A Meta-Synthesis Exploring the Experience of Postpartum Psychosis

Sophie Wicks, Anna Tickle, and Vanessa Dale-Hewitt

Abstract: Not as much research exists regarding postpartum psychosis as compared to other perinatal mental health disorders, such as postpartum depression. In this meta-ethnography, twelve qualitative studies were examined. Four themes were developed: support needs and preferences; the terrifying and surreal world of postpartum psychosis; stigma and dismissal; and process of recovery. Alongside the four themes identified, consideration of personal appraisals and regaining personal identity may assist with recovery. Women and their families should be part of decision-making and provided with appropriate information throughout treatment. Discourses surrounding postpartum psychosis require particular consideration to avoid stigma and promote early help-seeking.

Keywords: postpartum psychosis, qualitative research, pre and perinatal psychology

Postpartum psychosis is considered by health professionals as "the most serious perinatal mental disorder" and a debilitating medical emergency requiring urgent admission (Heron et al., 2012). It most commonly develops within 48 hours to two weeks following childbirth (Doucet, Letourneau, & Blackmore, 2012) and is experienced by approximately one

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in every 1000 women in the United Kingdom (Monzon, di Scalea, & Pearlstein, 2014). Postpartum psychosis shares symptoms with psychotic disorders, defined by the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as, "abnormalities in one or more of five domains: delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms" (American Psychiatric Association, 2013). However, with swift, efficient treatment, the prognosis for most women is encouraging, with recovery often occurring within a few weeks (Jones & Smith, 2009) although many women report that it may take at least one year to feel "fully recovered," often longer (Sit, Rothschild, & Wisner, 2006).

Postpartum psychosis is not currently a diagnostic category in the DSM-V (APA, 2013) or the International Classification of Diseases (World Health Organization, 1992), but the term remains prevalent in public and professional domains (Jones & Cantwell, 2010). A continuum model of psychosis has been proposed, suggesting that symptomology is also prevalent to varying degrees amongst non-clinical populations (Mannion & Slade, 2014). This suggests that many individuals experience symptoms but are considered sub-clinical due to lack of resulting distress (Bentall, 2003). Additionally, anxiety often increases throughout pregnancy (Newham & Martin, 2013), which may support a stress-vulnerability model (Zubin & Spring, 1977) for postpartum psychosis. Combined with the woman's environment and emotional experiences (Hooley, 2007), this may provide further understanding as to the development of postpartum psychosis.

Psychotic experiences often reflect personal and social context, for example, with relation to personal goals, stress-inducing events, wider societal pressures or events, unmet expectations of motherhood, or a perceived lack of control (Rhodes & Jakes, 2000). Within postpartum psychosis, the content of psychotic experiences often concerns the infant—for instance, beliefs that the infant is not theirs or is inhuman (Stein, 1998). Such beliefs may attract significant stigma and/or shame, given societal discourses regarding maternal instincts and the celebration of birth. It is therefore important for clinicians, women experiencing postpartum psychosis, and families, to have knowledge and understanding of the content of beliefs within postpartum psychosis to inform its management and treatment.

There has been more limited research of postpartum psychosis compared to the literature surrounding other perinatal mood disorders, such as postpartum depression (Cox, Murray, & Chapman, 1993). To date, research has largely focused on biomedical aspects, emphasizing clinical symptoms, diagnosis, and generating quantitative comparisons with non-perinatal psychosis (Robertson & Lyons, 2003). Less focus has been placed on the women's accounts of the experience, despite "first-person accounts" being valued within broader psychosis research due to their potential to

increase empathy and compassion, reduce stigma, and generate hope (Mowbray, Moxley, & Collins, 1998).

Effective treatment is essential in supporting recovery, yet the relative scarcity of literature highlights the need for deeper exploration of the experience of postpartum psychosis to influence and specify psychological recommendations, as per other postpartum disorders such as postpartum anxiety and postpartum depression. Whilst medicinal and other medical interventions are pivotal, without adequate psychological and practical support, there are likely negative repercussions for the mother-infant relationship (Bågedahl-Strindlund & Ruppert, 1998), mother-partner relationship (Engqvist & Nilsson, 2011), and ability to care for other children (Bågedahl-Strindlund, 1987). In some instances, inefficient care may result in suicide, accidental harm to the child, and in some rare, tragic cases, infanticide (Spinelli, 2004). Additionally, more specificity regarding psychological intervention may decrease use of anti-psychotic medication, where appropriate, as side effects can be harmful, particularly when the mother is breastfeeding and the infant may also be affected (Klinger, Stahl, Fusar-Poli, & Merlob, 2013).

