepressants and antipsychotic medication. Emily also attended weekly sessions with a psychologist prior to discharge from the MBU.

Emily did not experience postnatal distress after the birth of her second child. She attended psychological assessments during her second pregnancy but chose not to pre-emptively take psychiatric medication.

Narrative overview

Emily's account centres around a master narrative, that of her lived experience of postpartum psychosis. This is interwoven with a narrative of motherhood, in which the unknowns of new motherhood overlap with the turmoil and confusion of early maternal distress.

Emily starts her story of postnatal distress with the traumatic birth of her firstborn, which ended in an emergency caesarean section, followed by difficulties with breastfeeding. A temporal and explanatory line is thus traced between these experiences. In her narrative, early maternal distress is constructed as a frantic, disorganising, experience. This comes through both in her description of this time and in the somewhat fragmented nature of her account in parts. Describing her experience of being in the MBU, Emily says:

> It was some time before I was fully aware of kind of what was going on and I think, at the time, I felt aware but there's, there's kind of gaps between what I remember or, it merged a little bit

She does on to tell me: 'I couldn't quite work out when and how things had happened to be honest', and that, 'It's just all very random, I just remember it feeling quite random um just how it was happening'. The use of present tense here, 'It's just all very random', brings a sense of disorientation into the room and conveys an overlap between the gaps in Emily's memory, as she looks back on her experience, and the disjointed quality of the experience itself.

In the early stages of postnatal distress, Emily describes 'spiralling', not sleeping and not feeling able to look after herself. There is a powerful sense of bewilderment, which comes across as Emily tells me how, when in the MBU, she misrecognised staff and patients for people in her life outside of this context:

> And it was just weird like, it was an odd thing, but it was like, I, certain traits of the people around me I'd think, well you're like such and such, but I didn't necessarily think they're like them, I thought they were them

This bewilderment also seems to form part of Emily's experience of ECT, which is described as 'weird' and like 'going into some parallel universe'.

In her account, a recovery narrative overlaps with that of motherhood, as Emily suggests that being with her baby was integral to getting better: 'I don't see how I would have got that much better if I was apart from my baby'. She goes on to say: 'But it's the, it's the fact that I could still carry on being a mum'. Motherhood is thus constructed as both the cause of her difficulties, as well as the solution: 'You know, that was the point, you know, that was why I was in that situation and why I'd gone through that'.

Canonical narratives of motherhood are both drawn upon and contested. At one point, Emily constructs mothering as learnt rather than instinctive: 'I wouldn't have been able to still learn, you know, be a new mum', challenging a pervasive rhetoric in which being a mother is cast as instinctive and natural. However, at other points, she draws upon normative representations of motherhood in aligning herself with the construction of the 'good mother' in telling me how her ability to look after her baby was not compromised by her difficulties: 'I always focused on (baby), I would, there was no issue with that side of things'. This is explored further in section 4.3.

Strong feelings of frustration, loss and anguish come through in Emily's account, which tie into broader themes of agency and subjectivity. Emily describes a troubling experience of not being heard when initially seeking help, recounting: ‘And you do feel like, you’re not really listening to me here, and I do know myself better than I think anyone else knows me so I know when something’s not right’. This loss of voice is interwoven with a broader, emotive, theme of loss in Emily’s experience of new motherhood in the context of postnatal distress. This comes through at multiple points in her narrative; for instance, when she reflects upon the gaps in her memory from this time, symbolic of a broader loss in her experience of motherhood: ‘It was a chunk of time, you know, that is, you know, my little boy, and I think if I don’t remember all of that, then that’s just not right to me, you know’. Reflecting on the gaps in the photos she has from this time, this loss is reinforced as Emily poignantly describes her grief and regret for missing out on an expected experience of early motherhood:

> But there is a little period of time where there probably aren’t as many or there’s some that when we’re in hospital so it’s obviously a, different surroundings, and it’s a little bit like, oh, I don’t know about, not that I don’t want to remember but also that, that’s not how it should have been maybe

A sense of ambivalence comes through here as Emily suggests tensions between remembering and not remembering aspects of her difficult and distressing experience.

Similarly, Emily describes a loss in terms of being unable to access her feelings whilst on psychotropic medication, framing this missing out on a fundamental experience of the self. Describing her experience of coming off medication, she tells me:

> Once it was fully out of my system, I could feel, it felt like something had switched on *(uh huh)* in my brain um like just like felt awake and I just, weird, strange um but I think I‘ve said it just kept me at a level, the highs and lows, it was like a switch of, oh I can actually feel again, which is me, you know, that’s quite nice you know if I wanna cry, I cry, if I wanna laugh, I laugh

However, this rediscovery of herself echoes a sense of loss as Emily raises a question around whether she actually needed this medication, and, therefore, whether it had been necessary to endure these side effects: ‘I suppose when I think about it, the treatment I had that worked was the shock treatment and maybe I didn’t need all of the medication’.

Tone

Overall, the tone of Emily’s account is reflective, as she looks back and raises questions about her experience. At other points, the tone is lively and light-hearted; for instance, when Emily describes returning to her GP at her 6-week check. Here, introducing a comedic tone, she tells me, whilst laughing at points:

> I, I went outside the doctors and thought I’m just, I’m not happy with that, so I actually went back in, which the receptionist wasn’t too happy about, but I was like, I need to just carry on that conversation kind of thing

At other times, the tone shifts to being sorrowful and regretful, such when Emily talks about the impact of this experience on her husband and parents. This contrast, between humour and sadness, is emblematic of a tension that runs throughout Emily’s account, in which the suffering that accompanied this experience, both for herself and her family, is at points, acknowledged, whilst at other points, lightened and distanced through humour. This comes through in particular in a dialectic between acknowledging the losses associated with this experience and in the expression of gratitude for what went well.

Rhetorical function

In her account, Emily predominantly constructs herself as agentic and self-aware. This is reinforced through the way in which she portrays herself as active and discerning in making treatment choices when able to, such as deciding to come off psychotropic medication. She tells me: ‘But I remember coming out and think- you know, being very determined in that, well, I’m not going to be on this medication forever because this was an episode, I’m now over that’. As though justifying this decision, Emily talks about the troubling side-effects she experienced from the medication, implying that this interfered with her ability to parent: ‘I think it was the antipsychotics just made me really sleepy and like, just not with it at all, I can’t be like that, I’m like at home with a baby’. She later, poignantly, says: ‘It's not a way to live’. This is perhaps suggestive of a felt need to justify these decisions, highlighting the authoritative nature of psychiatric intervention in the treatment of postpartum psychosis. At the same time, it speaks to the possible influence of my own professional status coming into the room, as a trainee psychologist, and possible representation of a more medicalised stance.

The construction of an agentic self is set in contrast to a more passive, disempowered position that Emily constructs at other points in her narrative. For instance, when talking about the discharge process from MBU, she says: ’I’d be like, uh, I’m still here and, but I feel alright, why I, can’t I just be at home’. In her account, this infantilising position lies in tension with the expectations and demands of motherhood.

Postpartum psychosis is portrayed as unchartered territory. Arguably, this serves the rhetorical function of highlighting Emily's reliance on healthcare professionals for advice and guidance in this time, emphasising patient vulnerability and dependence. For instance, when talking about her experience of ECT, Emily says:

> I obviously had to consent to the shock treatment, which I do remember, I remember signing a form but again, you know, it was difficult cause it's like the whole way through, you know, you don't know, you've got no comparison, it's all new and its, you trust the doctors

Here, Emily undermines the credibility of patient consent in these kinds of circumstances, drawing attention to the authority and responsibility that health professionals hold. This also connects to a tension between criticism and praise of mental health services, which surfaces at different points in Emily's account. At one point, Emily tells me how she was let down by her GP and other health professionals; however, this is then countered by comments that seem to soften this criticism, as Emily states: 'Obviously the mind is a very complex thing and it must be the worst thing to treat'. In doing so, Emily constructs herself as reasonable and empathic, arguably distancing herself from stigmatising representations of mental ill-health, yet also perhaps protecting me from feeling this criticism.

Emily also reiterates how lucky she was in the treatment that she received, which further softens her criticism through the expression of gratitude: 'I was lucky that I could be in that hospital and get that treatment'. This speaks to an implicit narrative around everything that could have gone wrong had Emily not been able to access support in time, thereby emphasising the importance of early care and intervention for postnatal distress, and again, offering a subtle critique of health services in highlighting the risks involved in not responding adequately.

4.2.2. Catherine: *I tried to run away um and they kept bringing me my baby*

Catherine is a White-British, married woman, with two children. She is now retired, having previously worked as a bookkeeper and as a solicitor. Catherine responded to a research advert shared through the Association for Post-Natal Illness (APNI), where she volunteers.

Catherine experienced postpartum psychosis 37 years ago after the birth of her first child. Shortly after childbirth, Catherine was hospitalised in a general psychiatric unit for treatment. She was separated from her baby during this time. She went on to have another child and did not experience maternal distress.

Narrative overview

Catherine's account is rich, coherent and reflective. By starting her story with the idea of who she was before becoming a mother, a competent solicitor in her twenties, Catherine communicates a powerful rupture in her sense of self that accompanied motherhood and her experience of postpartum psychosis.

The master narrative that runs throughout Catherine's account concerns her lived experience of postnatal distress. This is recounted as beginning with a change in sensory perception, immediately following childbirth: 'I can remember hallucinating, patterns on the curtains and things were moving'. The experience is portrayed as a time of temporal discontinuity: 'It was as if time had been chopped up', and as terrifying and confusing, as illustrated by the horrifying beliefs that Catherine shares having experienced at the time:

> I was concerned that I had died and gone to heaven, and they were trying to get my kidneys. Actually what, what I realised they were trying to do was trying to give me an injection in my bottom to calm me down but I thought they were trying to take my kidneys out whilst I was still awake, so it was all very, very traumatic at the time

Catherine conveys her experience of postnatal distress as a time of profound reflection and existential questioning, telling me: ‘And I started making, trying to make sense of my life, and life’. At one point, these reflections are portrayed as inconsequential and unhelpful, as Catherine tells me: ‘I was just obviously digging myself in deeper and deeper and I have to get out of the hole rather than going back further, further in’. However, at another point, Catherine offers a thoughtful interpretation of her beliefs at the time, indicating that they may have been related to unresolved questions concerning personal identity and family heritage. She tells me that there had been a ‘missing link’ in the unknown figure of her paternal grandfather, which seemed to trouble her in relation to the identity of her newborn baby, stating: ‘My son is, obviously, had something in him from an unknown person’.

This connects to a theme of spirituality that comes through in Catherine’s narrative. Recounting her lived experience of postpartum psychosis, she describes having visions of God ‘telling her things’, and experiencing great confusion over whether her baby could have been Jesus or the devil. She tells me: ‘So it could have been God’s son, it could have been the devil, it could have been in disguise so it was a matter of, it could have been one of the other, so it was a trick, yeah’. The distressing and sensitive nature of this experience is later underscored as Catherine shares that she ‘didn’t want to be alone with the baby because um one of the things you think, of harming the baby’.

From the start of her account, Catherine’s narrative of psychosis overlaps markedly with a motherhood narrative in which Catherine describes the transition to motherhood as laden with ambivalence. At points, Catherine locates this ambivalence as central to her experience of postnatal distress; stating: ‘You know, I wasn’t really keen on doing that myself, at the time, because I had all other things going on, I think, you know, that was what it was all about’. In overlapping narratives of motherhood and postpartum psychosis, Catherine portrays herself as living in an inescapable nightmare and there is a real sense of powerlessness as she tells me how she desperately tried to get away from her baby, and from a life that she perhaps did not want for herself, at the time: ‘I tried to run away um and they kept bringing me my baby and I thought, how can I look after a baby, so it was quite distressing’.

Tone

In her narrative of postpartum psychosis, the tone is frantic and frenzied, which shifts to one of unease and panic as Catherine describes her attempts to escape hospital. At other times, particularly when reflecting on her experiences, the tone is wistful and serious.

In her narrative of motherhood, the tone is predominantly regretful and at times, self-critical, as Catherine looks back on her experience of becoming a mother and reflects upon some of her parenting practices at the time: ‘But I think, looking back, I was quite hard on him as a little boy’. At other points, the tone is derisive, such as when Catherine talks about traditional models of motherhood, embodied by her mother and mother-in law. This underscores her rejection of conventional forms of motherhood.

Rhetorical function

This is, largely, an explanatory story, in which Catherine foregrounds a reflective narrative, constructing the experience of postpartum psychosis as deeply embedded in her relationship with motherhood and unresolved questions around identity and heritage.

It could be argued that her critique of a traditional model of motherhood serves to justify the maternal ambivalence that Catherine experienced at the time, protecting her against judgement for feelings that might be considered taboo. Catherine also draws upon the concept of ‘matrescence’, which could be understood as a rhetorical means of normalising the struggles that she faced in her transition to motherhood.

Overall, Catherine constructs herself as agentic and resourceful in response to the psychological difficulties she encountered. Arguably, this offers continuity in the construction of selfhood, bridging a gap between Catherine’s pre- and post-motherhood self. She tells me: ‘I was always saying um everything negative has got the opposite positive, so the fact it was a very negative experience then, that means positives are huge afterwards (*yes*), because you’ve got so much to gain afterwards’. This connects to a story of personal resilience, in which Catherine cites her childhood experience of asthma as laying the foundations for overcoming future challenges:

> I mean, when I was a child, I was an asthmatic so quite poorly and quite (*okay*) and quite um, in hospital quite a lot um so you know you kind of think well, I’ve got over that, I can get over this

There also appears to be a tension between opening up a reflective space around her experience, and closing this space down by locating the experience firmly in the past: ‘That was then and this is now, and we move on’, echoing the use of humour in Emily’s account as a means of creating distance from the experience.

4.2.3. Rose: *How am I going to get out of this?*

Rose is a 66-year-old British-Caribbean woman. She has two children and is divorced. Rose is retired, having previously worked in the health sector.

Rose experienced postpartum psychosis after the birth of her first child. Rose’s difficulties were not responded to until her child was one year old, even though she recalled having struggled since childbirth. Rose was hospitalised in a general psychiatric unit and was prescribed psychopharmacology medication as a treatment intervention. She was separated from her baby during this time. Rose did not experience postnatal distress after having her second child.

Rose responded to a research advert through the Association for Post-Natal Illness (APNI).

Narrative overview

Rose presented rich, detailed and dramatic narratives in her account. The master narrative, that of her lived experience of postpartum psychosis, is interwoven with a number of other narratives, including that of motherhood, trauma, identity and a broader life narrative. Arguably, this serves the rhetorical function of explaining, and possibly justifying, Rose’s psychological difficulties during early motherhood by contextualising her struggles within a broader set of adversities. It also means that Rose’s story is most readily taken as a whole.

In Rose’s account, discussion of the lived experience of postpartum psychosis overlaps with a narrative of the transition to motherhood. Pregnancy is portrayed as an anxiety-ridden time, which, following a traumatic delivery, tips into a subjective state of disconnection and disorientation. Describing her journey home upon leaving hospital, Rose tells me:

> It was evening time and I got to the um roundabout and even the buildings didn't even look right, I had, I was just on a totally different, I was totally out of phase with the rest of the world, that's the only way I can describe it (*hmm hmm*), I didn't understand why and that was straight after, that was like from birth

Rose tells me how, despite feeling 'terribly, terribly anxious', she 'put a wall up' and hid her difficulties from her health visitor at the time. Similar to Catherine, in her account, time is fragmented, as Rose recalls, 'I can't put it on a timeline, I'd gone through a phase where I didn't feel right but I'm not sure when it was'. Echoing Emily's account, there is an overlap between the discontinuity of the experience and the fragmented nature of Rose's memory, as she tells me: 'I apologise cause it's very jumbled now, I mean we're going back a lot of years but also my brain wasn't functioning properly'.

Early motherhood is portrayed as a very difficult time, as Rose describes struggling to soothe her crying baby:

> And one point, once he started to cry, he would raise the crescendo, it would go, be a crescendo to the point where then he would shut his eyes and then you could not involve yourself with him so he couldn't see you, so you couldn't do that (*yeah*), he couldn't hear you because his voice was too loud to, he shut you out

On top of this, Rose recounts a number of adversities that she faced in her first year of motherhood, including a profound lack of family support, redundancy and a difficult house sale in which her mother 'gazumped' her. In her narrative, the angst and stress of everything that she endured in this first year of motherhood comes to a head whilst Rose is on a training course for a new job. She tells me how, as the course ended:

> I couldn't find my way, I was in the car driv- but didn't know, I didn't, on the day like we finished the training course, and then I was coming home, I was totally lost (*hmm hmm*), totally off on one

Linking her experience of postpartum psychosis to being separated from her baby whilst on training, postpartum psychosis is constructed as a more severe form of anxiety, at the extreme end of a continuum. She tells me: 'I was always worried something could happen to him (*hmm*) but it was whilst I was actually on the training course that I actually became psychotic'.

Rose draws upon rich metaphors to describe her experience of psychosis. She tells me, 'I could feel like my brain was being squeezed like a sponge' and foregrounds the physical sensations, such as feeling cold and shaky, to convey the embodied nature of her experience.

A theme of disconnection, introduced early on in her narrative, is later echoed as Rose describes her experience of being admitted to a psychiatric unit. She tells me: 'I can remember being, er thinking, how am I going to get out of this?', and goes on to say: 'So I didn't think, when I was actually discharged, that I'd ever get back up to speed with the rest of the world'. Rose describes feeling 'alienated' during this time and, slipping into the present tense, asks: 'The world's been bypassing me for so long now, for nearly a year, will I ever be the same as I was before?'. The use of the present tense here conveys a powerful sense of immediacy to Rose's narrative and reinforces the portrayal of psychosis as constituting a breach in Rose's connection with the rest of the world and with herself. It also hints at a more long-lasting change in identity in relation to this experience.

At points, Rose’s account shifts into a more explanatory narrative, as she draws upon experiences related to trauma, family and identity to account for her postnatal distress. Locating this realisation as pivotal to the start of her psychological difficulties, she tells me how knowing that her mother couldn’t have loved her in the way she loved her own baby prompted a profound questioning of her own maternal capabilities at the time: ‘I didn’t have anything to pull on, to draw on, to give, to give, I felt like I was gonna fail him (*hmm)* because I didn’t have that background of love to give him’. Indeed, throughout Rose’s account, family trauma is presented as intergenerational, with her own experience of postnatal distress constructed as something that carries implications for son’s current psychological wellbeing. In doing so, Rose shows great preoccupation for the potential impact that her experience of postnatal distress might have had on her child, drawing upon a canonical narrative that frames psychological difficulties as meaningful responses to adversity.

Finally, a broader life narrative within which Rose’s experiences are situated tells a story of struggle and adversity, whilst a compelling identity narrative constructs these experiences in terms of personal growth and transformation.

Tone

Within Rose’s account, the tone is a mix of optimism and pathos. The tone is optimistic when Rose talks about her personal growth and when she conveys hope to others who might be enduring similar experiences. This optimistic tone lies in contrast with one of sadness, regret and preoccupation, as Rose reflects upon the implications of early separation from her baby whilst in hospital. This gives the impression that aspects of the experience remain unresolved for her; for instance, when Rose says: ‘I do, I do, I do think about that’.

When discussing medical authority and patient records, the tone is confrontational and there is a powerful sense of frustration, as Rose states: ‘Am I entitled to the full picture; am I?’. At other times, the tone is more reflective, as Rose wonders about the causes of her psychological difficulties. Arguably, the reflective tone of her account reinforces some of the identity work being done around the kind of person that Rose presents herself as being, which sets her apart from the rest of her family, possibly supporting the construction of a more enlightened, and arguably, relationally superior, position in her narrative.

Rhetorical function

Rose’s account is replete with repetition, questions, dramatic statements and metaphors, creating an emotionally impactful story and conveying a powerful sense of immediacy that draws the listener in. The use of pathos is accompanied by a meandering style of storytelling, in which I felt I had to focus hard on Rose was trying to tell me. This could be seen as creating a more intimate connection between storytelling and listener, as Rose interweaves her experience of postpartum psychosis with her life story, whilst at the same time, keeping the listener at a distance.

Rose tells a powerful story of triumph over tragedy, and transformation from victim to survivor. Her use of extreme case formulations, ‘I never will’ and ‘I’m always going to blame myself’, add emphasis to the power of this experience for her. In situating her narrative of postpartum psychosis within a broader story of struggle, Rose emphasises her personal transformation and conveys her determination and resilience. This construction of a survivor position is reinforced as Rose recounts a conversation with one of the consultants in hospital; telling me:

> She just said, you’re one of our successes, she said, you’re one of our successes, which was probably, well it stayed with me (*hmm*), it stayed with me you know, I, I, weathered the storm, came out the other end and was able to move forward

4.2.4. Sophie: *I was wading through treacle*

Sophie is a 39-year-old, White British, married woman. She works in agriculture and has two children.

Sophie experienced postpartum psychosis in 2015 after the birth of her first child. This resulted in an admission to a MBU, lasting for approximately one month. Sophie did not go on to experience postpartum psychosis after the birth of her second child. Sophie has been given a tentative diagnosis of bipolar disorder.

Sophie responded to a research advert placed through Action on Postpartum Psychosis (APP).

Narrative overview

The master narrative in Sophie’s account concerns her lived experience of postpartum psychosis. This overlaps with a narrative of motherhood and a broader identity narrative.