Researchers recognize the necessity of furthering the understanding of women's experiences of postpartum psychosis (Doucet et al., 2012; Engqvist, 2011). Synthesizing the qualitative research regarding the experiences of the women themselves is one way in which the understanding of this phenomena can be developed. A more comprehensive understanding is likely to benefit women and their support networks, including health professionals, family members, and partners. Few qualitative papers have explored women's experiences of postpartum psychosis but those that have cover a range of related issues, including key aspects of the recovery process (McGrath, Peters, Wieck, & Wittkowski, 2013), perceived cause (Robertson & Lyons, 2003), support needs (Doucet et al., 2012), and the experience more broadly (Engqvist & Nilsson, 2011). A synthesis of qualitative studies can go beyond the findings of an individual qualitative study (Campbell et al., 2003) to develop knowledge about a phenomenon.

Meta-ethnography (Noblit & Hare, 1988) is an interpretative method which synthesizes findings across qualitative research papers to provide advanced analysis, understanding, and scope for future research questions (Finfgeld, 2003). This involves researching existing papers and synthesizing (combing and interpreting) their results to produce overarching findings (Atkins et al., 2008). Although meta-synthesis has attracted criticism for synthesizing tentative papers of differing qualities, it offers opportunity for new insights and approaches to emerge.

The first aim of this article was to systematically locate and critically appraise relevant qualitative research regarding the experience of postpartum psychosis. The second aim was to use a meta-ethnographic approach to synthesize the findings of identified papers and answer the

research question, "What is the experience of having postpartum psychosis?" The question was purposefully broad, as initial searches identified relatively few studies in the field with varied foci.

Method

The review involved three stages: a systematic search of available literature; critical appraisal of relevant studies; and a meta-ethnographic synthesis using the process described by Noblit and Hare (1988). A critical realist perspective was adopted throughout this paper. This approach acknowledges that individuals make sense of their experience and "reality" in different ways (Bhaskar, 1989). Additionally, socio-cultural experiences mediate access to this reality and allow transparency of the researcher(s)' and participants' interpretative resources (Smith, 2015).

Searching

Initial searches highlighted limitations in obtaining research focusing on specific elements of postpartum psychosis. The research question was subsequently reviewed and specified with use of an adapted "population-intervention-comparison-outcome" (PICO) table and research protocol (Boland, Cherry, & Dickson, 2013). The PICO table is a tool used to assist the author in defining the clinical question that forms the basis of the literature search.

A systematic search was undertaken on March 18, 2019. Four electronic databases were searched due to providing comprehensive coverage of relevant research across peer-reviewed journals, and proven efficiency in previous systematic literature reviews (Wright, Golder, & Lewis-Light, 2015): Medline (1946-present), PsycINFO (1806-present), Scopus (1960-present), and Cumulative Index to Nursing and Allied Health Sciences (CINAHL; 1981-present). Ethos and OpenGrey were searched to limit the risk of excluding potentially relevant, rich unpublished data (Evans, 2002), and the British Psychological Society (BPS) database was searched as a specialist psychology database. A hand search was also implemented, which included "back searching" (utilizing references of relevant papers) and "forward searching" (using Google Scholar to identify papers that cited relevant articles). Lastly, a specialist psychologist in the field of perinatal mental health was consulted to ascertain if any known papers had been missed.

Search Terms

Search terms were developed from examining similar literature reviews and Cochrane reviews, consultation with the subject librarian, and via databases thesauruses/Medical Subject Headings (MeSH) and

suggested search terms. Truncation tools and Boolean searches were also implemented where possible to maximize searches. Search terms were adapted according to result adequacy and appropriateness. The following search terms were employed: Postnatal Psychos?s, Postpartum Psychos?s, Puerperal Psychos?s, experience?, Birth N5 Psychos?s, Perception?, View?, Attitude?