Postnatal distress is portrayed as an overwhelming, frightening and confusing experience. There is a temporal quality to Sophie’s narrative as she describes the sequence of events that unfolded following the birth of her first baby, which ultimately culminated in a hospital admission. Her narrative begins with the description of a ‘traumatic’ delivery, involving third degree tearing and being ‘rushed into theatre’. Sophie tells me how this ‘was quite surreal’, and that she ‘felt really cold, and it felt out of body experience’. She describes having ‘racing thoughts’ whilst in hospital after having given birth, followed by engaging in frantic list-making and being unable to sleep. Sophie suggests that this period, which she describes as a ‘high’, lasted 3 months. Introducing a turning point in her narrative, Sophie then tells me how one day she felt ‘really depressed’ and ‘really down’. Conveying a sense of hopelessness and overwhelm, she describes her experience during this time in the following excerpt:

> And just feeling like I was wading through treacle and my head was spinning and I just didn’t want to be in such close contact with lots of people and just felt you know felt seriously like I couldn’t, I couldn’t do it

Sophie tells me how it is at this point that she visits her GP and is prescribed antidepressants in line with a diagnosis of postnatal depression. However, distinguishing her subjective experience at the time from that of postnatal depression, she tells me:

> I remember thinking this can’t be postnatal depression because if, like I knew a lot of people got that and I thought, how are people coping with it, cause it was just horrendous, I thought I was gonna kill (baby), had suicidal thoughts

Conveying a sense of intensifying and escalating distress, Sophie tells me that she then started to believe that her husband was ‘controlling time’ and describes experiencing extremely distressing images, such as her home burning down. In line with this, Sophie’s narrative conveys a disjointed experience of seeking and receiving help: she tells me how, eventually, she was admitted to hospital and prescribed olanzapine but was then discharged back home. During this time, things worsened for her. Powerfully, and in great detail, she describes her experience at this time:

> I got even worse and I was just sat rocking in a chair and I wouldn't eat, I wouldn't wash and I wouldn't drink, I was really dehydrated (*hmm*) um and then I started believing that everyone were Mormons so (husband) wasn't really my partner and my dad had lots of wives, one of them being (husband's) grandma um and I thought in some way I was going backwards so I thought I was (baby) um and I was going backwards so um the Mormons wanted this baby and were bringing a baby off a streetworker off the street and making them into a baby, which was me, I can't really explain it, sounds absolutely insane now but at the time I was convinced that (baby) was for the Mormons and the Mormons wanted her

Suggesting an alarming disparity between her internal world and the perception of others, she tells me how she was nearly discharged from the crisis team at this time, one of great distress:

> So when the lady came and she wanted to sign me off, cause you see different people don't you (*yeah*) depending on who's on shift, um I thought that she was telling (husband) I was gonna kill (husband) with her eyes (*hmm*) so I really wasn't well and then (husband) said she was actually saying she was gonna sign you off

Sophie tells me how she is eventually admitted to a mother and baby unit. At this point, her narrative conveys a sense of relief in the realisation that is not alone in her experience, contrasting with the disconnection and isolation of her earlier experience. Sophie tells me: 'And actually everyone had postpartum psychosis (*yes*)

I thought I was the only one'. She goes on to say: 'So, you know everyone was going, going through it'.

The remainder of Sophie's narrative follows a less defined temporal structure as she recounts tensions in her identity relating to psychiatric diagnosis and the prospect of taking psychotropic medication for the rest of her life. In the following excerpt, Sophie tells me about this:

> She's actually said to me, because I might have bipolar, just I'm gonna have to stay on quite a low dose of it for the rest of my life, don't try and come off it (*I see*) so (*gosh, yeah, how was that to hear, to hear her say that?*) horrible, really horrible

Later, poignantly, Sophie tells me: 'Life's completely changed', conveying a sense of postpartum psychosis as an irreconcilable experience.

At the core of Sophie's narrative lies a question that asks whether she would have experienced postpartum psychosis had she not become a mother. Tracing a line from postpartum psychosis to her tentative diagnosis of bipolar disorder, she wonders: 'Um so if I am bipolar, then obviously, I'm gonna be blaming the postpartum psychosis for making me that way, or I'm thinking if I hadn't had children, would I, would I be on this medication'. Later, Sophie formulates this into a question around motherhood, reflecting: 'There is that thing where you know, if I hadn't had her, would it have happened'. Highlighting the complicated and multifaceted nature of her thoughts and feelings around this, she tells me: 'But then I think, well, if I hadn't had her then she wouldn't be here and you know, I am, I would do it again, even going through all the same stuff and not knowing what it was'.

Sophie also raises a question regarding biological heritability in light of her own mother's psychological difficulties. Here, the cause of Sophie's struggles is, at least partly, attributed to genetic factors, creating a sense of inevitability that goes beyond that of becoming a mother, yet that also integrates the future of her children into the narrative. Sophie tells me: ‘I mean, it’s probably likely that I would have had some sort of episode from a stress in my life or something like that’. The suggestion that her experience of postpartum psychosis might have arisen from an inherited condition undermines a potential link with motherhood, possibly enabling the emergence of a less conflicted narrative.

Tone

Overall, the tone of Sophie’s narrative is tragic, supporting the construction of a story that charts great suffering, distress and life-changing experience.

As the narrative shifts to Sophie’s current reality and her imaginings about the future, the tone becomes preoccupied and has an unresolved quality, reflecting the untold nature of these future narratives and the uncertainties contained therein.

Rhetorical function

Sophie’s narrative is a combination of description, reflection and explanation. Her account is incredibly rich and full of detail. In constructing her identity in relation to her psychological difficulties, postpartum psychosis is portrayed as the start of a set of lifelong changes in her relationship with herself and with others. As a result, in her narrative, the experience of postnatal distress is less firmly located in the past than in other participants’ narratives, blending into the present and into the future in as yet unstoried ways. This results in her account conforming, in some ways to that of a ‘chaos narrative’ (Frank, 1995).

In describing her subjective experience of postnatal distress in such detail, Sophie illustrates, with great profundity and emotional resonance, what it is like to experience postpartum psychosis. Her story could be considered a means of constructing a sense of order in the context of an extremely disorganising experience; this is supported by the temporal structure of her narrative. At the same time, there is a fragmented quality to her narrative, as Sophie moves between different moments in time; again, possibly reflecting the disjointed nature of this experience.

4.2.5. Gwyneth: *Coming out the other side*

Gwyneth is 34 years old, married, and has a two-year-old son. She works as a project manager.

Gwyneth experienced postpartum psychosis in March 2020, just before the first UK lockdown in response to the Covid-19 pandemic. She spent just under two months at a MBU and was prescribed antipsychotics and antidepressants. Gwyneth is not currently taking any psychiatric medication, having completed a programme of gradual withdrawal subsequent to her discharge from the MBU.

Following her experiences, Gwyneth has taken up an active stance in campaigning for increased awareness of postpartum psychosis, participating in research studies and speaking at conferences. Gwyneth responded to my research advertisement placed through APP.

Narrative overview

The master narrative in Gwyneth's account concerns her experience of postnatal distress, constructed as a discrete episode in time. Similar to the other research participants, Gwyneth's narrative is intertwined with a narrative that charts her transition to motherhood, as well as a powerful recovery narrative. In framing her difficulties, Gwyneth draws upon canonical narratives of ‘mental illness’, motherhood and family life.

Gwyneth’s account of postnatal distress tells a story of an unexpected and bewildering experience. From the start, a contrast is drawn between her ‘straightforward pregnancy’ and subsequent ‘traumatic’ experience of childbirth. This culminates in an assisted delivery and immediate separation from her baby, as he is taken to the neonatal unit due to breathing difficulties and for treatment for an infection. Early on, this introduces a theme of loss, as childbirth is constructed as a double loss: not just of her desired birth experience but also of those first moments with her newborn baby. Gwyneth tells me: ‘I didn’t have that immediate bond (*hmm*) I suppose that you get when you first have a baby’, thereby invoking canonical narratives of motherhood and psychological discourses of bonding to evoke an experience that she missed out on. At the same time, she introduces the idea that this early separation from her baby played a role in her maternal feelings and in the development of her postnatal distress. This theme of loss runs throughout Gwyneth’s account of early motherhood.

In her narrative of psychosis, the immediate aftermath of childbirth and subsequent days are portrayed as a time of great anxiety and agitation. Gwyneth recounts a sense of confusion and chaos when she states ‘My, my emotions were just all over the place and I just didn’t know what I was thinking’. Conflating the experience of new motherhood with that of psychosis, she tells me how she started to question how she was feeling: ‘I didn’t know if it was my first baby, if this was normal, if this was part of what, what you’d feel like’, and how the possibility that this might not be ‘normal’ caused her further anxiety and panic.

Gwyneth recounts how she became increasingly unsettled and disturbed by what she describes as her ‘hallucinations’, convinced that her body was killing itself, reflecting a disturbing experience of postpartum embodiment. Conveying a sense of utter desperation, she tells me how, at the time, she ultimately locked herself in the bathroom, screaming ‘I’m schizophrenic’, and fearing that this was the moment that was going to die. It is around this point in the narrative that Gwyneth speaks of losing touch with reality and a crescendo is reached as she portrays herself as in a dreamlike state, questioning the existence of her father: ‘I was touching him and holding on to him and just saying, are you really here, like is this you?’.

This rising crescendo is followed by a significant drop in mood as Gwyneth recounts the beginnings of her ‘postnatal depression’. This is constructed as a malevolent force plaguing her with ‘negative thoughts’, causing her to feel ‘worthless’, ‘weak’ and ‘useless’. Personifying the experience of depression, she tells me: ‘The depression, it takes over you and it makes you think things and you feel very desperate’. Within Gwyneth’s account, this portrayed as a time in which she felt extremely low, despairing and hopeless, and struggling to connect with her baby. Powerfully, she recounts this experience to me in the following excerpt:

> But I was just, yeah, very low, desperate um in the mornings, it was, they were the worst, I think I’d just wake up after maybe being on the medication um that the night nurses would have the baby so I could go to sleep and then in the morning, I remember when they brought the baby to me in the, in the cot, I could hear the cot being dragged um from the next room going to my room and it would just always fill me with dread

Within Gwyneth’s narrative, tensions arise between embracing and rejecting motherhood, as she describes a difficult struggle with the experience of maternal ambivalence during the first few months of her baby’s life. Whilst she describes wanting to be near her baby and to care for him immediately after childbirth, motherhood is also portrayed as extremely overwhelming, and as encompassing painful and distressing thoughts and feelings. This sense of overwhelm is foregrounded as Gwyneth describes her experience of being in a MBU, eight days post-childbirth: ‘And then it was then just me, me and the baby so again, it’ll probably take a bit of a shock because now he was finally here and I had to look after him’. Gwyneth’s relationship with her baby at this point in the narrative is constructed as increasingly conflicted, interwoven with her relationship with herself as a mother. This comes through as she tells me:

> I just thought I was, I was a bad mum (*hmm*), I thought I was, I was not good because of um my mental health illness and was happened to me, I just thought I was just not um, I was not a fit mother

Within her recovery narrative, a biomedical discourse of ‘mental illness’ is drawn upon, as Gwyneth frames psychological wellbeing in quantifiable terms, as the absence of symptoms and as a full return to herself. Reflecting on the present, she tells me: ‘I feel I am fully recovered now and back to myself um 100%’. In this recovery narrative, Gwyneth expresses joy in her experience of motherhood and in her relationship with her child: ‘Actually having that feeling of, of, love and joy and excitement of, of being around him and him just smiling at you and just (*hmm)* calling you mummy it’s just (*hmm)* such a good feeling’. This contrasts with her earlier depiction of the experience of motherhood and implies having finally achieved what is constructed as an expected and desired, maternal experience.

Tone

The tone of Gwyneth's account is a mix of tragic and optimistic. When describing her experience of postnatal distress, the tone is serious and sad. At the start of her account, as Gwyneth speaks about how tired she felt towards the end of her pregnancy and how ready she felt for her baby to 'come out', the tone is foreboding and the linear structure - and then, and then, but then – conveys a sense of anticipation and anxiety that draws the listener in. The contrast between her expectations of childbirth and motherhood, and the extremely difficult reality, also weave peripeteia into the structure of her account from the start.

The tone is reflective tone as Gwyneth wonders what could have caused her postpartum psychosis, which is set in contrast to a hopeful tone as she recounts the positive changes in herself that she attributes to these difficult experiences, and when she speaks of her recovery. Within her recovery narrative, the tone is impassioned and positive, corresponding with Gwyneth's construction of herself as a vision of hope to others.

Rhetorical function

Gwyneth talks animatedly and with a sense of passion for the subject of postpartum psychosis. She is a very engaging speaker, which renders her account persuasive and impactful.

Postpartum psychosis and postnatal depression are constructed as discrete, finite, episodes of 'mental illness', which, whilst causing a rupture in her experience of selfhood, are also framed as leading to a process of personal transformation in which Gwyneth is constructed as a wiser and more mature version of herself.

Gwyneth's narrative suggests that in taking up an advocacy position, there is a sense of purpose and a new social role that involves an active, political stance, alongside helping others. Here, postpartum psychosis is transformed into a passion and a social cause. In this role, Gwyneth constructs herself as the embodiment of recovery, as illustrated by the following excerpt in which she reflects on a recent experience of speaking at a conference:

> People were coming up to me and were really positive and said that you know I was really brave and sort of, sort of inspiring them (*hmm)* that you know I could really talk about it and that I'm doing okay

4.3. Identity work

Identity work within participants' narratives mainly concerns the construction of the self in relation to the experience of psychological difficulties and to maternal subjectivity. Broadly, postpartum psychosis and motherhood are linked in a circular relationship, as motherhood is constructed as the trigger for psychosis, whilst psychosis is depicted as shaping the transition to, and experience of, motherhood.

The exploration of identity work within participants' narratives has been approached thematically. This is particularly the case regarding considerations of identity construction in relation to psychological difficulties, as discussed below.

4.3.1. The construction of identity in relation to psychological difficulties

4.3.1.1. A lost self

All of the women in this study constructed postpartum psychosis as an experience that caused a profound rupture in selfhood. This rupture is constructed as intertwined with the shock of new motherhood, compounding the disorientation and confusion in the experience of the self during this time. This breach in selfhood takes different forms at different points in these women's narratives; however, there is a general pattern in which the self is constructed as lost to the emergence of an unfamiliar, less authentic, version of selfhood that comes to the fore during the experience of postnatal distress. When re-found, the self is constructed as having undergone a profound and, largely, positive, transformation as a result of the experience.

Emily's narrative of postpartum psychosis is emblematic of the construction of a lost self. She tells me: 'I was just kind of, I don't know what the word is but not, just there but not there'. This self is constructed as distinct to Emily's actual identity: 'I was like a different person, really', underscored by the way in which she draws comparisons between how she acted during that time and the kind of person that she really is: 'There's no filter in certain things like I was saying um and I'd just say what I thought, there was no me worrying about what anyone thought, because that's what I'm like'. The way in which Emily slips into the present tense here, 'That's what I'm like' further emphasises the presentation of a more authentic self that is constructed as lost during postpartum psychosis.

Similarly, Rose recounts feeling 'like an alien' during postpartum psychosis, and describes herself as 'vacant' during this time. At one point, she asks, 'Will I ever be the same as I was before?', bringing loss of self into the present and constructing this disturbance of identity as unresolved.

Gwyneth also constructs her psychological difficulties as causing a breach in selfhood and, again, as not constituting an authentic expression of who she really is. She tells me: 'I just knew I just didn't feel my normal self', and later says, 'I knew I still needed a little bit more support, I knew I needed something a bit more just to help me back to that 100% and to the, the real Gwyneth'.

Correspondingly, Sophie's narrative retrospectively constructs a distinct self as emerging during the time of her postnatal difficulties. She tells me: 'Now I look back on it, I think that was a different, a different person that was doing that'. Alongside this, and perhaps connected to the ongoing nature of Sophie's psychological difficulties, her identity in the present is constructed as somewhat discontinuous and fragmented. She tells me:

> But it is weird having two selves really, or three selves really, cause I've got when I'm just like normal I'd say, which I'm on now (*hmm hmm*) and then obviously I've the high and then when I get low

These two selves, when Sophie feels 'low' and when she feels 'high', are constructed as distinct to an implicit, more authentic, form of selfhood: 'They both feel quite foreign'.

4.3.1.2. A medicalised self

The majority of the women in this study also constructed themselves in medicalised terms, drawing upon a biomedical framework to express aspects of their identity. For some of the women, this corresponded with taking up a patient position in relation to their experiences, as well as in relation to others, including to me.

The adoption of a patient role, as well as the tensions around this, comes through strongly in Sophie's account in which the self is, at times, constructed as vulnerable and at the mercy of an unpredictable mental illness. Sophie tells me:

> And I just hope I don’t go through it again, obviously I won’t go through postpartum psychosis again if I don’t have another child but if I have some sort of episode, that’s the only thing I’m kind of worried about (*hmm*), if I get stressed or something, things might go

In line with this, and arguably in an attempt to counter the loss of agency that accompanies this position of vulnerability, Sophie takes up the role of a ‘good patient’ in managing her mental health. For instance, in talking about medication, she tells me: ‘I take it to be well’. Sophie also constructs a relational context for this patient role, in which family members are portrayed as active in helping to monitor her behaviour and fluctuations in mood. Drawing upon psychiatric language, Sophie tells me: ‘Even my dad like, you’re on a bit of a high, aren’t you?’.

In navigating the tensions around diagnosis, medication and identity, Sophie can be seen as drawing upon a normalising narrative (Bury, 2001) in which the management of her difficulties through medication is portrayed as part and parcel of life: ‘It’s what I do’. Here, the self that is constructed by Sophie is one that has integrated a patient identity. However, there are noticeable tensions in this construction of selfhood. For instance, at one point, Sophie suggests that her diagnosis could be part of who she is: ‘Um so if I *am* bipolar’, whilst at another point, a more nuanced, fluid, relationship is alluded to, as she suggests that the credibility of a diagnosis of bipolar disorder is embedded within the relational context of mental health services, rather than as reflecting some inherent aspect of the self. She tells me: ‘So it doesn’t really feel like I’ve got it in a way because *(hmm)* because I’m not having anyone come in’. Sophie goes on to say ‘I suppose I kind of feel like I don’t need to label it’, further undermining psychiatric diagnosis and introducing the idea that there is an aspect of her embodied, subjective, experience that exists beyond this.

Other women in the study also constructed a patient position at points in their narratives. For instance, Emily tells me how her self-awareness enables her to monitor and manage her mental health: ‘When something isn’t right, I can pick up on it’. Whilst this can be seen as empowering, enabling Emily to seek support when needed, it could also be considered a form of self-regulatory discipline (Foucault, 1977) in which Emily monitors her behaviour in line with discourses around normality and abnormality, reinforcing canonical narratives of ‘mental illness’.

This also comes through in Gwyneth’s narrative, as she re-evaluates her subjective experience of pregnancy in light of her subsequent psychological difficulties. She tells me:

> When I look back at my pregnancy, I, well, I thought it was low risk, I thought I didn’t really have any issues but (*hmm*) there probably were some times when I was quite emotional or I did feel a little bit overwhelmed but again, I probably just thought that was down to, you know, your hormones and you’re growing a baby and things are changing

Here, Gwyneth’s emotions are retrospectively constructed as warning signs of psychological disturbance, and, accordingly, medicalised.

Rose’s account stands out for its rejection of a biomedical framework and of a patient identity. This comes through in drawing explicitly upon a psychological framework for explaining her difficulties and in the subtle critiques of psychiatric intervention that feature within her account: ‘I just remember mega doses of amitriptyline (*hmm*), hor- horrible stuff’. This is reinforced through the way in which

Rose foregrounds her professional identity when telling her narrative, which could be seen as a means of distancing herself from that of a patient position.

4.3.1.3. A transformed self

All of the women in this study portrayed themselves as having experienced a personal transformation in selfhood as a result of their experience of postnatal distress. This corresponds with the construction of an agentic and empowered survivor position.

The construction of a transformed self comes through in Emily's narrative, illustrated by the following statement: 'And as much as it was difficult, I came through it and I think, you know, it made me stronger'. Similarly, Sophie draws upon a discourse of posttraumatic growth in recounting identity changes as a result of her experience: 'Yes, I would say it's made me a lot stronger'. Rose also describes herself as having experienced personal growth, telling me that postpartum psychosis: 'Opened a mental dialogue within myself', and later stating, 'I'd say I'm more empowered than I was before'.

The construction of a transformed self is evident in Gwyneth's narrative as she tells me how her values have shifted as a result of her experience, and that she now prioritises health and family over 'material things'. When talking about this, postnatal distress is constructed as something that has not only enhanced who she is but also framed as an experience that was necessary in the context of her life at the time. She tells me:

> I wouldn't want anyone to go through psychosis or depression but to go through it and understand it all (*hmm hmm)* adds a little bit more to yourself because you, you feel you needed that to sort of readjust yourself again

Similarly, in the excerpt below, Catherine reflects on the profound change in identity that has accompanied her experience of postnatal distress, constructing a more empathic and knowledgeable self:

> I always think it’s like um when you’re a grown up, an adult, and you know who you are um and you’re like a jelly, you’re set, and then suddenly um an event like this happens and your jelly melts and you have to reset who you are, what you think you’re doing and um (*hmm hmm*) and maybe the previous set jelly that you were, it, you’d come to perhaps some wrong conclusions or anyway, you’ve, you’ve had a new experience of life (*yes*) and your new jelly, set jelly, is (*yes*) um has got more experience, more empathy, more understanding of the world if that makes sense

Part of the construction of a transformed identity comes through in the new social roles that women described taking up following their experiences. For example, all of the women in this study can be seen as constructing active, agentic, positions in raising awareness of postpartum psychosis, and in the ways in which they described looking out for others, using their first-hand knowledge and experience to spot the ‘signs’ of postnatal distress. Explaining her interest in this area, Sophie tells me ‘So that other women don’t get it and then not know what it is, and don’t go untreated for so long’. Similarly, Rose positions herself as a figure of hope and resilience for women who might have experienced these kinds of difficulties, stating: ‘There are women out there who maybe don’t feel like, feel that they can continue or maybe feel that the stigma knocks their confidence and yeah, you can go back to that, and you can have another one’.

In the construction of a transformed self, the experience of postnatal distress is integrated into participants’ self-narratives, aligning with a narrative of posttraumatic growth and survivor position (Neimeyer, 2006; Tadeschi & Calhourn, 1996). This integration can be seen in the recovery narratives that emerged within some of the women's accounts, as illustrated by the following excerpt from Gwyneth's account: 'But you know, it's two years on now and it's (*hmm*) starting to be just part of me and who I am'.

4.3.1.4. Tensions: Agency and disempowerment

Whilst the construction of a transformed self correlates with that of an agentic position, in each of the women's narratives, there were tensions between the construction of the self as agentic and as disempowered.

This is exemplified by Emily's account. When recounting her experience of postnatal distress, Emily constructs herself as agentic and self-aware in fighting for an adequate response from her GP, and later, in making intentional treatment choices. However, this agentic positioning is constructed as, at times, overpowered by medical authority, with a more helpless position emerging in these moments of her narrative. This comes through in the following excerpt in which Emily describes her forced admission to hospital:

> I did get to the point there I kind of said, I don't think I need this, you know, I'm looking after (baby) fine and I did refuse to take the medication, so they did have to section me at one point

The construction of a disempowered position is reinforced by the shift in pronouns from an active to passive voice here: 'They did have to section me'.

In Catherine's account, tensions between agency and disempowerment can most clearly be seen as playing out in relation to the transition to motherhood. Rather ambiguously, Catherine suggests that postpartum psychosis offered a retreat from facing the reality of motherhood:

> I think what it was, it was almost like your brain was going outside yourself to avoid the pain (*hmm*) if you see what, pain was like an object that my brain was not wanting to see (*right*) and so, you know, I was actually going out of myself in my head to try and avoid facing the pain, that's how I think about it now (*hmm, that's an interesting idea*) so yeah, so I was, and I had to decide to come back to look after my son really

Here, it could be argued that by (re)framing motherhood as a chosen act, Catherine constructs herself as agentic in a broader disempowering societal context in which motherhood and normative ideals of femininity are intertwined.

In Sophie's account, tensions also play out between the construction of the self as empowered and as disempowered. These tensions come through in the context of an ongoing relationship with mental health services and a corresponding set of power relations between service providers and service users. In this context, Sophie constructs herself as entangled within an unsatisfactory set of relationships with medical professionals, the rules of which appear to lie outside of her understanding and control. At times, this seems to equate with that of a disempowered position, such as when Sophie reflects on her current situation in her second interview:

> Um and then with, with, now having them putting my dosage up and the doctors saying they might refer me back to the mental health crisis team (*right*), um I mean she's not going to now because it's calmed down but I just feel like there's no support there (*hmm*), or there wasn't, there wasn't, there wasn't enough time even if

> I wanted to change my medication to, to have support there, it all just comes through the GP now

However, Sophie also constructs herself as knowledgeable and empowered in her understanding of medication and diagnosis: ‘But then to be diagnosed with bipolar *(hmm)* and obviously lithium or aripiprazole being maybe better *(hmm hmm)* cause obviously I’m not psychotic anymore’. Here, it could be argued that the use of psychiatric discourse adds weight and legitimacy to Sophie’s voice, offering a means to take up a more agentic position vis-à-vis mental health services, as well as possibly in the relational context of her interviews with me, a trainee psychologist.

Similarly, Gwyneth constructs herself as agentic in repeatedly seeking feedback from medical staff in the hospital when experiencing psychological difficulties immediately after the birth of her baby. She tells me: ‘I kept asking the midwives, I said is this normal how I’m feeling’, as well as turning to the internet in an attempt to understand what she was experiencing: ‘I was googling things on, on, these symptoms and then trying to work out okay, what do I need to then recover from this’. Whilst she constructs herself as active in this process, her lack of clarity and understanding, as well as the absence of an explanation from healthcare professionals, supports the construction of a more disempowered position during this time.

4.3.2. The construction of identity in relation to maternal subjectivity

4.3.2.1. The ‘good’ mother: Negotiating maternal subjectivity in the context of psychosis

I would suggest that across participants’ narratives, a lot of rhetorical work revolves around preserving their status as ‘good’ mothers. This comes through as participants highlight how they were still able, or at least wanting, to care for their babies whilst experiencing postnatal distress or in noting their distress from being separated from their babies. In doing so, participants constructed themselves as ‘good’ mothers, arguably as a means of balancing out difficulties in living up to normative standards of contemporary motherhood in their experience of psychological distress.

This also comes through in other ways in participants’ accounts. For instance, when Emily tells me about her decision not to breastfeed, she invokes a ‘fed is best’ discourse, arguably justifying a deviation from normative representations of ‘good’ motherhood: ‘It’s just what we chose, you know, they’re being fed, that’s the main thing you know’. Interestingly, her husband is invoked as a shared partner in this decision-making process, as though to back up a questionable choice: ‘That is our decision, as a couple, like we made that decision’.

In her account, Gwyneth positions herself as a caring, concerned, mother, and as wanting to be close to her baby during her experience of postpartum psychosis. Reflecting back on the immediate postpartum experience, she tells me:

> So, I would go up um in the evening, I would go up into the neonatal unit and sort of spend a bit of time with him even throughout the night and then I’d try and go back into my, my, bed and sort of have some sleep

Later, Gwyneth comments: ‘Even though I wasn’t well um and I could sort of try and sort myself out I was glad in a way that he was, I knew he was being looked after and cared for in the neonatal unit’. Here, Gwyneth constructs herself in line with normative ideals of the ‘good’ mother who loves and wants to care for her baby, and who puts the wellbeing of her baby first. In evoking representations of ‘bad’ motherhood, Gwyneth distances herself from this, reinforcing the construction of self in line with that of the ‘good’ mother: ‘There wasn’t any neglect there’. Whilst

Gwyneth later constructs herself as increasingly ambivalent in her relationship with her baby, it could be argued that her positioning as a ‘good’ mother is protected through ascribing her feelings to ‘postnatal depression’, which is personified as an externalised, malevolent, force. This, arguably, justifies an experience of maternal subjectivity that contradicts normative ideals of motherhood, and distances Gwyneth from the discursive construction of ‘bad’ motherhood.

In Catherine’s account, conventional norms of ‘good’ motherhood are both evoked and rejected. Whilst Catherine does not position herself in line with normative representations of motherhood as clearly as some of the other research participants, I would argue that a lot of rhetorical work within her narrative revolves around what it means to be a ‘good’ mother and, more broadly, maternal subjectivity. In her account, traditional mothering norms are implicated as central to Catherine’s relationship with motherhood at the time of her experience of postnatal distress and in the experience of maternal ambivalence. Reflecting on becoming a mother for the first time, she tells me: ‘I think, I’ve got my mother-in-law showing me how to sweep the floor and I was going, oh gosh, is this my life from now on, learning how to clean the house’. At one point, when discussing traditional motherhood, Catherine says: ‘You know, we want more than that don’t we’; the use of ‘we’ here both draws me in, as holding similar aspirations to her, and speaks to a broader group of emancipated women that Catherine positions herself within. Catherine largely constructs herself in opposition to a traditional ‘feminine’ role (Lewis & Nicolson, 1998), telling me how she wanted to do ‘other things’ with her child, outside of the domestic sphere. However, at times, the impact of this is questioned, introducing the idea that deviating from normative models of motherhood may have carried some negative repercussions. This comes through in the following excerpt as Catherine reflects back on her experience of motherhood:

> When I came back from work, I was out every afternoon, I didn't want to go and stay home, my son didn't really, cause he didn't, he wasn't used to being at home with me (*yeah*) cause we'd always go out and meet friends (*yeah*) and yeah, he wasn't a cuddly baby and I didn't encourage him to be cuddly, I don't think he was that kind of baby anyway (*hmm)*, he was very independent and I just encouraged him to be independent (*hmm*) but when I had my daughter, she was very cuddly but that could have been my, could have been my response to him couldn't it (*I guess I wonder what it's like to find yourself asking, asking those questions and, and looking back?*) well, you feel guilty, a mother always feel guilt

Tensions around maternal subjectivity are less focal in Rose's account: she predominantly constructs herself in line with normative ideals of the 'good' mother, positioning herself as self-sacrificing and embracing the life of a 'stay-at-home mum'. This is contrasted with her own mother, as illustrated in the following except:

> My kids don't ap-don't appreciate it cause they've got a different life, they've got a different mum to the mum I had and, I'd like to think anyway, they um, as soon as, I was making cross stitches for before they were born so they've got a massive big thing going welcome little one with their date of birth and the time they were born and it's all on there, just in case I forgot ever you know, so it's all there cause I wanted to make sure that they, they know they were wanted, they know that they're loved and they know, and to give them sort of grounding which I feel that I didn't have

In comparing her mothering to that of her own mother, it could be argued that Rose draws upon and reinforces binary constructions of motherhood in 'good' and 'bad' terms, locating herself firmly in the camp of ‘good’ mothers. This positioning is, arguably, reinforced as she distances herself from the construction of ‘dangerous’ motherhood:

> When you see the adverts on the telly I can’t, you see the films and mums are going to harm their babies, it makes me angry, maybe I’m a clinical trial of one but there’s never one did I think I would harm my child (*hmm*) or want to harm my child

Here, Rose critiques a dominant discourse that positions mothers with psychological difficulties as dangerous, and therefore, as ‘bad’. At another point in her narrative, Rose draws upon a cultural discourse of mother-blame and maternal responsibility (Chase & Rogers, 2001) in expressing guilt and self-blame for the potential impact of her experiences on her son. She says: 'Um I think is it my fault? Because I wasn't well that he has this trauma now, I don't know and I never will'. This is echoed when she tells me: 'Cause I'm always gonna blame myself; you know, because I'll think how I was afterwards'.

4.4. Thematic priorities and relationships

4.4.1. Overview

Stage 4 of CNA involves working systematically to identity themes within the narratives and to explore their meanings (Langdridge, 2007). This involves a fine balance between identifying major themes whilst retaining an overall sense of the narratives presented (Langdridge, 2007).

For Stage 4, I worked through the texts systematically to identity key themes. After initially noting themes on each interview transcript as I went along, I then documented all themes from across the interviews in a separate word document before grouping the main themes together in an excel spreadsheet (See Appendix 12). This process involved collapsing some themes together and categorising others into subthemes, as well as discarding some themes from the final analysis as I refined categories across the narratives (Langdridge, 2007). The final themes, as discussed below, appeared in at least half of all of the women's narratives.

In my analysis of the data, five main themes were considered focal: explanatory frameworks; power; the multidimensional nature of family support; stigma and recovery. These are outlined in Table 2 below, along with sub-themes.

Table 2: Main themes and sub-themes across participant narratives

Main themes	**Sub-themes**
Explanatory frameworks	• Multiple explanatory frameworks • Not knowing
Power	• Medical authority • Medical incompetence
The multidimensional nature of family support	
Stigma	
Recovery	

4.4.2. Explanatory frameworks

The theme of explanatory frameworks runs across all of these women's accounts. This theme comprises two sub-themes: 'multiple explanatory frameworks', and 'not knowing'. I will explore each in turn below.

4.4.2.1. Multiple explanatory frameworks

Participants drew upon multiple explanatory frameworks to make sense of having experienced severe postnatal distress. These explanatory frameworks spanned psychological, biological and sociological explanations. A range of psychological explanations were noted, including birth trauma, the transition to motherhood, social isolation and developmental history. Whilst women spoke with clarity about the loss of control that they experienced during childbirth and were explicit in drawing links between their traumatic birth experiences and postpartum psychosis, birth trauma was not put forwards as the only potential cause of postnatal distress. Instead, participants cited a number of other potential reasons for their psychosis alongside that of birth trauma, suggesting more of a 'both/and' rather than 'either/or' approach.

When reflecting on childbirth, Emily tells me 'But then it took a U-turn and I had to, so maybe yeah, maybe there is a point in that too as to why things impacted me more because I wasn't then in control of that'. However, Emily also suggests that the social isolation of new motherhood may have contributed to her difficulties, along with the pressure of normative expectations of motherhood. She tells me: 'And I think I mentioned like breastfeeding as well, I think that, I think that impacted me a little bit cause I was quite set on, I'm gonna breastfeed, because you do get that pressure', adding, 'It did feel like a bit of a failure at the time'. Additionally, Emily cites sleep deprivation as a potential contributing factor, telling me, 'Sleep I think for me was a big trigger', and that, 'Maybe the impact on my, my mind was quite catastrophic'.

Similarly, Gwyneth cites sleep deprivation as a ‘trigger’ for her difficulties: ‘Um but when I look back and think, the sleep was a very, very big trigger for me'. At the same time, she emphasises the impact of her traumatic childbirth experience, recounting:

> And then from the traumatic birth, cause I think I was a 72 hour labour in the end I think that, that really traumatised me as well so I remember I was still um getting really anxious and worked up um after the birth because of what I'd gone through

Alongside these explanations, Gwyneth raises a question around genetic heritability, stating: ‘You do think, you question, is there a history there, is there something there?'.

Sophie also wonders about heritability, in terms of her own experience of postpartum psychosis and her children’s potential future experiences. Again, genetic factors are cited alongside alternative explanations, such as her traumatic birth, as well as other major contextual factors. She tells me: ‘And the fact that I quit my job and moved back to the farm and made quite big life changing decisions'.

Rose mainly draws upon psychologically informed explanations for her postnatal distress. At times, this is mentioned alongside biological causes, as illustrated by the following excerpt: ‘I don’t know, you know, losing blood, losing hormones, thinking your child’s died, the, the shock of not going into a straightforward labour’. However, at another point in her account, Rose foregrounds the idea that her experience of postpartum psychosis was caused by factors stemming from her developmental history and from attachment wounds in her relationship with her mum. In telling me about her mum letting her down in not offering support in the postnatal period, and her subsequent ‘realisation’ that her mum didn’t care, she tells me: ‘That’s I think what caused the psychosis because I was coming to terms with that and learning about that’. At other times, postpartum psychosis is predominantly constructed as arising from an excess of overwhelming, traumatic, experiences, as Rose states: ‘As well as possibly all the other traumatic things that were going on, it was just too much’.

Out of all of the participants, Catherine is the most explicit in drawing upon a biomedical explanatory framework. She tells me: ‘Apparently it was something to do with um, they reckon it, because my progesterone was very high, my hormone levels were very high when pregnant'. In discussing this, she reiterates the view of a psychiatrist whom she consulted when pregnant with her second child, telling me: ‘When I had my daughter, I did take progesterone, cause she was saying it's like um a drug withdrawal having a baby and that was why I had such a severe, just like coming off a powerful drug'. However, at another point, Catherine broadens her explanations to also include her experience of childbirth, telling me: ‘And then the shock of the reality of giving birth and exhaustion'. Interestingly, whilst the psychological transition to motherhood and questions of identity were prominent in Catherine’s narrative, she does not foreground these ideas in her discussion of the causes of postpartum psychosis when talking with me.

4.4.2.2. Not knowing

At some point in their narratives, Catherine, Gwyneth, Emily and Sophie all raise doubts as to why exactly they might have experienced postpartum psychosis, conveying an unexplained and unresolved aspect of sense-making in these women’s narratives.

In Catherine’s account, this comes through when, in contrast to the clarity expressed when discussing the role of hormones, she states:

> It’s just whether the epidural that caused it, you never know, that goes straight to your brain doesn’t it, you know, whether that triggered it off, whether it’s the exhaustion, don’t know, you don’t know what or whether in my naivety of not knowing what to expect (*hmm*) and don’t know, don’t know what actually triggered it or just my personality, don’t know

Not knowing is echoed by Emily as she states: ‘But then you know, there might not have been a particular reason'. Similarly, at one point, Gwyneth puts her experience down to a case of bad luck, telling me: 'I was just a little bit unlucky at the time’. Along a similar vein, Sophie tells me: ‘I don’t think I have made sense of it’.

Not knowing also corresponds with a set of questions that arise in these women’s accounts as to why this experience happened to them in particular. Here, postpartum psychosis is framed as reflecting something specific and personal. This comes through in Gwyneth’s account as she states, ‘You just feel like why is it me um why did it happen to us', and, similarly, when Catherine says: ‘I'm wondering what it's such an extreme reaction’. Correspondingly, Rose states: ‘But I just think, what is it about me that made that, made that happen to me?', conveying an existential quality to this not knowing.

4.4.3. Power

The theme of power comprises two sub-themes: ‘medical authority’ and ‘medical incompetence’. These will be discussed below.

4.4.3.1. Medical authority

The sub-theme of medical authority arises in participants’ narratives as a tension between the legitimacy of women’s embodied knowledge and that of authoritative, medical, knowledge (Jordan, 1997). This is evident in Emily and Gwyneth’s accounts in the context of seeking help, in which both they both suggested drawing upon a form of intuitive knowledge in relating to their subjective experiences at the time of postnatal distress. Gwyneth tells me, 'I knew in myself that I wasn't right', whilst Emily states: ‘I didn’t feel quite right sort of mentally wise, I knew there was something not right, I don't, I couldn't quite at the time put my finger on what it was'. For both Emily and Gwyneth, the label used by health professionals to explain their difficulties, ‘baby blues’, did not fit with their subjective experiences at the time. Whilst Emily indicates a dismissing dynamic with her GP, Gwyneth tells me: ‘One of the doctors did talk to me about baby blues but I didn't think, I didn’t think it was that, I didn’t think that’s what I had um I thought it was something more than that'.

Embodied and authoritative knowledge take on the form of competing forms of knowledge in these narratives, bringing questions of power and medical authority to the fore. Whilst Emily portrays herself as fighting for the severity of her difficulties to be recognised, Gwyneth suggests a lack of transparency regarding her diagnosis from health professions: ‘The nurses has already probably picked up about psychosis but again, at this time, no one ever mentioned it to me'.

Medical authority is echoed in Rose’s account as she laments not being able to access medical records from the time of her postpartum psychosis experience. She tells me:

> I’ve no record of anything, I’ve not been told anything, I asked my GP, the practice I’m with now, who should I have on record, what went on, do I get to see any of it, oh, there’s no, no record, I don’t know and I don’t write that and I would like to know

She draws upon a number of metaphors in an attempt to convey the difficult emotional impact of this for her:

> I’ve got words for the story but not the picture of the book, I’ve not got the scrip- I’ve got the story, in my head, I’ve got the story of what’s happened (*yes*) or whatever, the words on the page but I don’t have the front cover, I don’t have the synopsis

Medical authority takes on great significance in the context of patient vulnerability in these women’s narratives. This comes through in Emily’s account as she tells me how not knowing what she was experiencing at the time left her even more dependent on medical professionals: ‘It was difficult cause it's like the whole way through you know you don't know, you've got no comparison, it's all new and it's, you trust um doctors'.

This authority takes on a sinister and manipulative edge in Rose’s account as she goes further in implying a level of deception in her experience of psychiatric treatment. Recounting her experience of hospital admission, speaking in the third person, she tells me: ‘You're just here to monitor your sleep and then the next day they started plying me with the drugs'. In Catherine’s account, the theme of medical authority is conveyed as an internalised future threat, leading her to destroy the notes she made during her experience of psychosis, ‘Because I thought, this is gonna be used against me’.

4.4.3.2. Medical incompetence

A number of the participants also suggested encountering some form or another of medical incompetence from health professionals involved in their care, involving both the nature and severity of these women's experiences. This comes through in comments such as, 'They didn't know what they were dealing with' by Emily, and 'Obviously at other times, they didn't really have a clue what was happening in my head, they just viewed it as postnatal depression still' by Sophie.

In Sophie's account, the theme of medical incompetence encompasses a specific lack of understanding around postpartum psychosis. Painting a confusing picture, she recounts:

> I mean none of the doctors, they all kept saying oh some of them said oh you got postpartum psychosis when you got depressed and some of them said oh you had, you got this the minute she was born

In her narrative, Sophie also suggests a lack of interest from health professionals in developing a deeper understanding of the nature of this kind of postnatal distress. Furthermore, she indicates that her own ongoing interest in this area has been (mis)interpreted as a worrying reflection of growing 'obsession':

> Um no one could really pinpoint how, why and how and (*no*) I have not met anyone that sort of tried to work out why (*hmm*) um and I, I've become quite obsessed with it as well (*hmm hmm*) um my last psychiatrist said it probably wasn't so good, my obsession, just um I've brought every book that there is about it, every memoir

In this excerpt, medical professionals are constructed as holding influence in shaping the ways in which Sophie's engagement with postpartum psychosis is interpreted, both by herself and others. This speaks to a discursive, hermeneutic, dimension of power arising in the context of medical authority and incompetence.