Selection

Papers were included if they:

1. Were original research into the first-person perspective of having postpartum psychosis.
2. Used recognized qualitative methodology, including participant quotations.
3. Included participants aged 18 years or older.
4. Were published in English.

Papers were excluded if they:

1. Were mixed methods papers where qualitative components could not be independently extracted.
2. Contained mixed person accounts where first-person accounts could not be independently extracted.
3. Described multiple perinatal disorders, yet findings with regards to postpartum psychosis could not be independently extracted.

One paper was inaccessible after request through the database, university, inter-library loan, and contacting the author.

Analysis

Data Abstraction & Synthesis of Findings

Papers were read and re-read, and relevant data was identified using a data extraction tool, which informed quality appraisal of papers, and synthesizing findings.

This interpretive method of synthetization proposes a deeper level of understanding, as opposed to other reviews, which merely provide a "basic comparability between phenomena" (Noblit & Hare, 1988, p. 15). Noblit and Hare (1988) describe three methods of synthesis that were employed within this review: reciprocal translations of themes from one study to another (what themes do the papers have in common?); refutational synthesis (what differences in findings between studies exist?); and the line-of-argument synthesis, through which the synthesis is described and new understandings are offered.

Within metasynthesis, it has become common to think about the distinction between first, second, and third order constructs. "First-order

constructs" refers to direct participant quotes within included studies. "Second-order constructs" are the interpretations of the authors of included studies (i.e. usually found in the "results" section of papers). "Third-order constructs" are the synthesist's interpretations of both first- and second-order constructs (i.e. the themes constructed through the process of the synthesis).

Quality Appraisal

Debate exists surrounding use of critical appraisal within meta-synthesis. Some professionals describe critical appraisal as a useful tool for determining inclusion/exclusion of studies, whereas others view it as an interpretative tool for developing exploration and insight (Spencer, Ritchie, Lewis, & Dillon, 2003). There is a lack of consensus on preferred, "gold standard" criteria for critically appraising qualitative research (Walsh & Downe, 2005). Subsequently, an adapted Critical Appraisal Skills Programme (CASP; Public Health Resource Unit, 2010) tool was used in this paper to determine quality of research papers included. The CASP tool provided prompts for consideration across each broad domain of research (e.g., method used, how findings represented), to assess the "quality" of each research paper.

Criteria were added regarding epistemological position (the way the author views the pursuit of knowledge), consideration of diagnosis of postpartum psychosis, and length of time between the episode of psychosis and recall of it by the participant in the research. Criteria regarding diagnosis and length of recall were deemed important after speaking to a specialist perinatal clinical psychologist and researching these aspects further, due to an increase in reliability and validity of the research if adequately considered and standardized.

Scores of zero, one, and two were given to indicate whether criteria were unmet, partially met, or fully met. This provided a clear total score for each paper. The stance taken was acknowledging importance of ascertaining quality and "weighting" of studies within the review, yet recognizing all research provides important findings in this field (Sandelowski, Doherty, & Emden, 1997). No papers were excluded on the basis of the quality appraisal.

Reflexivity

The process of meta-synthesis is subjective and shaped by the researchers' own experiences, position, and perspective (Noblit & Hare, 1988). As this cannot be completely eradicated, transparency is crucial in ensuring quality of the synthesis (Finlay, 2006). This "transparency" may include aspects such as the age of the researcher and their personal experiences, which will likely impact the way they interpret the research

papers. The researchers strongly believe that the public and other professionals should be more aware of the experience of postpartum psychosis, including treatment and recovery. They believe it is important to aid women to have their voices heard, while diminishing stigma and misconceptions associated with postpartum psychosis. Consideration was given to the urge to align with the mothers' views over alternative views, for example those that might give primacy to the child, family members, or issues of risk. The first author became aware of a negative bias towards papers which were perceived to be stigmatizing women.