4.4.4. The multidimensional nature of family support

Relationships were thematised throughout all of the participants’ accounts. Women talked about relationships as a vital source of support during postnatal distress, yet also as sites of conflict, particularly in the context of compulsory admission for psychiatric treatment. Participants foregrounded the impact of these experiences on their loved ones, highlighting a lack of support and attention for partners and family members. ‘The multidimensional nature of family support’ encompasses these distinct relational components.

Broadly, participants acknowledged the support that their partners offered during their experiences of postnatal distress, whilst also highlighting the emotional implications of this. For instance, whilst Gwyneth hails the support of her husband, she also acknowledges the toll of this experience on him and on their relationship. She says: ‘Our relationship had, you know, it's put a massive strain on our relationship'. She tells me that her husband was impacted ‘significantly’ by the experience and that 'he's still not fully come to terms with it'. Similarly, at one point, Catherine tells me ‘I was very supported by my husband', yet at another point states: 'He was, you know, he took the brunt of it really. I don't know whether he had any support at all'. Emily also highlights the emotional impact of this experience on her husband; reflecting back, she tells me: ‘He's got to go home to an empty house, it must be, just a horrible thought really'. The use of the present tense here further emphasises the emotional resonance of this experience.

In some of the participants' narratives, relationships are also framed as sites of conflict. This comes through in Emily's and Sophie's accounts in the context of compulsory admission to hospital. Highlighting differences in opinion between her husband and her parents, Sophie tells me: 'My parents didn't want me to go anywhere to get help, they thought they could help, help me by staying at home and husband was trying to get me some help'. Similarly, Emily questions the support that her partner received in his involvement in her compulsory hospital admission, as well as highlighting the family conflicts that emerged during this time. This is illustrated by the following excerpt:

> And I'm not sure what support he got with that because that's something completely new to him, you know, talking about medication, talking about sectioning your wife like it doesn't bear thinking about really, to be in that situation, then you've got my parents who were completely helpless and they're saying, well we shouldn't, you shouldn't be doing that

Relational conflict also emerges as a theme in Rose's account. This comes through at different points in her narrative, conveying a profound lack of support from family members during her experience of postnatal distress. For instance, when reflecting upon her experience of reaching crisis point, she tells me:

> Um my husband, I was, I still didn't obviously trust him and I was like, I'll be okay, can I go and stay at mum's, I'll go and stay at mum's for a while with baby sort of thing and he was like no, you're not doing that, my mum came round cause he'd rang her and he wouldn't, and he was like no, you can't go and stay with her, can't go and stay with me, mum can I come and stay with yours, it was like no, you're better off here so the G, he rang and spoke to the GP

Rose also suggests that whilst her family expressed concern for her, at times, they misunderstood, or even judged, how she was acting. She tells me:

> Um and my sister looked at me and she said, are you drunk? I was like no, I'm just, I, cause my speech was slow (*hmm*) I was slurring (*hmm hmm*) that, that was, that's like a couple of days before I ended up in hospital

This also comes through as Rose tells me how her mother-in-law questioned her abilities as a mother as a result of her psychosis experience, telling me: 'I believe my mother-in-law was saying things like, oh do you trust her being at home with a child on her own'.

4.4.5. Stigma

This theme arose in Emily, Rose and Catherine's narratives.

When reflecting on the birth of her second child, Emily tells me how she was concerned that her mothering was being judged by health professionals based on her previous experience of postpartum psychosis. She tells me:

> It felt like a little bit being judged that I am not wanting to hold my baby straight after (*hmm*) and I did, for a period of time, they were like, we need to obviously do some stiches and I was like I can't, I can't hold her while you're doing that because I had to, like gas and air, like it, you know, it's not, but I felt like they're thinking oh, she's rejecting her baby or something like that because they'd, they'd already passed a few comments around like, they'd said it in front of me like oh she had psychosis the first time round, which, like, I'm here, I'm a person, you know

Underscoring the impact of this experience, Emily goes on to say: 'It could trigger something worse in someone, you know, being treated in this wrong way'.

Stigma and shame are interwoven in Rose's account as she tells me how she hid her difficulties from the health visitor for the first year of her baby's life. Presenting a harrowing juxtaposition between her internal world and the impression given to others, she tells me:

> I can remember when the health visitor used to come, I used to make the place spotless, and he would be spotless, so she probably thought ah nothing's going on um and I can't give you a timeframe of this thing, this experience, but I can recall thinking that my ex-husband at the time was poisoning me and I didn't wanna eat his food

Later, Rose tells me how she did not want her manager to visit her in hospital due to feeling 'ashamed'. Drawing attention to potential generational differences in the experience of stigma, she goes on to tell me:

> I've lived with the stigma of being in hospital and feeling like I'm a lunatic, if you see what I mean, and I shouldn't do, maybe it's, I don't know, maybe it's, it's um generations isn't it, I suppose and how things have progressed and we wouldn't think maybe that way now whereas in those days there was a lot of stigma to go with it

In her second interview, Rose introduces the idea that stigma around psychological difficulties may have also contributed to difficulties in her marriage at the time, asking the question, 'Did it make him fear that I wasn't normal?'

In Catherine's account, stigma arises in relation to the question of disclosure of her experience of postnatal distress. In the following excerpt, she tells me how she chose to ignore her mother's advice not to tell other people about having experienced postnatal distress: 'I know my own mother told me not to tell anybody about the experience cause like cause people would judge me (*hmm*) um but I didn't take notice of that'.

4.4.6. Recovery

A recovery theme featured in Catherine, Gwyneth and Sophie's accounts.

In Gwyneth's account, the process of recovery is constructed as emerging in line with learning about postpartum psychosis whilst in the MBU, instilling a sense of relief and hope. She tells me about this in the following excerpt:

> That was when I started seeing signs and leaflets about psychosis and when I was reading up the symptoms um I just thought yeah, that's exactly what I've got, that, that's what I have and then it was a relief to know that it's recoverable, that, you know you (*yes, yeah*) can recover, you know, it's 100% recovery and that these places um mother and baby units are, they're special places for recovery and then they focus on you and your baby so at that point I thought, yeah, this is where I need to be, I'm in the right place

Here, postpartum psychosis is distinguished from other forms of 'mental illness' and constructed as a more hopeful diagnosis. However, the process of recovery is still portrayed as a lengthy and difficult process, comprising moments of self-doubt and hopelessness: 'I just didn't think I could do my job again'.

In Catherine's account, at one point, recovery is portrayed in objective terms, such as by a return to work. Comparing her experience of receiving treatment in a psychiatric unit to that of her friend's daughter who stayed in a MBU, Catherine tells me: 'And I don't know, and it's been a long, drawn-out, period of recovery whereas mine was um short and sharp and um you know, I was able to go back to work in 6 months'. However, at another point, Catherine describes a longer, internal, process of change, telling me: ‘I don’t think I felt myself until about a year, a year later, I suddenly thought oh, I, I didn’t feel so depressed (*right*) probably took a year (*hmm hmm*) for me to feel better’.

Recovery also emerges as a theme in Sophie’s narrative, although she does not use this language, instead speaking of getting ‘back to normal’. Echoing Gwyneth’s narrative, recovery is portrayed as protracted, extending way beyond the point of hospital discharge. Sophie states:

> But it was a very slow process to get back to normal, I thought when I got discharged, it’s alright, I’ll be fine now and I tried to come off the olanzapine and I just, that didn’t work at all

Later, the process of recovery is likened to that of a bereavement, as Sophie tells me:

> But obviously things get easier, I suppose it’s like when people talk about um losing someone close to them and you, you know, keep saying oh it’s getting harder every day and for some, sometimes it did feel like it was harder

4.5. Stage 5: Destabilising the narratives

Stage 5 of CNA involves completing the hermeneutic circle through the application of a critical hermeneutic of suspicion to participants’ narratives (Langdridge, 2007). Destabilising the narratives through the use of a critical hermeneutic holds a ‘liberatory potential’, opening up future possibilities through different readings of the text (Langdridge, 2007, p. 150). As hitherto discussed, I have chosen to use feminist theory as my chosen critical hermeneutic of suspicion.

4.5.1. The application of a hermeneutic of suspicion: Feminist theory

The female body is positioned as abject, as other, as site of deficiency and disease, of that there is no doubt

(Ussher, 2006, p.151)

In utilising a feminist lens to destabilise participants' narratives, I have mainly drawn upon feminist theory that critically examines the discursive construction of psychological distress. From a feminist viewpoint, biomedical discourse medicalises, pathologises and individualises women's distress, negating the role that political, economic and social factors play in shaping women's experiences (Oakley, 1980; Nicolson, 1986; Ussher, 1991). Feminist scholars have argued that this not only renders feelings that fall outside of the confines of normative motherhood abnormal and signs of a mental disorder (Mauthner, 1993) but also legitimates control over what is considered to be an 'unruly' female reproductive body (Ussher, 2011).

Drawing upon the writings of Michel Foucault, Ussher posits that these disciplinary practices shape the discursive construction of gendered subjectivity, enabling particular subject positions and identities, which are then taken up by women, thereby reinforcing dominant discourses around femininity (Ussher, 2011). From a Foucauldian, feminist, perspective, this may be considered a form of subjection in which women internalise regimes of power and knowledge (Foucault, 1977; Foucault, 1982), along with concomitant practices of self-surveillance and self-regulation (Ussher, 2006; Ussher, 2011).

Accordingly, when subjected to a feminist discursive critique, two canonical narratives from participants' accounts may be problematised: a biomedical discourse of ‘mental illness’ and a canonical narrative of the ‘good’ mother. These will be critically examined below from a feminist lens.

4.5.2. Problematising a biomedical discourse of postnatal distress: Postpartum psychosis as a ‘mental illness’

In section 4.3. I put forward the idea that some of the identity work in these women’s narratives involved the construction of self in line with a patient identity, and use of a biomedical discourse in which postnatal distress is framed as a form of ‘mental illness’. I suggested that participants constructed a patient identity through detailing the different strategies they used to manage their mental health, such as though monitoring thoughts and feelings, as well as taking medication in line with the ‘good patient’ (Ussher, 2011). Recovery narratives, in which postpartum psychosis is equated with an illness experience, also featured biomedical discourses of mental health, as postnatal distress is framed as something to ‘get better’ from.

From a feminist perspective, I would suggest that, in drawing upon a biomedical discourse, the distress that these women experienced is cast as a form of internal pathology and rendered an ‘abnormal’ response to motherhood (Ussher, 2006), reinforcing patriarchal representations of the female body (Brown, 2021). In doing so, it could be argued that prevailing myths of motherhood, along with other systemic structures and oppressive social norms, remain unchallenged (Johnston and Swanson, 2003; Oakley, 1979; Ussher, 2006). However, this is not to suggest that these women are passive in their relationship with wider discourses. Indeed, feminists have drawn attention to the range of ways in which women negotiate discursive frameworks and concomitant subject positions (Stoppard, 2013), and have argued that women make active, situated, decisions in negotiating these frameworks (Ussher, 2006). As such, the women in this study can be seen as making agentic choices in relation to culturally available discourses to make sense of their experiences. This can be seen in the ways in which participants adopted a questioning stance in relation to their difficulties, and in the integration of psychosocial explanations alongside biomedical frameworks (Gavey, 1989). This could be considered a means of introducing subtle forms of challenge or resistance to dominant biomedical discourse in undermining its status and exclusivity (Gavey, 1989). Furthermore, whilst most of the women took up a patient position at times in their narratives, this did not always correspond with the construction of the self as passive or disempowered, as hitherto discussed.

Different forms of knowledge and subject positionings diverge in the power and authority that they confer (Gavey, 1989). It could be argued that the construction of postpartum psychosis as a medical condition may also enable women to adopt a more agentic stance vis-à-vis health professionals, in speaking a shared psychiatric language, including in conversations with me, a psychologist in training. This can be seen in Sophie’s narrative in particular. Furthermore, it has been argued that hormonal theories of distress may offer women a means of attributing the cause of their difficulties to factors outside their control, thereby minimising the possibility of blame and responsibility (Stoppard, 2013). The meaning of blame and responsibility in the context of motherhood will be explored below in relation to canonical narratives of ‘good’ motherhood.

4.5.3. Problematising canonical narratives of motherhood: The ‘good’ mother

Dominant discourses of motherhood featured across participants’ narratives. A number of the women shared feeling as though they had failed for not living up to normative representations of ‘good’ motherhood, such as by not having a vaginal delivery or in decisions to bottle feed. Maternal guilt and self-blame also featured in a number of the women's narratives in relation to the potential impact of their postpartum difficulties on their children. Whilst, at points, participants critiqued societal expectations of motherhood, holding them to account for some of their difficulties in the early postnatal period, at the same time, they used a range of rhetorical devices to simultaneously re-locate themselves discursively in line with normative representations of the 'good' mother. From a feminist perspective, this not only attests to the pervasive nature of normative ideals and dominant ideologies of motherhood but also suggests a potentially limited range of subject positions available to these women in relation to broader discursive constructions of mothering (Singh, 2004; Stoppard, 2013).

Importantly, the women in this study can be understood as navigating discursive constructions of motherhood in a context in which their mothering abilities might be brought into question due to their psychological difficulties (Tuohy, 2014). Indeed, societal stigma of having experienced a 'mental illness' in motherhood (Nicolson et al., 1998) presents particular challenges for women in living up to ideals of the 'good' mother, as mothers who have used mental health services face particular challenges in navigating seemingly contradictory aspects of their dual identity (Davies & Allen, 2007). Arguably, for the women in this study, the problematic subject position of being a mother with a 'mental illness' could have thus added to the importance of constructing themselves in line with normative ideals of 'good' motherhood. However, in their rhetorical claims, participants can also be seen as challenging dominant discourses by constructing themselves as 'good' mothers alongside the experience of postnatal distress. As a result, participants offer a radical alternative to the idea that postnatal distress implies 'bad' mothering.

4.6. Conclusion

Across participants' narratives, the construction of a more authentic version of the self that is portrayed as lost or waylaid in the experience of psychosis powerfully communicates the rupture in identity and self-narrative that may accompany this kind of experience for new mothers (Neimeyer, 2006). However, at the same time, it could be argued that by constructing identity along these lines, the women in this study also distanced themselves from the kind of person that they were when experiencing postnatal distress. This could be seen as a means of presenting a particular image of the self, dissociated from the 'madness' of psychosis.

The women in the study can also be understood as constructing identity in relation to wider cultural discourses of motherhood, drawing upon a range of interpretive devices to position themselves in line with the 'good' mother, whilst at times, offering counter-narratives that challenged these normative ideals (Andrews, 2004). The absence of viable alternative discursive frameworks, such as those informed by feminist psycho-social theory, could be considered as contributing to the ways in which psychosis in the postpartum period is predominantly framed as an abnormal individual response to the physiological changes and psychosocial challenges of new motherhood, rather than as located within problematic social, economic and political conditions of motherhood (Gavey, 1989; Oakley, 2005; Stoppard, 2013; Ussher, 2006).

Subjecting the narratives to a critical hermeneutic using feminist theory highlights the complex rhetorical work that these women engaged with in locating their subjective experiences of postnatal distress within broader discourses of 'mental illness' and motherhood. This opens up the possibility to consider the ways in which normative representations of motherhood, as a time of bliss and fulfilment, coalesce with biomedical discourses in shaping the construction of psychosis in the postnatal period as a disordered response to the demands of motherhood and as a ‘mental illness’ that requires management or from which one recovers. However, it also enables consideration of the agentic ways in which participants engage with broader discourses in their narratives. A feminist analysis thus opens up space for greater critical engagement with the nuances in the discursive construction of motherhood and of maternal subjectivity, as well as the possibilities that are open to women in navigating these discursive frameworks when making sense of their subjective experiences.

Chapter Five

Discussion

5.0. Overview

Five women participated in this research, all of whom had experienced what was described as postpartum psychosis after the birth of their first child, ranging from between 2 and 37 years before the time of their interviews. Three of the women received treatment in a MBU, whilst two of the women were admitted to psychiatric units and separated from their babies during this time.

The women who participated in this research offered rich, reflective, accounts of their experiences of postpartum psychosis with overlapping narratives of postnatal distress, motherhood, identity and recovery. Canonical narratives of motherhood featured strongly and were both drawn upon and contested. Similarly, a biomedical discourse of ‘mental illness’ was utilised at times in the construction of identity and in sense making. Broadly, participants’ accounts portray postpartum psychosis as a terrifying and bewildering experience, and as a time of isolation and disconnection from the rest of the world. This echoes accounts from women who have experienced psychosis in the postnatal period, as documented in the wider literature (Engqvist et al., 2011; Glover et al., 2014; Robertson & Lyons, 2003).

For most of the women who participated in this research, the experience of severe postnatal distress is presented as a stark and bewildering contrast to their expectations of new motherhood. Participants described feeling lost and confused around whether their difficulties were an expected result of motherhood, a hitherto unknown experience, or an indication of something else. This echoes findings from the literature on postpartum psychosis (McGrath et al., 2013). For the participants in this research, not knowing what to expect in new motherhood compounded their reliance on healthcare professionals during this time, and, sadly, there is a prominent theme of being failed by the medical system in feeling dismissed or misunderstood during their early experiences of psychosis.

Finally, whilst the experience of postpartum psychosis was often distanced through the use of humour or in being located in the past, as a time-bounded experience, unresolved questions regarding the cause of postnatal distress, at times linked to ontological concerns regarding the self, cut through this temporal distance and added an unresolved quality to these women’s narratives.

Table 3 below outlines the main organising categories chosen to represent identity work within the narratives, as well as thematic priorities across narratives and the application of a critical hermeneutic of feminism.

Table 3. CNA analytic summary

Identity work	
The construction of identity in relation to psychological difficulties	• A lost self • A medicalised self • A transformed self • Tensions: Agency and disempowerment
The construction of identity in relation to maternal subjectivity	• The ‘good mother’
Thematic priorities	**Sub-themes**
Explanatory frameworks	• Multiple explanatory frameworks • Not knowing
Power	• Medical authority • Medical incompetence
The multidimensional nature of family support	
Stigma	

Recovery	
Destabilising narratives: A critical hermeneutic of feminism	• Postpartum psychosis as a ‘mental illness’ • Canonical narratives of motherhood

Findings from this research will now be discussed in relation to the broader literature.

5.1. Selfhood in the context of postpartum psychosis

Across participants’ accounts, postpartum psychosis is narrated as an experience that caused a profound rupture in selfhood, akin to chronic illness narratives. The experience of postpartum psychosis is constructed as a form of biographical disruption and as breaching taken-for-granted assumptions about the self (Bury, 1982). Most of the women constructed this biographical disruption as temporary, narrating a sense of self as concomitantly re-found and as transformed positively by the experience. However, whilst Sophie spoke about positive changes in herself following her experiences, the biographical disruption caused by early maternal distress is, at times, constructed as ongoing and projected into the future, concurrent with her subsequent diagnosis of bipolar disorder.

Arguably, for these women, framing the experience of postpartum psychosis within a time-bounded past supports the construction of an essentialist self that is distinguished from the experience of ‘mental illness’ (Kelly & Dickinson, 1997). As discussed in Chapter Four, I have argued that when reflecting on their experiences of early maternal distress, the women in this study suggested that who they were during this time was different to, and somehow less authentic than, who they *really* are, separating their 'psychotic self' and 'real self'. Writing about illness narratives, Frank states: 'The temporarily broken-down body becomes "it" to be cured. Thus the self is dissociated from the body' (Frank, 1995, p.102). Accordingly, the construction of selfhood in relation to the experience of early maternal distress in these women's narratives could also be considered a means of distinguishing their sense of self from the corporeality of a sick body in which psychosis is objectified and detached from more authentic aspects of subjectivity (Frank, 1995).

This corresponds with findings from Kinderman and colleagues (2006), who found that outpatients in remission from psychosis drew a distinction between their illness experiences and their current selves, describing their current selves as more real and as more valid (Kinderman et al., 2006). Outpatients also created a sense of separation by temporally locating their experiences of psychosis in the past, and drew distinctions between who they are in their current lives and their thoughts and behaviours during the time of their 'illness' (Kinderman et al., 2006). However, whilst the outpatient participants in Kinderman et al.'s research (2006) expressed a lack of agency and hope, the women in this research, broadly, constructed their current selves as agentic and expressed hope for the future. One potential reason for this difference lies in the associations that the diagnosis of postpartum psychosis holds, as a distinct form of 'mental illness' that is temporally bound and recoverable (Robertson & Lyons, 2003).

Kinderman and colleagues posit that these distinctions in selfhood may serve a relational function in enabling patients to engage collaboratively with mental health services (Kinderman et al., 2006). Constructing oneself as having recovered from a 'mental illness' may, they suggest, offer greater opportunities for taking up an agentic and empowered position. As I have suggested, this may also be considered a relational strategy in these women's narratives, including in their dialogues with me, a trainee counselling psychologist.

Concurrently, in their research, Pitt and colleagues suggest that having a diagnosis of psychosis enabled participants to externalise their distressing experiences, minimise personal responsibility and conceptualise their experiences as part of an illness that is separate to the self (Pitt et al., 2019). However, they also found that participants moved between framing their diagnosis as 'something they have' and 'something that they are' (Pitt et al., 2019, p.421), akin to the construction of bipolar disorder within Sophie's account. Pitt and colleagues argue that these tensions undermine the potential for medical diagnosis to be used as a means of externalising and distancing illness experiences (Pitt et al., 2019). I would also hypothesise that these tensions perhaps express different ways of relating to the subjective experience of psychological distress, not only shaped by broader discursive frameworks, yet also by the particular relational interactions in which certain kinds of subject positions and identity claims are possible. Indeed, Sophie offered a nuanced perspective on this in linking bipolar disorder to the construction of the self as a patient embedded within mental health services.