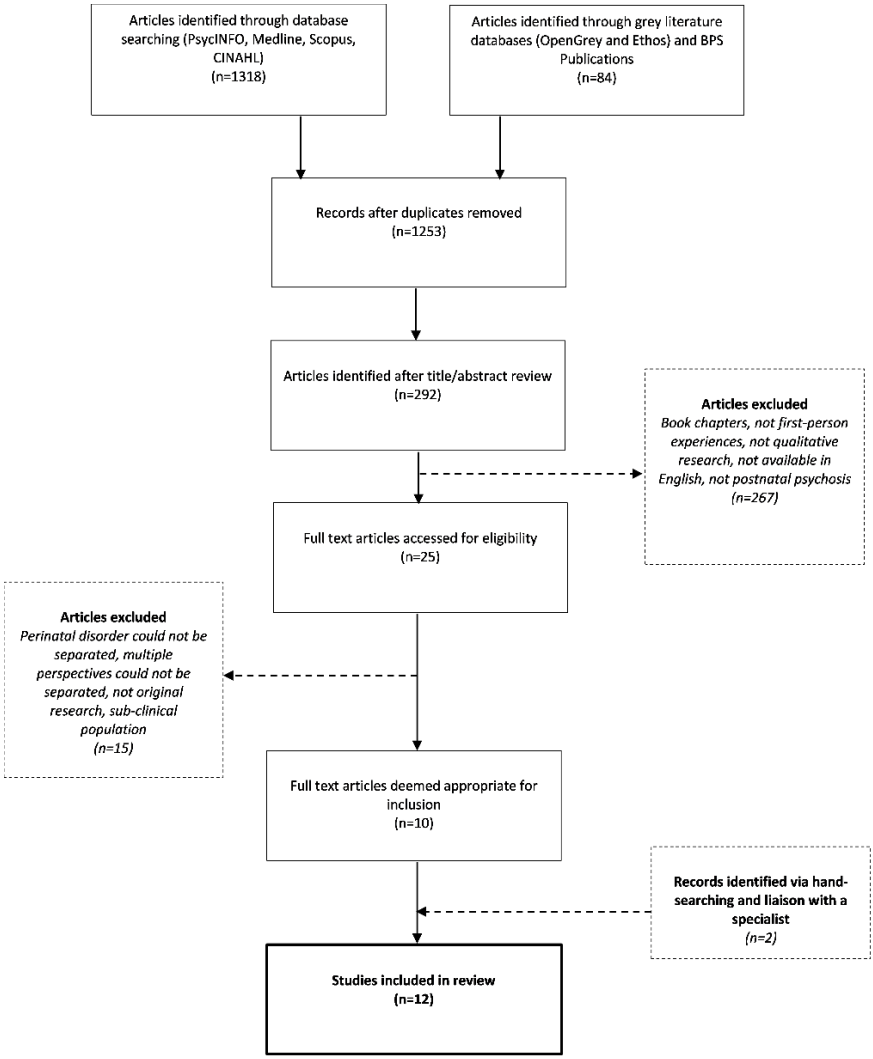
To minimize bias and expectations, it was important to remain open-minded and include papers which discussed potentially "unusual" or unexpected aspects of the experience. During synthesis, conflicting accounts were purposely given careful consideration, and potential third order constructs were discussed within supervision (Toye et al., 2013). Papers were also discussed in a workshop for peers interested in meta-synthesis, which allowed consideration of others' interpretations of the data. It was also critical to ensure proposed themes were supported by first order constructs (original data) and overall data (Toye et al., 2013).

Results

Study Selection

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher, Liberati, Tetzlaff, & Altman, 2009) was implemented as a framework for paper selection. This process is described in Figure 1.

Figure 1



The 12 included studies were conducted between 2002 and 2016, with nine studies occurring in the United Kingdom, one in Sweden, one within the United States of America and Canada, and one study was unclear on location (3). Please see Table 1 for further information regarding paper characteristics.