The notion of a distinct form of selfhood as arising during postnatal distress also speaks to the phenomenological experience of postpartum psychosis as reflected in the wider literature. For instance, the women who participated in Chotai's research (2016) talked about an unfamiliar and unrecognisable self during their psychosis experience. Similarly, the women in Robertson and Lyons' research (2003) talked of losing themselves during the experience of postpartum psychosis and suggested that the process of recovery offered a means of finding oneself again, paralleling the recovery narrative that comes through in Gwyneth's account.

5.2. Post-traumatic growth and illness narratives

As discussed in Chapter Four, concurrent with the construction of self as lost during early maternal distress, all of the women in this study constructed themselves as transformed by the experience, noting increased empathy and self-awareness as a result of their experiences, as well as having a renewed perspective on life. This could be conceptualised as illustrative of a 'quest narrative' in which the experience of early maternal distress is framed as a personal journey from which a new identity can be claimed, along with concomitant forms of social action (Frank, 1995).

The construction of a transformed self is consistent with the broader research on postpartum psychosis (Engqvist & Nilsson, 2013; Chotai, 2016; Heron et al., 2012 Robertson & Lyons, 2003). Research has suggested that developing a positive perspective on the experience can aid acceptance and integration, and can form part of a recovery process (McGrath et al., 2013). These findings are echoed by this research, illustrated by participants' positive reflections on the valued changes within the self that have arisen as a result of postnatal distress, and in the integration of the experience in line with the construction of a 'transformed self'.

The use of a posttraumatic growth discourse (Tedeschi & Calhoun, 1995) in participants' narratives corresponds with the construction of an agentic subject position. This was most clearly exemplified by Gwyneth, who, in her recovery narrative, spoke of her active participation in interviews and conferences about postpartum psychosis. This is also consistent with findings from the wider research; for instance, the women in Chotai's study described taking up an active stance following postpartum psychosis, using their experiences as a basis for change and to campaign for greater awareness (Chotai, 2016). This mirrors findings from Hunter's research into the discursive construction of maternal distress, in which participants described personal transformation as a result of their experiences and taking up an active role in educating others, 're-authoring' the experience to construct a more positive social account in line with a 'survivor' identity (Hunter, 2013, p.76).

5.3. Explanatory frameworks

In using a range of explanatory models of mental health to make sense of their experiences, the women in this study offered accounts that mirrored, and also deviated from, those found within the wider literature. For instance, the women who participated in McGrath et al.'s research (2013) also expressed uncertainty over the causes of their experience of postpartum psychosis, and listed multiple potential explanations that included, but were not limited to, a medical model. This correlates with other qualitative research that has documented participants' use of multiple explanatory frameworks (Glover et al., 2014) as well as the expression of unresolved questions surrounding the cause of postpartum psychosis (Chotai, 2016). In citing triggers such as sleep deprivation, lack of social support and traumatic delivery, accounts from these women also cohered with those reflected in the wider literature (Glover et al., 2014).

However, in foregrounding explanatory models, accounts from the women in this study contrasted with those documented by Robertson and Lyons (2003), who note that the women in their study spoke briefly about potential causes. Differences in findings need to be considered in relation to the interpersonal context of the interviews. In this study, participants were aware that they were sharing their experiences with a trainee counselling psychologist and were informed as to my interest in hearing exploratory accounts, which may have influenced the amount of time and attention that the women paid to these kinds of questions. Indeed, research has indicated that women reconstruct their accounts of postnatal distress based on the sociocultural and relational context in which they were created (McGrath et al., 2013), as narratives are co-created and relationally constructed (Riessman, 2001).

Bringing together both lay and expert narratives to make sense of their experiences, the explanatory frameworks used by participants in this study can also be considered overlapping forms of ‘contingent’ and ‘moral’ narratives (Bury, 2001). Bury suggests that whilst contingent narratives outline the causes of an illness, its symptoms and effects, moral narratives concern evaluative elements, such as accounting for, and justifying, changes in the self, drawing from biographical and social elements (Bury, 2001). I would suggest that the moral narratives within these participants’ stories are foregrounded in the identity work around being a mother experiencing psychological difficulties, contextualised within dominant, pervasive, cultural narratives that idealise motherhood. For the participants in this study, this may have added to a felt need to account for changes within the self that deviated from these normative representations. My status as a mother will have also, undoubtedly, entered the relational frame of the interviews, thereby shaping the rhetorical work around motherhood that participants engaged in whilst in conversation with me.

5.4. Power and help seeking in the context of early maternal distress

There were multiple dimensions of power that featured within these women’s narratives. One aspect concerned the authority of health professionals to conceptualise the difficulties that women presented with within a diagnostic framework, and in determining access to specialist services and certain kinds of intervention. This came through at different points in participants' narratives; for instance, in the context of help seeking during the early stages of postnatal distress, in which Emily and Gwyneth's embodied, intuitive, knowledge was constructed as disregarded by health professionals.

The existence of embodied, subjective, awareness of internal changes during the experience of early maternal distress has been documented elsewhere, along with feelings of disappointment and frustration over the experience of seeking help during early maternal distress (Doucet et al., 2012; Engqvist et al., 2011; Glover et al., 2014; Heron et al.,2012). Grouping these experiences under the superordinate theme, 'something is not quite right', Chotai highlights participants' intrinsic awareness of something being amiss in the postnatal period, and frustrations over this being missed (2016). Similarly, Stone and Kokanovic note that the women who participated in their research 'Had an embodied sense of something being amiss, but without the language to explain this sense, other explanations crept in' (Stone & Kokanovic, 2016, p.103). Broader literature has also documented how women's embodied experiences may be disregarded or dismissed in the context of childbirth (Reed, Sharman & Inglis, 2017), as well as that women are discerning in making decisions regarding recommendations based on their embodied knowledge, taking their own subjective awareness seriously (Browner & Press, 1996). This was echoed in this research, played out through tensions between the construction of self as agentic and as disempowered within a medical context.

It is possible that in the context of postpartum psychosis, women may be dismissed or misdiagnosed due to a lack of awareness from medical professionals of the different forms that postnatal distress may take. However, the struggles that these women recounted experiencing when seeking help, as reflected by the wider literature, also speak to a widespread and authoritative psychiatric discourse that constructs those experiencing psychosis as having a lack of insight, or awareness, into their ‘illness’ (Aleman et al., 2006). The findings from this research, in relation to an embodied awareness of the experience of psychosis in the postnatal period, not only lend support to a multidimensional model of insight (Beck-Sander, 1998; Cooke et al., 2005) but also indicate that women may face unnecessary and potentially dangerous delays in getting the support that they need due to assumptions around how women experiencing postpartum psychosis may present and respond to their own experiences. Taking women who are experiencing maternal distress seriously when they seek help is particularly important given the potential reluctance that women may experience in expressing their difficulties if this is seen to undermine their status as ‘good’ mothers (Davies & Allen, 2007).

Moreover, participants’ experiences of being dismissed echo a broader set of epistemological concerns raised by feminist scholars regarding the production of knowledge, which, they argue, has historically ignored or distorted women’s subjective experiences (Oakley, 1974; Stanley & Wise, 2002). Given that dominant motherhood ideologies continue to exclude the experience of psychological distress in representations of idealised motherhood (Davies & Allen, 2007), there is perhaps still some resistance to acknowledging the full extent and nature of some forms of postnatal distress, with health professionals leaning towards understanding women’s experiences as manifestations of more palatable presentations, such as Postnatal Depression (PND), or ‘baby blues’. This also reflects concerns around the use of PND as a generic diagnosis in the context of maternal distress (Edwards & Timmons, 2005), a finding echoed by this research.

Other dimensions of power that arose within participants' narratives concern dependency and trust. Some of the participants suggested that their vulnerability at the time increased their dependence upon medical professionals, with the unknowns of new motherhood compounding this. This echoes findings from other research into women's experiences of psychosis in the postnatal period, in which women have reported a sense of powerlessness and loss of control, exacerbated by a lack understanding or knowledge of postpartum psychosis, and a lack of strategies to manage their symptoms (Robertson & Lyons, 2003; McGrath et al., 2013). For the women who participated in McGrath et al.'s research (2013), there was a conflict between their reliance on medical professionals and a lack of trust (McGrath et al., 2013). Controlling symptoms related to their mental health was posited as a solution to this, as participants felt an increased sense of self-efficacy (McGrath et al., 2013), adding weight to the idea that the construction of a patient identity may, in some circumstances, correspond to an agentic position in the negotiation of relationships within a predominantly biomedical context.

As discussed in Chapter Four, the women in this study also constructed health professionals as somewhat unreliable in their care, and as being, at times, unskilled, inexperienced and insensitive. This also echoes findings from the wider research. For instance, women have expressed anger towards medical staff for the poor care that they have received when experiencing postpartum psychosis, and have reported a lack of available information, as well as rushed consultations (Engqvist et al., 2011). Research has also indicated that women often face delays in accessing care and support for psychosis in the postnatal period and struggle to obtain recognition of their psychological difficulties (Edwards & Timmons, 2005), as well as a lack of post-discharge support (Heron et al., 2012).

5.5. Relationships and postpartum psychosis

A number of the women from this study spoke about the lack of support that their partners and husbands received during their experiences of postnatal distress. They indicated that their partners had found these experiences distressing and had struggled to contend with managing work commitments whilst navigating new fatherhood. Participants also suggested that making difficult treatment decisions, such as regarding compulsory admission, also impacted negatively on their partners and contributed to family conflict.

The impact of early maternal distress on women’s immediate and family relationships is reflected in the wider research (Griffiths et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003; Roxburgh et al., 2023). Research indicates that women perceive relationships as important sources of support during postpartum psychosis, yet also as sources of worry and concern (Heron et al., 2012), echoing findings from this study. The lack of support that male partners receive in the context of postpartum psychosis has also been highlighted elsewhere (Griffiths et al., 2019; Robertson & Lyons, 2003; Roxburgh et al., 2023), as has the fact that women may feel dismissed or let down by family members in not receiving the kind of support they needed during this time (Glover et al., 2014).

Interestingly, the majority of the participants in this research emphasised the support of their partners and family members during this time, with Rose standing out as an exception to this. Whilst this may be connected to demographic factors (Prezza & Pacilli, 2002), it is possible that women who had experienced a lack of support from family members may have been less inclined to participate in this research, given the potentially distressing nature of these experiences and risks of re-traumatisation.

5.6. Motherhood and early maternal distress

As hitherto discussed, I posit that a lot of the rhetorical work in participants' narratives revolves around the dominant cultural ideology of motherhood, with women locating themselves discursively in line with 'good' motherhood (Johnston & Swanson, 2003). Alongside this, a number of the women in this study expressed feelings of guilt and failure for not living up to normative expectations of motherhood; for instance, in their birth experiences, in relation to breastfeeding and for having experienced early maternal distress. Whilst societal expectations were, at times, critiqued, by the women in this study, the pervasive nature of these expectations was palpable in the presence of discursive constructions of motherhood that featured across accounts.

The discrepancy between broader constructions of motherhood and women's lived experiences has been documented elsewhere (Johnston & Swanson, 2003). Wider research into women's experiences of postnatal distress in the form of psychosis has demonstrated that women experience guilt and shame for failing to live up to normative standards of motherhood, and may worry about the impact of their difficulties on their children (McGrath et al., 2013). Research has also indicated that women may express a sense of failure for experiencing early maternal distress or for feeling unable to take care of their babies during this time (Engqvist et al., 2011; Heron et al., 2012). Similarly, women have reported feelings of guilt and inadequacy for missing out on the first few months of motherhood (Robertson & Lyons, 2003), akin to the loss that is thematised within Emily's account. Interestingly, whilst the women in Engqvist and colleagues' research spoke of feeling, or being, unable to look after their babies during this time, the women in this study emphasised how they were still able, or wanting, to care for their babies (Engqvist et al., 2011), which has been conceptualised as part of the construction of ‘good’ mothering within participants’ accounts. It is also possible that this may have been influenced by my disclosure of being a mother, bringing normative expectations into the room in a more immediate, relational, sense.

In Chapter Four, two canonical narratives that featured within women’s accounts were problematised through a feminist lens: a biomedical discourse of ‘mental illness’ and a canonical narrative of the ‘good’ mother. It could be argued that constructing early maternal distress as a ‘mental illness’ may enable participants to avoid blame and responsibility for having thoughts, feelings and actions that may position them as ‘bad’ mothers (Stoppard, 2013). This corresponds with the Foucauldian argument put forward by Stone and Kokanovic, that in relation to the experience of maternal distress, women prefer ‘to be ‘sick mothers in recovery’, rather than ‘plain bad’ mothers’ (Stone & Kokanovic, 2016, p.104). From a feminist perspective, this speaks to the complexities of negotiating a limited repertoire of subject positions available within a patriarchal culture in which women continue to be pathologised for distress (Ussher, 2011) or stigmatised for deviating from idealised representations of motherhood.

Normative expectations of motherhood also featured in some of the participants’ accounts in relation to shame and stigma around their postnatal distress experiences. Rose described hiding her difficulties from the health visitor and Emily spoke passionately about the judgement she perceived from health professionals during her second labour. This supports findings from the wider research, with one study indicating that the distressing nature of postpartum psychosis may be compounded by a fear of being judged as an incompetent mother (Engqvist et al., 2011). Research has also indicated that women may perceive themselves as inadequate when experiencing psychological difficulties in motherhood and may hide their difficulties from others (Edwards & Timmons, 2005), echoing some of the findings from this research. Edwards and Timmons also posit that feelings of failure in this context may be compounded by broader societal expectations of ‘good’ motherhood, and suggest that women may engage in forms of ‘self-stigma’ (Corrigan & Watson, 2002, in Edwards & Timmons, 2005, p. 477). This may be considered a feature of Rose and Catherine’s accounts in their expression of guilt and self-blame for having experienced postnatal distress.

5.7. Limitations and opportunities for future research

This research has offered a rich description of the experience of early maternal distress through a phenomenologically-grounded narrative analysis (Langdridge, 2007). The use of an idiographic, qualitative, methodology aligns with a focus on meaning, and in the production of an inherently partial and subjective analytic account (Braun & Clarke, 2013). In contrast to quantitative research, this study, therefore, does not attempt to show general patterns across a population, or to establish cause and effect (Braun & Clarke, 2013). However, given the overrepresentation of quantitative, biomedically-grounded research in the literature on postpartum psychosis, a focus on meaning and deep understanding constitutes a strength of this research in enriching the literature on this topic.

Due to the constraints of this research, a number of aspects related to women’s narratives of early maternal distress remain unexamined. For instance, this research has not been able to explore the intersections between discourses of motherhood and areas of difference and diversity, such as social class, race, ethnicity, gender and sexuality. However, this research recognises that discourses of motherhood are ‘classed and raced’ (Goodwin & Huppatz, 2010, p.5) and that social class and ethnicity have been shown to shape the ways in which women relate to broader motherhood ideologies (Christopher, 2012). This study would have benefitted from greater and more extensive consideration of these factors in its analysis; concurrently, the application of a critical intersectional perspective to this topic constitutes an area for future research. Equally, this research might have benefitted from a more thorough, psychologically-informed, exploration of the embodied, relational, experience of early maternal distress (Stone & Kokanovic, 2016). This may have balanced attention given to socio-cultural factors in the analysis of participants’ narratives.

The fact that a number of the women intuited an embodied awareness of the early stages of their psychosis indicates a need for both further research into the embodied experience of psychosis in the postnatal period as well as in non-postpartum forms of psychosis. Future research opportunities also involve exploring men’s experiences of navigating early maternal distress, alongside consideration of the role of broader discourses of gender and fatherhood. Refining an understanding of the specific types of support and intervention that partners might take up, and benefit from, clearly constitutes an important area of future research. Similarly, given some of the frustrations that the women in this study expressed in relation to their medical care, an important area of potential future research includes exploration of the ways in which postpartum psychosis is talked about by health professionals, perhaps using a critical discursive approach, such as FDA.

The role that the societal constructions of motherhood play in shaping women’s relationships with themselves as mothers in the context of postnatal distress highlights the pervasive and detrimental nature of the dominant ‘good’ mother ideology and underscores the importance of further research into the relationship between discursive constructions of motherhood and early maternal distress in the form of psychosis. Given that understandings of, and forms of intervention for, postpartum psychosis continue to be dominated by a biomedical paradigm, as reflected in the wider literature, further research is needed that incorporates a critical perspective on the role of discourse in narrating these kinds of experience, and that deepens psychologically-informed understandings. This could include the adoption of a critical stance towards ways of conceptualising postpartum psychosis, which is particularly pertinent for the discipline of counselling psychology given the power of the ‘psy’ disciplines in shaping how people relate to their experiences (Rose, 1985; Rose, 1999).

5.8. Clinical implications and relevance to counselling psychology

This research has highlighted a number of important implications for supporting women who are experiencing postnatal distress in the form of psychosis. Sadly, the challenges that some of the participants faced in seeking help for their distress suggests that there is an unaddressed need for more timely, responsive, support and intervention. Women’s stories highlight ongoing training needs for health professionals, such as GPs and health visitors, to best enable them to spot the signs of psychosis in the postnatal period and to support women in navigating the complexities of new motherhood and early maternal distress. This might also include support in disentangling the unknowns of new motherhood and the experience of psychosis in the postnatal period, something that the women in this study expressed confusion about, and that might delay help-seeking.

Correspondingly, this study adds weight to research that indicates the importance of information provision for women during postpartum psychosis (Heron et al., 2012) and suggests that women might benefit from greater transparency and openness from health professionals; for instance, in sharing psychological formulations and psychiatric diagnoses. Gwyneth’s story in particular indicates that her frantic search to understand her bewildering experience exacerbated her anxiety and distress during the early stages of her psychosis experience, and that the diagnosis of postpartum psychosis was experienced as a relief and source of hope. This corresponds to research in which women have expressed strong feelings of relief and reassurance upon receiving a diagnosis of postpartum psychosis (Edwards & Timmons, 2005). Whilst Heron and colleagues (Heron et al., 2012) note that the women in their study were not well enough to seek information during the early stages of their difficulties, and that information needed to be adjusted to the stage of recovery, a number of the women in this study indicated a desire to put a name to their experiences early on. Again, due to the constraints of this research, participants’ relationships with medical diagnosis have not been explored in as much depth as other areas; unpacking the complexities of this in future research would add clarity on how best health professionals may be able to support women in this context.

However, on a more critical level, this study holds clear implications for the role that discursive constructions of ‘good’ mothering play in how women make sense of their experiences of postnatal distress. There is a need for greater consideration of broader ideological frameworks in the context of new motherhood. Part of this concerns the role of health professionals. Indeed, Davies and Allen argue that, in caring for women who are both mothers and patients with mental health difficulties, health professions face the task of moving between two interactional frames in which the women is a mother and a patient within the ‘same clinical encounter’ (Davies & Allen, 2007, p.373). From a Foucauldian perspective, they argue that this generates an opportunity for health professionals to use their power in a beneficial way, enabling women to construct an identity in which experiencing maternal distress may be integrated into their conception of what it means to be a ‘good’ mother (Davies & Allen, 2007). Finally, Davies and Allen suggest that societal conceptions of ‘good’ motherhood in the context of psychological distress may be challenged on a structural level, such as in the design of outpatient services that may include play areas for children alongside clinical spaces for female patients who are mothers (Davies & Allen, 2007). This research adds support to the importance of enabling women to integrate their experiences of postnatal distress into what it means to be a ‘good’ mother. However, a broader feminist aim would be for a more vocal critique of the socio-political context in which women become mothers and in which motherhood is discursively represented, ultimately moving away from binary conceptions of ‘good’ and ‘bad’ mothering to allow for more holistic, multifaceted, representations of maternal subjectivity.

Whilst ideological change needs to happen on a systemic level, this research indicates that it may benefit women to have the opportunity to consider questions of motherhood and identity in the pre-natal period, as well as give thought to the range of birth scenarios that they may encounter. All of the women in this study recounted having difficult, ‘traumatic’, birth experiences, including emergency caesarean sections, instrumental deliveries and obstetric emergencies. The women also considered their traumatic childbirth experiences to constitute one of the potential causes of their postpartum psychosis experiences. This indicates a need for health professionals to develop greater awareness and understanding of the psychological sequelae of traumatic birth experiences, and to tailor support appropriately. This, alongside broader considerations of the psychological transition to motherhood, could be reflected in a fuller set of NICE (2014) guidelines for interventions for postpartum psychosis.

It has been suggested that self-concept may be disrupted in the transition to motherhood, as discrepancies between a woman’s expectations for birth and actual experiences may undermine foundational assumptions about the self (Holt et al., 2018). Holt and colleagues note that ‘Women who prior to birth believe themselves to be competent, organised and in control may have difficulties making sense of an experience where they feel out of control, inept and a failure’ (Holt et al., 2018, p.535). This not only points to a need for additional psychological input from health professionals for women who consider their birth experiences as traumatic (Bastos et al., 2015), but also highlights a fruitful avenue for further research into the links between traumatic birth, self-concept, psychotic-like experiences (PLEs) and postpartum psychosis (Holt et al., 2018). This would also contribute to research into psychosis as a dimensional, rather than categorical, phenomenon (Johns & van Os, 2001).

In exploring the subjective experience of postnatal distress, along with attending to broader socio-political processes in the construction of women’s narratives, this research speaks to concerns that lie at the heart of counselling psychology (Rafalin, 2010). Given the current, and future, challenges that the discipline faces in navigating political and economic systems (Goldstein, 2010; Tindall et al., 2010), this research underscores the importance of the core values of counselling psychology. It also acts as an invitation to return to these values in both research and practice, integrating an understanding of socio-political context and subjective lived experience.

The findings from this research are also of relevance to counselling psychology in the context of psychological therapy, in highlighting potentially meaningful areas of exploration for clinicians. In attending to individual and broader cultural narratives, this research encourages reflection on the kinds of stories that may be told within the therapeutic encounter, informed by broader cultural narratives and taken-for-granted theories (Davy, 2010). Attending to these questions, and their inextricable links with power and the production of knowledge, also aligns with the discipline’s reflective-practitioner identity (Goldstein, 2010).

Chapter Six

Concluding Thoughts

6.0. Summary

This research purported to explore the ways in which women make sense of their subjective experiences of postpartum psychosis through narrative. It also aimed to examine critically how women engage with discursive constructions of perinatal mental health and motherhood in their narrative accounts, as well as to understand women's support needs during and after experiences of postnatal distress. In employing a phenomenologically-informed narrative methodology, this research has contributed to a critical, psychological, understanding of the experience and narration of early maternal distress in the form of psychosis. The use of feminist theory as an additional analytic layer has elucidated the influence of broader cultural ideological frameworks in women's sense-making processes and identity claims.

Below, I offer some final reflections on the analytic process.

6.1. Analytic reflexivity

When reflecting on identity work within the narratives, I considered how my positioning as a trainee psychologist may have invited women to take up a complementary 'patient' position at times. In my reflections, I also considered the ways in which I may have unwittingly invited a biomedical construction of the subjective experience of postnatal distress in my own use of the diagnostic label, 'postpartum psychosis', in participant recruitment and in reference to these women's experiences. If the parameters of this research had allowed it, I would have been curious to perform an additional analysis on my engagement during interviews to unpack my own positioning and identity work and the emerging dialogical interactions between myself and participants.

When analysing the data, I was surprised by how little the women spoke about what might be considered the ‘symptoms’ of postpartum psychosis. Whilst, to varying degrees, participants talked about the unusual and often, distressing, beliefs and visions that experienced at the time, their accounts foregrounded the confusion, panic, bodily experiences, attempts to seek help and descent into something unfathomable and terrifying. Furthermore, subjective experiences were presented as interwoven with broader narratives of identity and motherhood as women moved between descriptions of their experiences at the time and discussing the context in which they arose, the aftermath and meanings of the experience. In many ways, this is not surprising; however, it left me reflecting on how much my initial engagement with this topic had been informed by the search for discrete descriptors and ‘symptoms’, in line with more of a psychiatric stance.

Furthermore, whilst loss featured as a theme within some of the women’s narratives, I was surprised that this did not emerge as a main theme in my analysis. However, I wondered if loss could have been conceptualised thematically within the narratives in alternative ways, such as in the loss of self that the women described when experiencing postnatal distress or even in the experience of being a hospital patient, as a loss of agency. In my application of CNA as an analytic method, these experiences have been conceptualised through the frame of identity work, perhaps marginalising what might otherwise be considered phenomenological experiences of loss.

Finally, reflecting on the analytic process, I noticed tensions arising relating to my subjective interpretation of the data. These tensions really came to the fore in Stage 5 of the analysis in which I experienced a conflict between my attempts to offer a fair representation of participants' experiences and the application of a feminist reading to the data. It felt as though engaging in a discursive critique invalidated the phenomenological experience that women recounted in their narratives and I found myself presenting counter-arguments in my head, as though I were trying to defend the women's narratives. This left me reflecting on how binaries within discursive frameworks have also, inevitably, shaped my engagement with the data, possibly contributing to a struggle to capture the nuances within the women's narratives when applying social theory. My concerns around the application of a discursive critique also speak to some of the broader tensions in narrative research in navigating poststructuralist and humanistic foundations (Squire et al., 2008). It also raises critical questions regarding power, subjectivity and representation in this research, and in narrative research more broadly.

6.2. Power, truth and representation

In Chapter Three, I considered the question of validity in the context of qualitative research. In my analysis, I hope to have offered a 'thick description' of the experience of postnatal distress as described by participants (Geertz, 1973), and to have paid consideration to both the immediate relational context of the research as well as to the socio-political context in which these experiences are narrated (Morrow, 2007). In evaluating the validity of the 'story told by the researcher' (Riessman, 2008, p.195), an audit trail of the different analytic stages may be found in the appendices, which, I hope, offers a coherent overview of the ways in which I have reached the conclusions drawn and in my analytic claims. In foregrounding ‘trustworthiness’, over ‘truth’, I have sought to examine meaning rather than convey facts (Riessman, 2008). I acknowledge that this is just one of many stories that could have been told. Whilst I have reflected upon the myriad ways in which my own subjectivity has shaped the outcomes of this research, inevitably, knowledge of the self is partial and I acknowledge that I will have influenced this research in more ways that I can recognise (Corlett & Mavin, 2018).

This research has walked an ambiguous line in framing women’s experiences in diagnostic terms, as ‘postpartum psychosis’ and more broadly, as ‘postnatal distress’. This perhaps speaks to conceptual ambiguities on a diagnostic level, as reflected in the literature, and also in these women’s narratives in their struggles to conceptualise their experiences and to be heard in expressing their distress at the time. Ultimately, I hope that in referring to both ‘postpartum psychosis’ and ‘postnatal distress’, I have used a common diagnostic term that speaks to these women’s experiences, whilst also not losing sight of broader conceptualisations that move beyond psychiatric diagnosis and that invoke curiosity and foreground meaning.

6.3. The unexplored

There are so many unexplored parts to this research. For instance, whilst maternal ambivalence featured in the implicit across some of the narratives, this was not foregrounded. I have been left wondering how this may relate to the experience of maternal ambivalence as a source of shame, or how it might even reflect a lack of words to express this aspect of maternal subjectivity. These are only speculations but if I were to repeat this research or expand upon it further, I would be curious to name this in conversation with the participants and open more of a reflective space to explore maternal ambivalence in the context of postnatal distress.

Equally, across multiple stages, this research has been shaped by the application of a feminist lens. A number of different hermeneutics could have been applied in Stage 5 of the analysis (Langdridge, 2007), which would have inevitably contributed to a different set of analytic claims. For instance, a hermeneutic concerning age would have enabled me to attend to generational differences in participants' narratives, not just in the phenomenology of their experiences but also in the rhetorical devices, identity claims and discursive frameworks used (Langdridge, 2007). This would have been an interesting endeavour given the generational differences across participants. Similarly, an application of a class analysis, or race and ethnicity analysis, would have enriched my understanding of these women's stories in different ways (Langdridge, 2007). Analysis of these different intersectional identities may have also prompted me to reflect more deeply on points of difference in the research relationships, something that this research would have benefitted from in exploring the relational context of storytelling more critically.

6.4. Narratives as a meaningful site of change

In exploring the phenomenological experience of postpartum psychosis alongside a feminist critique, this research has integrated experience-centred and socially-oriented narrative approaches (Patterson, 2008; Squire, 2008). I have considered personal narratives as meaningful sites of engagement, whilst also holding the view that narratives are co-constructed and reconstituted over time and place (Patterson, 2008; Squire, 2008). Drawing upon Riessman, I have also conceptualised the telling of narratives as 'situated and strategic' (Riessman, 2008, p.194), and as 'taking place in institutional and cultural contexts with circulating discourses and regulatory practices' (Riessman, 2008, p.194).

The narratives that emerged within this research cohere with Bruner's conceptualisation of narrative as a breach of a canonical script and also as a site for cultural negotiation (Bruner, 1991). In applying a feminist hermeneutic, I attended to the negotiation of wider discursive frameworks in participants' narratives. This was informed by the notion that dominant narratives structure the world in intelligible ways and act as a broad socio-cultural frame that shape possible identity constructions and discourses (Bamberg, 2004). Using a feminist lens, I foregrounded participants' engagement with dominant discourses of motherhood and mental health. Accordingly, I argued that some of the identity work in participants' narratives concerned the construction of self in line with biomedical conceptualisations of selfhood, as well as broader normative representations of 'good' motherhood. However, I also suggested that participants' identity claims constitute acts of agentic negotiation in the context of culturally available discursive frameworks (Stoppard, 2013; Ussher, 2006), as participants offered subtle challenges to dominant discourses around motherhood and mental health, drawing upon counter-narratives to do so (Andrews, 2004). This, I would argue, renders them a site of change and underscores the emancipatory potential of narrative research (Bamberg, 2004; Squire et al., 2008).

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Appendices

Appendix 1: Metanoia Research Ethics Committee ethical approval letter

METANOIA
INSTITUTE

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Sarah Griffiths
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

15th January 2020
Ref: 03/19-20

Dear Sarah,

Re: What's in a Story? A Narrative Inquiry into Women's Experiences of Postnatal Psychological Distress

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

J Challenor.

Dr Julianna Challenor
Director of Studies DCPsych
Faculty of Post-Qualification and Professional Doctorates

On behalf of Metanoia Research Ethics Committee

Registered in England at the
above address No. 2918520

Registered Charity No. 1050175

Appendix 2: Screening protocol

SCREENING PROTOCOL

What’s in a Story? A Narrative Inquiry into Women’s Experiences of Postnatal Psychological Distress

Aim of protocol

The purpose of this protocol is to screen prospective participants for risk of psychological harm that may arise as a result of participation in the research project. It is intended to be used as a guide for the principal researcher to assess participant suitability in discussion with the research supervisor.

Script

Thank you for your interest in taking part in this research study. My name is Sarah and I am the principal researcher for this study.

As a reminder, this research aims to explore how women talk about their experiences of postnatal distress, specifically when this distress resulted in a diagnosis of postpartum psychosis. It aims to understand how women make sense of these experiences through the stories they tell.

Would you mind confirming whether you have read the Participant Information Sheet about this study?

- If Y, do you have any questions about the research and what participation involves? (If N, proceed)
- If N, provide a copy of the Participant Information Sheet and allow time for this to be read. Then ask for questions.

As mentioned in the Participant Information Sheet, the purpose of this initial meeting is to carefully consider the risks of psychological distress resulting from participation in light of your individual experiences and current support network, so that I can balance the potential risks and benefits of participation. It is possible that you will not be chosen to participate in the research due to concerns about the emotional impact of participation. In the case of this happening, the reasons for this will be discussed with you and you will be signposted to relevant support services. It is expected that this meeting will last for approximately 30 minutes – 1 hour.

- Do you have any questions about this? (If Y, respond to questions. If N, proceed)
- Would you like to continue? (If Y, proceed. If N, discuss reasons with participant and thank them for their interest)

Screening Questions

Could I please confirm your full name? ……………………………………………………………………………….

I am now going to ask you some questions about your experience of postnatal distress and how you are feeling at the moment. Some of the questions are of a sensitive nature, so if you would like to take a break at any point, please do let me know.

The information that you share with me today will be kept confidential and only shared with the research supervisor, Dr Tanya Lecchi. This is to be able to make a decision regarding the suitability of your participation. However, if you share anything that indicates that you or someone else might be at risk of harm, I may need to share this information elsewhere (e.g. with your GP, therapist, other professionals involved). If this is the case, I will inform you about this and where possible, involve you in the process. Take contact details of GP and other relevant professionals involved (e.g. psychologist / psychotherapist).

Screening Questions	**Participant responses**	**Follow-up questions / notes**	**Concerns regarding participation in research?**	**Imminent concerns?**
1.Could you please confirm exactly how long ago you experienced postnatal distress?		Did this result in a diagnosis of PPP?		
2.What kind of treatment and support did you receive at the time (e.g. hospitalisation, medication, psychological therapies)?		Did you access any kind of psychological therapy (e.g. counselling/psychotherapy) at the time or afterwards?		
3.Are you currently accessing psychological therapy? (e.g. counselling, psychotherapy)		If Y, check whether they find this helpful, type of therapy, frequency and participant's plans to continue. Check whether participant would plan on sharing their involvement in the research study with their therapist.		
4.Are you experiencing any		If Y – enquire further re: what		

emotional difficulties or distress at the moment?		kind of emotional distress, the impact it is having on participant's functioning/relationships, whether they have accessed any support / treatment.		
5.Have you ever hurt yourself in the past? (disclaimer, the next two questions are of a sensitive nature. However, it is important that we cover them in light of the potentially distressing nature of participation in this study)		If yes, obtain further information – when, how, frequency, reasons. Assess whether this is ongoing (if so, clarify nature of self-harm and current support in place)		
6.Have you ever thought a lot about death or wished you were dead?		If yes, obtain further information – when, method, any suicide attempts. Assess whether there is current suicidal ideation and participant's intentions to act on this (method, means) and management plan (including protective factors and support)		
7.Participation in this study involves talking		What do you consider to be some of the		

about your experience of postnatal distress at length on two occasions with me. How do you imagine this will be for you?		emotional impacts of participation?		
8.Finally, could you please briefly tell me about your reasons for wanting to participate in this research study?		Do you have any concerns about your participation? Do you think other people close to you or supporting you would have any concerns? If you were able to participate, would you still choose to do so?		

In the case of no risk concerns:

That’s all of my questions. Thank you for going through them with me. How did you find it? How are you feeling now? If participant appears distressed, enquire further into what they will be doing next and who they will talk to about this. If participant discloses some mild emotional distress, encourage them to contact any professional(s) involved in their care. Provide all participants with list of support services.

As I am discussing all meetings with prospective participants with my research supervisor, I hope to be in touch within the next few weeks to discuss your potential participation. If you have any questions or concerns in the meantime, please do contact me or my research supervisor (provide contact details again if necessary).

Before we end, do you have any questions, concerns or reflections that you wish to discuss with me?

Thank you very much for your time.

In the case of non-imminent risk concerns:

That’s all of my questions. Thank you for going through them with me. How did you find it? How are you feeling now? If participant appears distressed, enquire further into what they will be doing next and who they will talk to about this. *If participant* *discloses some mild emotional distress, encourage them to contact any professional(s) involved in their care. Provide all participants with list of support services and discuss any relevant referrals (e.g. psychology services, social services). Offer to make referral and/or share information with any professionals involved in participant's case.*

As I am discussing all meetings with prospective participants with my research supervisor, I hope to be in touch within the next few weeks to discuss your potential participation. If you have any questions or concerns in the meantime, please do contact me or my research supervisor (provide contact details again if necessary).

Before we end, do you have any questions, concerns or reflections that you wish to discuss with me?

In the case of imminent risk concerns:

Thank participant for going through these questions. How did you find it? How are you feeling now?

Inform participant of my concerns and that I would like to contact my research supervisor to discuss them. Explain that this is to ensure participant's safety.

Contact research supervisor and discuss plan of action – e.g. calling participant's GP or other professional(s) involved.

Contact professional(s) involved, preferably involving participant (e.g. they could make the call).

Ensure participant's immediate safety, following guidance from professional(s) involved, GP, or emergency services.

If appropriate:

As I am discussing all meetings with prospective participants with my research supervisor, I hope to be in touch within the next few weeks to discuss your potential participation. If you have any questions or concerns in the meantime, please do contact me or my research supervisor (provide contact details again if necessary).

Before we end, do you have any questions, concerns or reflections that you wish to discuss with me?

Thank you very much for your time.

This distress protocol has been adapted from Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing*, *23*(5), 343-350.

Appendix 3: Distress protocol

DISTRESS PROTOCOL

What's in a Story? A Narrative Inquiry into Women's Experiences of Postnatal Psychological Distress

Aim of protocol

The purpose of this protocol is to provide guidance to the principal researcher on responding to participant distress during and following research interviews. It also serves as a guide for responding to acute distress or safety concerns during research interviews.

Before interviews

Principal researcher to remind participant of the potentially distressing nature of interviews and to ask for potential indicators that they are feeling distressed during the interview. Researcher to enquire about what kind of response participant might find helpful and what strategies they use in moments of distress (e.g. grounding techniques for flashbacks). Researcher to inform participants that if they see any of these indicators or perceive participant to be feeling upset or overwhelmed, they will offer to pause the tape with the option of stopping the interview at this point.

Researcher to regain verbal consent before starting interview.

During interviews

Researcher to use the following guide to respond to distress during interviews.

Indicators of distress	Researcher response	Are there concerns about continuing the interview? Y/N
Use specific indicators participant has mentioned and/or uncontrolled crying, indicators of a trauma response (e.g. dissociation, flashbacks) or verbal/non-verbal cues of distress or feeling overwhelmed.	Offer to pause interview and use therapeutic skills to provide emotional support and contain distress. If necessary, try to clarify nature of distress – thoughts/feelings/flashbacks. In the event of a trauma response, use grounding techniques. Use responses that participant has mentioned are usually helpful.	**If N:** once distress appears to have subsided, researcher to check in with participant to enquire about how they are feeling and to see if they would like to continue with the interview or stop (regain verbal consent). Researcher to reiterate that there will be no negative repercussions following termination of the interview and/or withdrawal from the study. If participant chooses to stop the interview but expresses an interest in scheduling another interview, researcher to schedule another date with participant and

		then discuss any concerns with supervisor. **If Y:** encourage and support participant to either contact clinician involved in their case (e.g. psychologist, therapist, social worker) or their GP. If there are imminent safety concerns and/or patient is unable to speak to clinician involved in their case, researcher to support patient to contact GP and/or attend A&E. Researcher to contact research supervisor to discuss any imminent concerns before taking action.

After interviews

After interviews, researcher to provide a 15-30 minute debrief. A loose structure for this is as follows:

- Ask participant how they found the experience
- Ask participant how they are feeling now
- Enquire into what participant will be doing next and if they will talk to anyone about this

For concerns regarding mild distress, encourage and support participant to either contact clinician/professional involved in their case (e.g. psychologist, therapist, social worker) or their GP.

If there are imminent safety concerns and/or patient is unable to speak to clinician involved in their case, researcher to support patient to contact GP and/or attend A&E. Researcher to contact research supervisor to discuss any imminent concerns before taking action.

- Provide participant with a list of support services and discuss any relevant referrals (e.g. social services, mental health services)
- Regain verbal consent for taking part and schedule 2nd interview if this is 1st interview

Appendix 4: Research advert

Have you experienced postpartum psychosis?

Could you help with research?

If so, I would like to hear your story. I am looking for women who previously received a diagnosis of postpartum psychosis to take part in my counselling psychology doctoral research study.

What does participation involve?

Your participation in this study would involve attending up to two interviews, lasting approximately one hour each.

During the interviews, you will be invited to share your story of early motherhood and to reflect upon your experience of postpartum psychosis.

How can I take part?

If you are interested in participating or would like to know more, please contact Sarah Griffiths at sarah.griffiths@metanoia.ac.uk or on 07878 174 497. You will be sent a Participant Information Sheet and will have the chance to ask any questions you might have about the study.

This research is being supervised and overseen by Dr Tanya Lecchi and has full ethical approval by the Metanoia Institute Research Ethics Committee.

Middlesex University London

METANOIA INSTITUTE

Appendix 5: Indicative interview guide

Indicative Interview Guide

What's in a Story? A Narrative Inquiry into Women's Experiences of Postnatal Psychological Distress

Prior to the first interview

- Thank participant for their interest in taking part in this research study
- Ensure that screening interview has been completed and that any concerns have been discussed with the Research Supervisor.
- Review Participant Information Sheet
- Review Distress Protocol
- Provide an opportunity for questions or for participant to voice any concerns regarding participation
- Outline structure and style of planned interview. Explain that the purpose of the interview is to hear the participant's account of their experience. Explain that the researcher will offer prompts and may encourage the participant to clarify anything that is not clear. Explain that the researcher might take some notes during the interaction but that these will be kept confidential and stored securely following the interview. Explain that participant can choose not to answer any questions asked or to have a break in the interview, and that a debrief will be offered after the interview.
- Review Consent Form
- Obtain basic demographic information – date of birth, ethnicity, marital status, number of children, occupation
- Discuss any questions about the process and obtain verbal consent to participate

First interview

- **Question 1.** Can you tell me about your experience of postpartum psychosis?

Prompts:

- Can you tell me more about that? What was that experience like for you? Do you remember anything else? And what happened next?

Follow-up questions that may be asked:

- How do you think this experience has impacted you (e.g. sense of self, relationship with others, roles, functioning)?
- How was it to receive a diagnosis of postpartum psychosis?
- How do you make sense of what happened during this time?
- What was your experience of accessing and receiving support from health services?

Question 2: Is there anything else you would like to talk about that has not already been covered, or any questions you have for me?

After the interview

- Invite participant to reflect on their experience of the interview and enquire into how they have been left feeling
- Obtain verbal consent again to use material recorded for analysis and write-up
- Review next steps – book second interview if not done so already
- Provide list of support services

Prior to the second interview

- Review Consent Form and Distress Protocol. Provide an opportunity for questions or for participant to voice any concerns they have about participation.
- Note expected duration of interview (1 hour). Explain that in this second interview, the researcher is keen to hear about any reflections the participant has had regarding their experience following the first interview.
- Remind participant that they can choose not to answer any questions asked or to have a break in the interview
- Discuss any questions about the process and obtain verbal consent to participate

Second Interview

Question 1: Can you tell me about how it was for you to talk with me about your story when we last met? *Follow up: how did that leave you?*

Question 2: Have you noticed any further reflections about your experience of postpartum psychosis? *Prompt: is there anything else that you would like to add to your account?*

General prompts and follow-up questions:

- Could you tell me a bit more about that?
- And what happened after that?
- What was that like for you?