Table 1. *Paper characteristics*

Study	Author, year, location	Research title	Qualitative methodology utilized	Number of participants and recruitment strategy	Data analysis method
1	Engqvist & Nilsson. 2013. Sweden.	Experiences of the first days of postpartum psychosis: An interview study with women and next of kin in Sweden.	Face-to-face interviews.	Advertised by author on a radio station. Utilized network 'Swedish Patients Association.' Snowball sampling via participants contacting other women they met with postnatal psychosis. Advertised via article in a mental health journal. 13 participants.	Content analysis.
2	Heron et al. 2012. UK.	Information and support needs during recovery from postpartum psychosis.	Face-to-face interviews.	Via network 'Action on Postpartum Psychosis' (APP). 5 participants.	Grounded analytic induction.

3	Robertson & Lyons. 2003. Unclear location.	Living with puerperal psychosis: A qualitative analysis.	Face-to-face interviews.	All participants had previously taken part in related research and agreed to be contacted in event of further research. An advertisement in a mental health newsletter was also utilized. 10 participants.	Grounded theory.
4	Chotai. 2016. UK.	Postpartum psychosis and beyond: Exploring mothers' experiences of postpartum psychosis and recovery.	Face-to-face interviews.	Advertising via online forums and social networking sites linked with charities that support women with postnatal psychosis. 8 participants.	Interpretative phenomenological analysis.
5	Glover, Jomeen, Urquhart, & Martin. 2014. UK (North England).	Puerperal psychosis - a qualitative study of women's experiences.	Face-to-face interviews.	Recruited via a local specialist psychiatry service for mothers and babies in North England. 7 participants.	Thematic analysis.

6	Hunter. 2013. UK.	Postpartum psychosis: A Foucaldian analysis of women's experiences living with this diagnosis.	Interviews (unspecified whether face-to-face)	Advertisement posted by an online Postpartum Psychosis Charity Network. Some participants recruited through making contact with key researcher in area of qualitative research in postnatal psychosis. 10 participants.	Foucauldian discourse analysis.
7	Day. 2002. UK (London).	A qualitative analysis of women's accounts of puerperal psychosis and postnatal depression: the search for similarity, difference and understanding .	Face-to-face interviews.	Mother and baby unit in London. 3 participants.[1]	Interpretive phenomenological analysis.

[1] This study recruited six participants in total, but three had postnatal psychosis.

8	Doucet, Letourneau & Blackmore. 2012. USA and Canada.	Support needs of mothers who experience postpartum psychosis and their partners	Face-to-face and telephone interviews.	Variety of community and hospital agencies that provide services for mothers in postpartum period. 9 participants.	Thematic analysis.
9	McGrath, Peters, Wieck & Wittkowski. 2013. UK.	The process of recovery in women who experienced psychosis following childbirth.	Face-to-face and (one) telephone interview.	Recruited via a mother and baby unit in North-West England. Advertisements placed on website forums and newsletters for women with experience of postnatal psychosis. 12 participants.	Grounded theory.
10	Plunkett, Peter, Wieck & Wittkowski. 2016. UK (England).	A qualitative investigation in the role of the baby in recovery from postpartum psychosis.	Face-to-face and telephone interviews.	A mother and baby unit in England. Advertisement on website forums for mothers who have experienced postpartum psychosis. 12 participants.	Thematic analysis.

11	Wyatt, Murray, Davies & Jomeen. 2015. UK (England)	Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others.	Face-to-face interviews.	NHS perinatal mental health services and online via social media and Action on Postpartum Psychosis website. 7 dyads, 14 participants.	Interpretive phenomenological analysis.
12	Stockley. 2018. UK (England and Wales)	Women's experiences of postpartum psychosis during the onset and early days.	Face-to-face interviews.	Action on Postpartum Psychosis Facebook page. 7 participants.	Interpretive phenomenological analysis.

The quality of papers was variable, ranging from a total score of 11-21, and explicit points for consideration published by CASP qualitative research criteria were used to assign points. Papers were appraised by two authors in an effort to increase reliability of scoring. It should be noted that unpublished theses are not constrained by editor preferences and strict word counts, which may account for higher quality scores as they are able to include more detail. Please see Table 2 for a summary of findings.

Table 2.