After the interview

- Invite participant to reflect on their experience of the interview
- Obtain verbal consent again to use material recorded for analysis and write-up
- Review next steps – sharing initial analysis, anticipated completion of project
- Offer advice about emotional support

Appendix 6: Participant consent form

CONSENT FORM

Participant Identification Number:

Title of Project: What's in a Story? A Narrative Inquiry into Women's Experiences of Postnatal Psychological Distress

Name of Researcher: Sarah Griffiths

Please initial box

1. I confirm that I have read and understand the information sheet dated ....……………. for the above study and have had an opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason up to 3 months after my interviews. You may withdraw by telling the principal researcher that you wish to do so. This can be via email, telephone or face-to-face. If I choose to withdraw, any data I have provided will be destroyed. ☐
3. I understand that all interviews will be taped and subsequently transcribed. ☐

4. I agree to take part in the above study. ☐

5. I agree that this form, which bears my name and signature, may be seen by a designated auditor. ☐

________________________ _____________ ____________________

Name of participant Date Signature

________________________ _____________ ____________________

Name of person taking consent Date Signature

(if different from researcher)

________________________ _____________ ____________________

Principal Researcher Date Signature

1 copy for participant; 1 copy for researcher

Appendix 7: Participant information sheet

PARTICIPANT INFORMATION SHEET

What's in a Story? A Narrative Inquiry into Women's Experiences of Postnatal Psychological Distress

Invitation to the study

You are invited to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why this research is being done and what it will involve. Please take time to read the following information carefully and to discuss it with others, if you wish, before deciding whether or not you would like to take part. Please do ask if there is anything that is not clear or if you would like more information.

Thank you for taking the time to read this.

Purpose of the study

Women may experience a range of psychological difficulties after they have given birth, including low mood, depression and anxiety. However, sometimes, women experience intense psychological distress in the postnatal period, which professionals may then label as postpartum psychosis. This occurs in approximately 1-2 of every 1000 births. This distress may include extreme anxiety about the baby and/or difficulties sleeping or concentrating, as well as rapid and unusual changes in mood. Whilst research has explored some of the possible causes of this kind of distress, few studies, particularly from the field of psychology, have looked at how women make sense of intense postnatal distress and the stories that they tell about their experiences.

This research, therefore, aims to explore how women talk about their experiences of postnatal distress when this distress resulted in a diagnosis of postpartum psychosis. It aims to understand how women make sense of these experiences through the stories they tell, and to explore how wider notions of mental health and motherhood may shape these stories. In doing so, it is hoped that health professionals, such as psychologists, nurses and midwifes, will be able to provide more helpful and meaningful support to women experiencing psychological distress in the postnatal period.

Participation

Participation in this research is entirely voluntary: you do not have to take part if you do not wish to. If you decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form, which you will also be given a copy of. You will be part of a small group of 3-4 research participants, although you will not meet or hear anything about the other participants as you will only meet 1:1 with the principal researcher. In addition to written consent, you will also be asked for verbal consent before and after all interviews. You may withdraw from the study up to 3 months after your interviews without giving a reason (after which point you will have had a chance to review the initial analysis). Following withdrawal from the research, any data obtained from you will be destroyed and will not be used in the final write-up.

What participation involves

Participation in this research involves an initial meeting with a female researcher to discuss the potential emotional implications of taking part in this study and to consider the nature of your support network. During this initial meeting, will be asked to reflect upon how involvement in this study may affect your emotional wellbeing. You will be given the chance to talk through any concerns you have regarding participation and to ask questions to clarify the nature of the research and of your expected involvement. It is possible that following this interview, you will not be chosen to participate in the research due to concerns about the emotional impact of participation. In the case of this happening, the reasons for this will be discussed with you and you will be signposted to relevant support services.

If there are no significant concerns about the emotional impact of your participation and you decide you would like to take part, following this initial meeting, you will be asked to participate in two audio-recorded interviews with a female researcher (principal researcher). In these interviews, you will be asked to talk about your experience of pregnancy and early motherhood, including your experience of postnatal distress. It is expected that there will be a gap of approximately 2-4 weeks between the two interviews. Each interview is expected to last approximately one hour and a debrief with the researcher will be provided immediately after each interview to reflect on what came up for you and to go through any questions or reflections you might have. Interviews will take place at a mutually convenient location that is quiet and confidential or over MS Teams/Zoom. Travel expenses will be reimbursed by the principal researcher.

You will also be asked for basic demographic details; this information will be kept separate to other information provided as part of the research, such as your interview transcripts.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

Possible disadvantages and risks of taking part

It is possible that actively remembering and sharing your experience of postnatal distress during, between and after interviews will be emotionally difficult and may leave you feeling distressed or unsettled. Whilst you will be provided with a list of relevant support services that you can turn to, it is possible that taking part may result in considerable emotional disturbance. You will be encouraged to share these feelings with your pre-existing support network and with the researcher, who may explore additional support services with you.

Can I take part?

To take part in this research, it is asked that you have experienced postnatal psychological distress that resulted in a diagnosis of postpartum psychosis. It is also asked that you accessed psychological treatment (e.g. talking therapy) as part of your recovery and that you are over 18 years of age.

As a result of the potentially distressing nature of the research, women who are currently receiving psychological treatment from secondary care mental health services and/or who experienced postnatal distress and/or a hospital admission for psychological distress within the last two years will not be able to take part. For participants who are pregnant or become pregnant during the study, opportunities for participation will be assessed on a case-by-case basis, taking into consideration a number of factors including the previous nature of postnatal distress and current support available.

Possible benefits of taking part

By better understanding women's experiences of postnatal distress, it is hoped that psychologists and other health professionals will be able to offer more helpful support to women who are experiencing, or have experienced, postnatal distress in the future. It is also hoped that you will also benefit from participating in this study; however, this cannot be guaranteed.

Will my participation in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All written data will be stored in a locked cabinet that only the principal researcher can access and audio files will be stored on an encrypted USB device. Audio recordings will be destroyed following submission of the thesis. All other data, including consent forms and interview transcripts, will be destroyed 2 years after publication of the research and all storage and processing of personal data will be complaint with current data protection regulations.

In cases where the researcher has grounds for concern over your safety or risk of harm to others, it may be necessary to breach confidentiality by, for instance, contacting your GP. In the case of this happening, the researcher would endeavour to inform you of this beforehand and involve you in the process.

What will happen to the results of the research study?

The results of the research study will be published as a final research project for a Doctorate in Counselling Psychology and Integrative Psychotherapy. The expected year of publication is 2022-2023. The research will be accessible online on a doctoral dissertation repository and it is expected that a condensed version of the research will be published in a number of psychology journals and presented at psychology conferences. Any identifying features of participants will be removed or changed, so you will not be identified in the final report.

If you have participated in the research, you will be offered a summary of the main research findings. You will also be offered a copy of your interview transcripts and given an opportunity to discuss the researcher's initial analyses of your interviews before the final write-up.

Who has reviewed the study?

This study has been given full ethical approval by Metanoia Research Ethics Committee.

Contact for further information

If you wish to discuss any aspect of the research project, below are contact details of the principal researcher and the research supervisor.

Principal Researcher – Sarah Griffiths

Email: sarah.griffiths@metanoia.ac.uk

Address: 13 Gunnersbury Avenue, Ealing, London, W5 3XD

Mobile: 07878 174 497

Research Supervisor – Dr Tanya Lecchi

Email: tanya.lecchi@metanoia.ac.uk

Address: 13 Gunnersbury Avenue, Ealing, London, W5 3XD

Thank you for your interest in taking part in this research!

Yours sincerely,

Sarah Griffiths

Appendix 8: Debriefing support services

Support Services

Thank you again for your participation in this research. If you are left with any questions regarding this research or would like to discuss your participation, please do not hesitate to contact either myself or my research supervisor:

Principal Researcher - Sarah Griffiths

sarah.griffiths@metanoia.ac.uk, 07878 174 497

Research Supervisor – Dr Tanya Lecchi

Tanya.lecchi@metanoia.ac.uk

In addition to your support network, the following organisations/services might be helpful if you are feeling upset or affected by having shared your experiences with me.

The Samaritans – call 116 123 for free or email jo@samaritans.org. Open to people of all ages 24/7. Use this to contact and talk to a Samaritans listening volunteer.

Association of Postnatal Illness – call 0207 386 0868 (10am-2pm) or email info@apni.org.

Action on Postpartum Psychosis (APP) - https://www.app-network.org/. Postpartum psychosis support forum: https://app-network.com/pptalk

If you are experiencing a **mental health crisis**, seek urgent support:

- If within business hours, ask to see a health professional, such as your **GP** for an urgent appointment.
- Call **111** for free and choose option **2** – open to people of all ages 24/7. A trained mental health professional will be able to offer assessment and support.
- Attend your local **A&E** department if you feel in imminent danger or call **999**.

Appendix 9: Literature search strategy

Literature Search Strategy

In reviewing the literature, I conducted a search using the following databases, accessed through Middlesex University:

- APAPsychInfo
- PEPweb
- Web of Science

EBSCO/PSYCHINFO

A number of searches were carried out on this database, using Boolean/Phrase search modes.

A search using the keywords ‘postpartum psychosis OR postnatal psychosis OR puerperal psychosis OR post-partum psychosis’ with a date range from 1970-2023 initially yielded 791 results. Limiting the date range on this search to 2000-2023 reduced this to 523 results.

Subsequently, a search using the keywords ‘postpartum psychosis OR postnatal psychosis OR puerperal psychosis OR post-partum psychosis’ AND ‘motherhood’ with a date range from 2000-2023 yielded 110 results, whilst a search using the keywords ‘postpartum psychosis OR postnatal psychosis OR puerperal psychosis OR post-partum psychosis’ AND ‘femin*’, yielded just 7 results.

A search using the keyword ‘perinatal distress’ yielded 142 results, whilst a search for ‘maternal distress AND psychosis’ yielded just 1 result.

A search using the keywords ‘postpartum psychosis OR postnatal psychosis OR puerperal psychosis OR post-partum psychosis’ AND ‘narrative’ yielded 12 results, whilst amending this to ‘postpartum psychosis OR postnatal psychosis OR puerperal psychosis OR post-partum psychosis’ AND ‘critical narrative analysis’ yielded 0 results.

PEPWEB

A search for ‘postpartum psychosis’ on PEPweb yielded 51 results.

Web of Science

A search for ‘postpartum psychosis’ with a date range from 1970-2023 yielded 911 results.

Appendix 10: Excerpt from research journal (1)

Excerpt from Research Journal: Reflections after second research interview with Catherine

I felt the interview went well. It was more dialogical than my first interview and I found myself asking more questions when there was a natural break. I noticed themes of motherhood and identity featuring quite strongly in Catherine's account – lots of interesting data about the tensions between being a competent, independent, solicitor and being a mother – the dread of the realm of the domestic – and lots of rich metaphors that Catherine used to describe her experience. I also heard themes of maternal ambivalence, morality and faith. Again, I am noticing that Catherine spoke fairly briefly about her actual experience of psychosis, spending more time reflecting on the broader context. She mentioned a couple of times that she would be shocked if anyone was actually interested in her story – I was left wondering if that reflects something of her relationship with motherhood.

Before the interviews, I remember being interested in research that looked at potential links between postpartum psychosis and trauma. I think this offered me an alternative explanation to the biomedical paradigm, which felt lacking in helping me to understand my mum's distress. I found it really hard, then, when Catherine talked positively about ECT in her recovery; I think this is possibly reflected in the fact that I am not sure I engaged fully with these comments as I struggled to integrate them with my own attitudes towards how damaging these interventions, and the biomedical paradigm, can be.

During the interview, I encountered a strong feeling of incompetence, perhaps reminiscent of my early developmental experiences, and I also realise that I put a lot of focus on this idea of 'sense making', again, perhaps due to my own (defensive?) need to understand what was going on with my mum. I can hear some of this premature naming in the interviews, that I am quick to put a label on it rather than allow more of the experience to emerge in the dialogue and to be curious about this.

I am feeling utterly overwhelmed by the prospect of transcribing a second interview when I haven't even transcribed the first. This project is really off the ground now and I would love to just immerse myself in it but the constraints of my life make that impossible. Another tension here where motherhood is getting in the way for me!

Appendix 11: Excerpt from research journal (2)

Excerpt from research journal: reflections following first research interview with Emily

First research interview done! Phew. I can't quite believe it – all this build up and reading/preparation and it's over. It feels like time has stood still for the last two hours and now I am left feeling exhausted, quite headachy (probably partly from looking at the screen), anxious that the recording hasn't saved and with a multitude of questions about how it went – did I elicit enough narratives; how did I position myself; how was it for the participant?

I already have a sense of some of the things I will do differently next time – when reviewing the consent form, Emily suggested we could use Docusign and then shared her consent form with me for us to review together. I found myself wondering whether I perhaps appeared incompetent by not offering to do this myself but then also noticed that this perhaps offered an opportunity for her to step into a different role to that of participant. Was there something here about shifting power dynamics? How comfortable was I with being the one who didn't know? Perhaps there doesn't need to be that dialectic in such extreme terms.

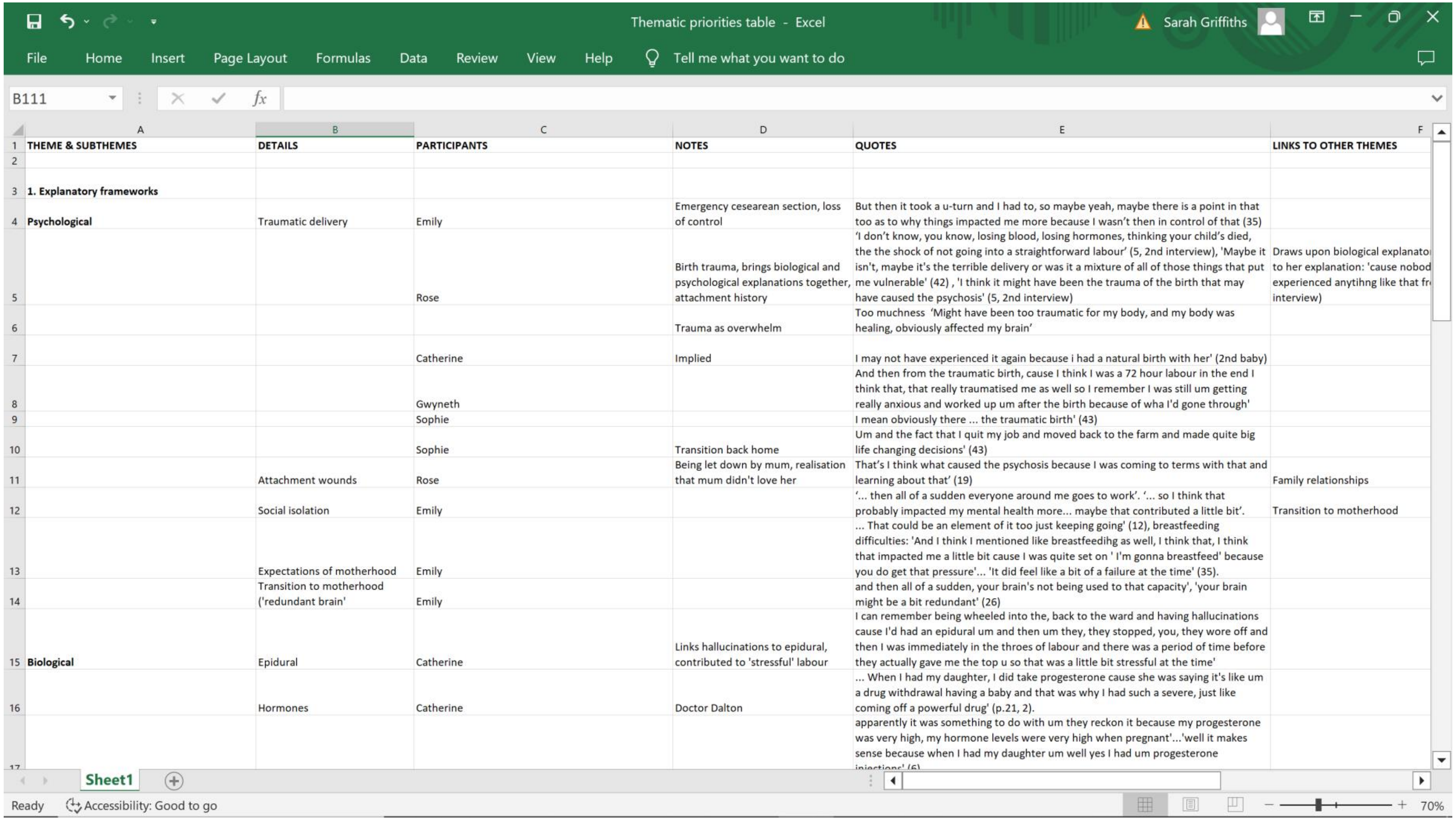
I noticed that I said fairly little for large chunks of the interview – this was partly intentional, as I was cautious of shaping Emily's story but on reflection, I acknowledge that this is perhaps a realist viewpoint and that I, of course, was influencing her story by my presence, non-verbal body language (raising eyebrows at points to join in / acknowledge elements such as surprise in the story), and the few questions/responses I did give. I have also found myself wondering if it was conversational enough. I felt there were some moments of misattunement where, perhaps coming from some of my anxiety about having been quiet, I tried to say a bit more but found myself cutting Emily off or talking for that bit too long when she was trying to respond. I also think that I perhaps ended the interview too abruptly – even though we had the debrief, it felt like a difficult transition but I was concerned of opening up another story / going back into the story and I perceived some fatigue from Emily, and also sensed that If I was feeling tired, she might feel so too.

Thinking about it now, I noticed being focused on showing Emily that I was getting her story, that it made sense to me, that I was alongside her, both as an audience member and a participant in the storytelling. Was this connected to a desire to counteract any sense of shame that I imagined might be there for her? To normalise something that can be pathologized?

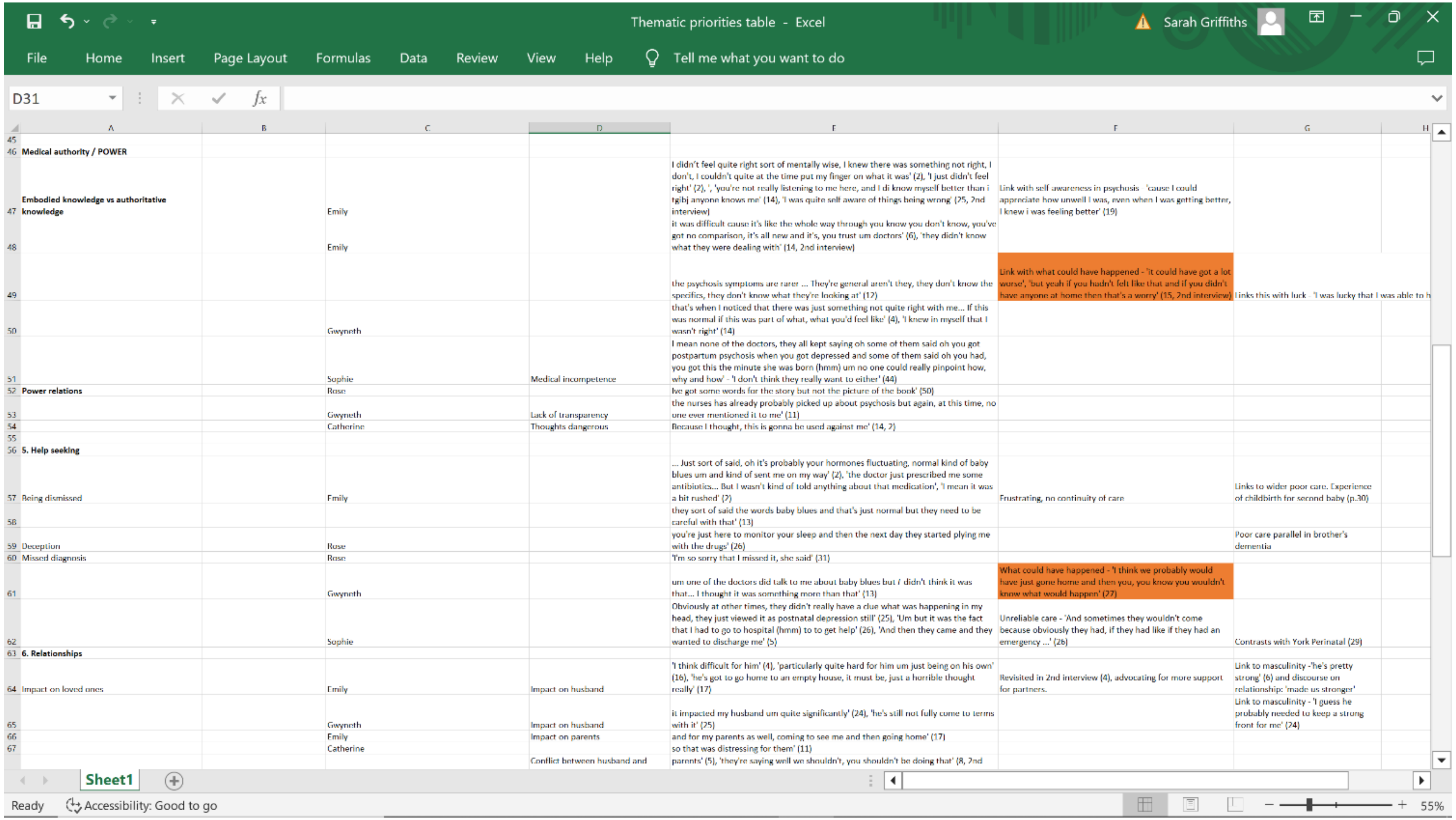
I noticed that Emily's narrative was non-linear and that we went backwards/forwards in time. Perhaps this reflects something of the circular, iterative, nature of storytelling but also perhaps the fragmented nature of trauma?

I am thinking that in the second interview, I'd really like to hear more about the impact of postpartum psychosis on Emily's sense of self.

Appendix 12: Emerging thematic priorities excel tables

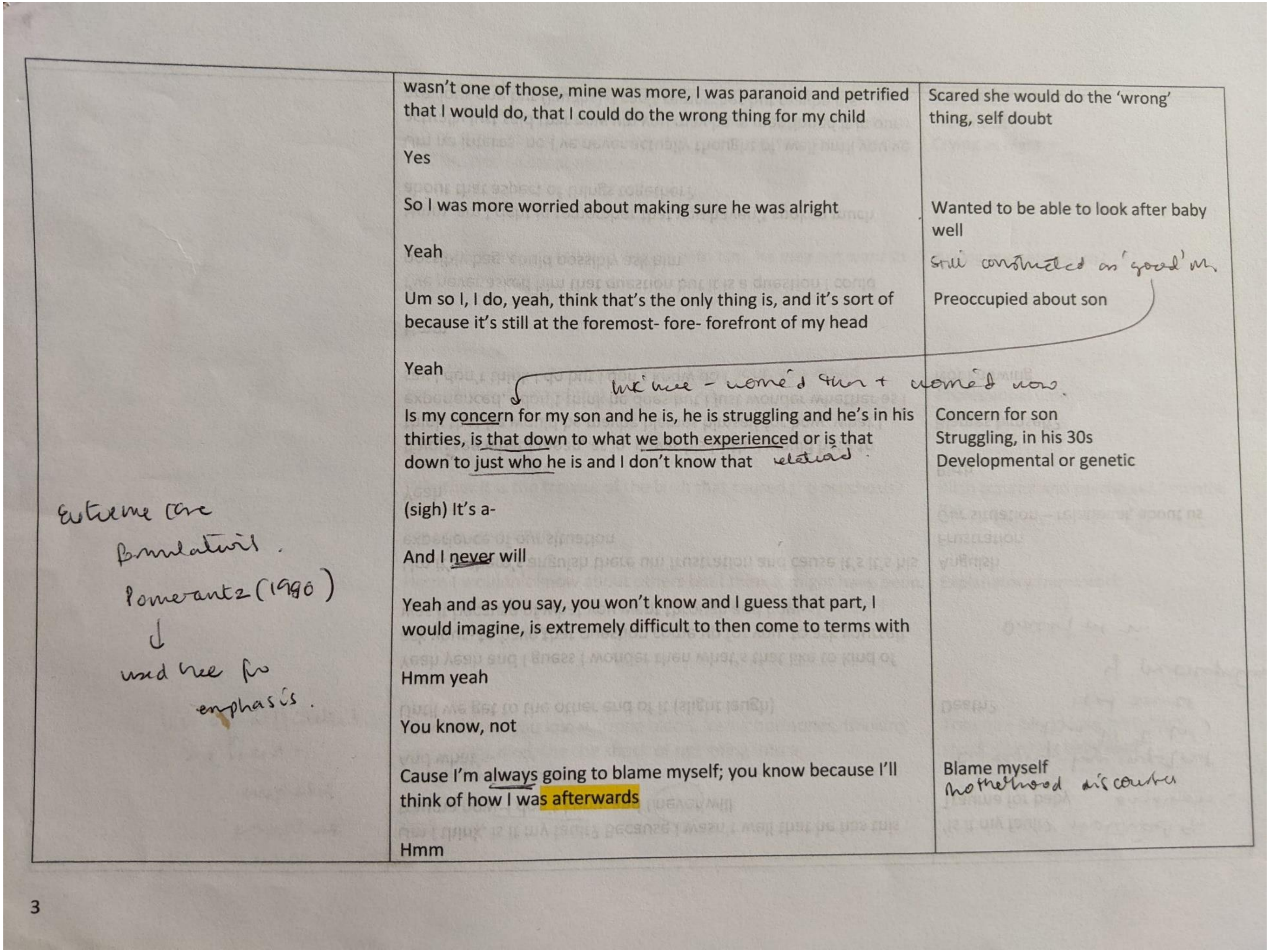


	A	B	C	D	E	F
1	**THEME & SUBTHEMES**	**DETAILS**	**PARTICIPANTS**	**NOTES**	**QUOTES**	**LINKS TO OTHER THEMES**
2						
3	**1. Explanatory frameworks**					
4	**Psychological**	Traumatic delivery	Emily	Emergency cesearean section, loss of control	But then it took a u-turn and I had to, so maybe yeah, maybe there is a point in that too as to why things impacted me more because I wasn't then in control of that (35)	
5			Rose	Birth trauma, brings biological and psychological explanations together, attachment history	'I don't know, you know, losing blood, losing hormones, thinking your child's died, the the shock of not going into a straightforward labour' (5, 2nd interview), 'Maybe it isn't, maybe it's the terrible delivery or was it a mixture of all of those things that put me vulnerable' (42) , 'I think it might have been the trauma of the birth that may have caused the psychosis' (5, 2nd interview)	Draws upon biological explanato to her explanation: 'cause nobod experienced anytihng like that fr interview)
6				Trauma as overwhelm	Too muchness 'Might have been too traumatic for my body, and my body was healing, obviously affected my brain'	
7			Catherine	Implied	I may not have experienced it again because i had a natural birth with her' (2nd baby)	
8			Gwyneth		And then from the traumatic birth, cause I think I was a 72 hour labour in the end I think that, that really traumatised me as well so I remember I was still um getting really anxious and worked up um after the birth because of wha I'd gone through'	
9			Sophie		I mean obviously there ... the traumatic birth' (43)	
10			Sophie	Transition back home	Um and the fact that I quit my job and moved back to the farm and made quite big life changing decisions' (43)	
11		Attachment wounds	Rose	Being let down by mum, realisation that mum didn't love her	That's I think what caused the psychosis because I was coming to terms with that and learning about that' (19)	Family relationships
12		Social isolation	Emily		'... then all of a sudden everyone around me goes to work'. '... so I think that probably impacted my mental health more... maybe that contributed a little bit'.	Transition to motherhood
13		Expectations of motherhood	Emily		... That could be an element of it too just keeping going' (12), breastfeeding difficulties: 'And I think I mentioned like breastfeedihg as well, I think that, I think that impacted me a little bit cause I was quite set on ' I'm gonna breastfeed' because you do get that pressure'... 'It did feel like a bit of a failure at the time' (35).	
14		Transition to motherhood ('redundant brain'	Emily		and then all of a sudden, your brain's not being used to that capacity', 'your brain might be a bit redundant' (26)	
15	**Biological**	Epidural	Catherine	Links hallucinations to epidural, contributed to 'stressful' labour	I can remember being wheeled into the, back to the ward and having hallucinations cause I'd had an epidural um and then um they, they stopped, you, they wore off and then I was immediately in the throes of labour and there was a period of time before they actually gave me the top u so that was a little bit stressful at the time'	
16		Hormones	Catherine	Doctor Dalton	... When I had my daughter, I did take progesterone cause she was saying it's like um a drug withdrawal having a baby and that was why I had such a severe, just like coming off a powerful drug' (p.21, 2).	
17					apparently it was something to do with um they reckon it because my progesterone was very high, my hormone levels were very high when pregnant'...'well it makes sense because when I had my daughter um well yes I had um progesterone injections' (6)	



	A	B	C	D	E	F	G	H
45								
46	**Medical authority / POWER**							
47	**Embodied knowledge vs authoritative knowledge**		Emily		I didn't feel quite right sort of mentally wise, I knew there was something not right, I don't, I couldn't quite at the time put my finger on what it was' (2), 'I just didn't feel right' (2), ', 'you're not really listening to me here, and I di know myself better than i tgibj anyone knows me' (14), 'I was quite self aware of things being wrong' (25, 2nd interview)	Link with self awareness in psychosis - 'cause I could appreciate how unwell I was, even when I was getting better, I knew i was feeling better' (19)		
48			Emily		it was difficult cause it's like the whole way through you know you don't know, you've got no comparison, it's all new and it's, you trust um doctors' (6), 'they didn't know what they were dealing with' (14, 2nd interview)			
49					the psychosis symptoms are rarer ... They're general aren't they, they don't know the specifics, they don't know what they're looking at' (12)	Link with what could have happened - 'it could have got a lot worse', 'but yeah if you hadn't felt like that and if you didn't have anyone at home then that's a worry' (15, 2nd interview)	Links this with luck - 'I was lucky that I was able to h	
50			Gwyneth		that's when I noticed that there was just something not quite right with me... If this was normal if this was part of what, what you'd feel like' (4), 'I knew in myself that I wasn't right' (14)			
51			Sophie	Medical incompetence	I mean none of the doctors, they all kept saying oh some of them said oh you got postpartum psychosis when you got depressed and some of them said oh you had, you got this the minute she was born (hmm) um no one could really pinpoint how, why and how' - 'I don't think they really want to either' (44)			
52	**Power relations**		Rose		Ive got some words for the story but not the picture of the book' (50)			
53			Gwyneth	Lack of transparency	the nurses has already probably picked up about psychosis but again, at this time, no one ever mentioned it to me' (11)			
54			Catherine	Thoughts dangerous	Because I thought, this is gonna be used against me' (14, 2)			
55								
56	**5. Help seeking**							
57	Being dismissed		Emily		... Just sort of said, oh it's probably your hormones fluctuating, normal kind of baby blues um and kind of sent me on my way' (2), 'the doctor just prescribed me some antibiotics... But I wasn't kind of told anything about that medication', 'I mean it was a bit rushed' (2)	Frustrating, no continuity of care	Links to wider poor care. Experience of childbirth for second baby (p.30)	
58					they sort of said the words baby blues and that's just normal but they need to be careful with that' (13)			
59	Deception		Rose		you're just here to monitor your sleep and then the next day they started plying me with the drugs' (26)		Poor care parallel in brother's dementia	
60	Missed diagnosis		Rose		'I'm so sorry that I missed it, she said' (31)			
61			Gwyneth		um one of the doctors did talk to me about baby blues but I didn't think it was that... I thought it was something more than that' (13)	What could have happened - 'I think we probably would have just gone home and then you, you know you wouldn't know what would happen' (27)		
62			Sophie		Obviously at other times, they didn't really have a clue what was happening in my head, they just viewed it as postnatal depression still' (25), 'Um but it was the fact that I had to go to hospital (hmm) to to get help' (26), 'And then they came and they wanted to discharge me' (5)	Unreliable care - 'And sometimes they wouldn't come because obviously they had, if they had like if they had an emergency ...' (26)	Contrasts with York Perinatal (29)	
63	**6. Relationships**							
64	Impact on loved ones		Emily	Impact on husband	'I think difficult for him' (4), 'particularly quite hard for him um just being on his own' (16), 'he's got to go home to an empty house, it must be, just a horrible thought really' (17)	Revisited in 2nd interview (4), advocating for more support for partners.	Link to masculinity -'he's pretty strong' (6) and discourse on relationship: 'made us stronger'	
65			Gwyneth	Impact on husband	it impacted my husband um quite significantly' (24), 'he's still not fully come to terms with it' (25)		Link to masculinity - 'I guess he probably needed to keep a strong front for me' (24)	
66			Emily	Impact on parents	and for my parents as well, coming to see me and then going home' (17)			
67			Catherine		so that was distressing for them' (11)			
				Conflict between husband and	parents' (5), 'they're saying well we shouldn't, you shouldn't be doing that' (8, 2nd			

Appendix 13: Initial reading of participant transcripts

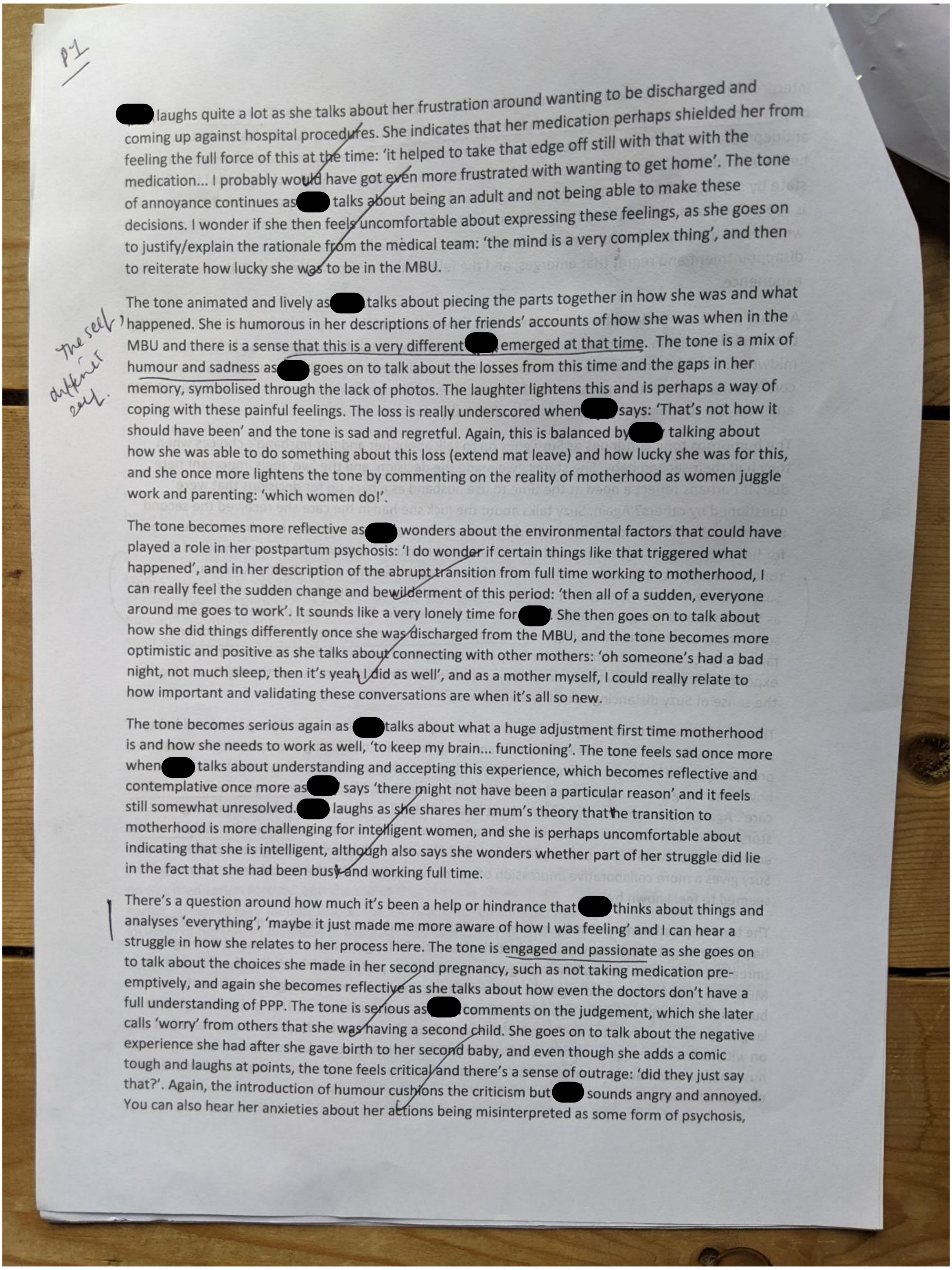


	wasn't one of those, mine was more, I was paranoid and petrified that I would do, that I could do the wrong thing for my child	Scared she would do the 'wrong' thing, self doubt
	Yes	
	So I was more worried about making sure he was alright	Wanted to be able to look after baby well
	Yeah	Still constructed as 'good' m.
	Um so I, I do, yeah, think that's the only thing is, and it's sort of because it's still at the foremost- fore- forefront of my head	Preoccupied about son
	Yeah we were - worried then + worried now.	
	Is my concern for my son and he is, he is struggling and he's in his thirties, is that down to what we both experienced or is that down to just who he is and I don't know that relational.	Concern for son Struggling, in his 30s Developmental or genetic
Extreme case formulation. Pomerantz (1980) ↓ used here for emphasis.	(sigh) It's a-	
	And I never will	
	Yeah and as you say, you won't know and I guess that part, I would imagine, is extremely difficult to then come to terms with	
	Hmm yeah	
	You know, not	
	Cause I'm always going to blame myself; you know because I'll think of how I was afterwards	Blame myself motherhood discourse
	Hmm	

3

	A wide audience like that before um	
	Yeah	
How I am as a person, how I have responded to the experience	But you know I yeah it's sort of I talk about it I'm open about it I'm honest about what happened and everything so	
	Hmm	
distancing from who she was during psychosis – able to talk & it as not going through it right now	I'm in a good place to talk about it but um I think speaking in front of people and that group size, I think that really affected me because I I've never done that before	
	Hmm	
new opportunities PTG brave inspiring	And I don't think I would have done it before either (laughs) so I think that, it made, it made me a bit sort of nervous at the beginning of everything but I was fine and people were coming up to me and were really positive and said that you know I was really brave and sort of, sort of inspiring them	
story & self.	Hmm	
offering hope to others.	That you know I could really talk about it and that I'm doing okay and everything so	
	Hmm hmm	
	So yeah like this last month it's been sort of non-stop talking about it (laughs) which is fine um	

Appendix 14: Example initial analysis of tone



P1

[redacted] laughs quite a lot as she talks about her frustration around wanting to be discharged and coming up against hospital procedures. She indicates that her medication perhaps shielded her from feeling the full force of this at the time: 'it helped to take that edge off still with that with the medication... I probably would have got even more frustrated with wanting to get home'. The tone of annoyance continues as [redacted] talks about being an adult and not being able to make these decisions. I wonder if she then feels uncomfortable about expressing these feelings, as she goes on to justify/explain the rationale from the medical team: 'the mind is a very complex thing', and then to reiterate how lucky she was to be in the MBU.

The self, different self.

The tone animated and lively as [redacted] talks about piecing the parts together in how she was and what happened. She is humorous in her descriptions of her friends' accounts of how she was when in the MBU and there is a sense that this is a very different [redacted] emerged at that time. The tone is a mix of humour and sadness as [redacted] goes on to talk about the losses from this time and the gaps in her memory, symbolised through the lack of photos. The laughter lightens this and is perhaps a way of coping with these painful feelings. The loss is really underscored when [redacted] says: 'That's not how it should have been' and the tone is sad and regretful. Again, this is balanced by [redacted] talking about how she was able to do something about this loss (extend mat leave) and how lucky she was for this, and she once more lightens the tone by commenting on the reality of motherhood as women juggle work and parenting: 'which women do!'.

The tone becomes more reflective as [redacted] wonders about the environmental factors that could have played a role in her postpartum psychosis: 'I do wonder if certain things like that triggered what happened', and in her description of the abrupt transition from full time working to motherhood, I can really feel the sudden change and bewilderment of this period: 'then all of a sudden, everyone around me goes to work'. It sounds like a very lonely time for [redacted]. She then goes on to talk about how she did things differently once she was discharged from the MBU, and the tone becomes more optimistic and positive as she talks about connecting with other mothers: 'oh someone's had a bad night, not much sleep, then it's yeah I did as well', and as a mother myself, I could really relate to how important and validating these conversations are when it's all so new.

The tone becomes serious again as [redacted] talks about what a huge adjustment first time motherhood is and how she needs to work as well, 'to keep my brain... functioning'. The tone feels sad once more when [redacted] talks about understanding and accepting this experience, which becomes reflective and contemplative once more as [redacted] says 'there might not have been a particular reason' and it feels still somewhat unresolved. [redacted] laughs as she shares her mum's theory that the transition to motherhood is more challenging for intelligent women, and she is perhaps uncomfortable about indicating that she is intelligent, although also says she wonders whether part of her struggle did lie in the fact that she had been busy and working full time.

There's a question around how much it's been a help or hindrance that [redacted] thinks about things and analyses 'everything', 'maybe it just made me more aware of how I was feeling' and I can hear a struggle in how she relates to her process here. The tone is engaged and passionate as she goes on to talk about the choices she made in her second pregnancy, such as not taking medication pre-emptively, and again she becomes reflective as she talks about how even the doctors don't have a full understanding of PPP. The tone is serious as [redacted] comments on the judgement, which she later calls 'worry' from others that she was having a second child. She goes on to talk about the negative experience she had after she gave birth to her second baby, and even though she adds a comic tough and laughs at points, the tone feels critical and there's a sense of outrage: 'did they just say that?'. Again, the introduction of humour cushions the criticism but [redacted] sounds angry and annoyed. You can also hear her anxieties about her actions being misinterpreted as some form of psychosis,