CASP Criteria	1	2	3	4	5	6	7	8	9	10	11	12
Clear statement of aims?	2	2	2	2	2	2	2	2	2	2	2	2
Qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2	2	2	2
Research design appropriate to aims?	1	1	1	1	1	2	1	1	1	1	2	1
Recruitment strategy appropriate to aims?	1	1	2	2	1	2	1	2	2	2	1	2
Data collected in a way that addressed the research issue?	1	1	2	2	2	2	2	1	2	1	1	1
Relationship between researcher and participants adequately considered?	0	0	1	1	0	2	2	0	2	1	1	2
Ethical issues taken into consideration?	1	1	1	1	1	2	0	1	1	1	1	2
Data analysis sufficiently rigorous?	1	1	1	2	1	2	2	1	2	1	2	1

Clear statement of findings?	2	1	1	2	2	2	1	1	2	2	2	2	1					
Epistemological position stated?	0	0	0	2	0	2	2	0	2	0	0	0	1					
Diagnosis checked and critiqued?	0	1	1	1	2	1	2	1	2	1	2	2	1					
Length of time between episode and recall adequate and critiqued?	1	1	1	0	1	0	2	1	1	1	1	1	1					
Total score	*12*	*12*	*15*	*19*	*15*	*21*	*19*	*13*	*21*	*16*	*15*	*17*						

Critical appraisal of studies included in review

It was not presence of bias, but rather transparency regarding potential bias by researchers, which was appraised, and therefore explicit consideration of the impact of the researcher on the study, participants, and analysis, was imperative (Jootun, McGhee, & Marland, 2009).

However, only three studies fully met criteria regarding researcher bias or consideration of reflexivity (6, 9, 12), while another five studies partially met this criteria through brief reference (3, 4, 7, 10, 11). Five papers (4, 6, 7, 9, 12) stated their epistemological position.

Overall strengths within research papers included appropriate use of methodology (semi-structured interviews), clearly stated research aims, clear rationale for research design (except 6), data provided to support second-order constructs (suggested by original authors), and clear third-order constructs.

Overall weaknesses across papers included: not justifying choice of research design which led to eleven studies only partially meeting this criteria (except 6); lack of data regarding participant demographics (exceptions 4, 6, 7, 9, 11); inadequate consideration of ethical issues (except 6, 12); variable time elapsed since episode (except 7); adequate discussion of the evidence both for and against the researcher's arguments and discussion of credibility of findings (except 1, 4, 5, 6, 9, 10, 11); little exploration of contradictory findings and researcher bias (exceptions 2, 3, 7, 8, 12); and lacking rigorousness of diagnosis (exceptions 5, 7, 9). Time elapsed since episode collectively ranged from 1-32 years. Memory is variable over this period of time and may become distorted and therefore unrepresentative (Collins, Gathercole, Conway, & Morris, 1995). Conversely, one paper (1) suggested that due to the intensity of this life-changing experience, women are likely to recall details accurately. However, this may be questionable given the perceptual difficulties that are inherent for individuals experiencing psychosis. Study (7) provided findings in multiple complex tables, and headings did not consistently match table descriptions, which impaired understanding. One study (5) presented second order constructs that at times appeared to have more overlap than distinction, with subthemes that did not clearly connect to overarching themes. This led to aspects of their second-order themes being synthesized under third-order constructs with which there was a more obvious connection. One paper (11) had much overlap between themes and three themes were not distinctly different from each other. Another study (7) listed multiple causes concerning the over-arching theme of "explanations for distress," yet did not differentiate between causes of distress and causes of postpartum psychosis. The assumption that these causes are correlated and comparable is inconsistent with current research (Bentall, 2003).

Six studies justified the recruitment strategy and considered limitations, including potential bias (3, 4, 6, 8, 9, 10). Two studies (2, 7) recruited from one service but did not justify or critique this. Three studies (1, 11, 12) did not adequately justify or critique their recruitment strategy, and one study (5) did not explain why seven individuals were excluded from participating. Few papers critiqued the role of "gatekeepers" (professionals who had the power to suggest or deny potential participants

from taking part either directly or due to the level to which they promoted the research study) during the recruitment strategy, or other potential biases resulting from the recruitment strategy (e.g., only recruiting from one service).

Synthesis

Themes across papers were not in direct opposition but offered a range of explanations. Table 3 summarizes third-order construct themes and subthemes resulting from the synthesis. Overarching themes were: the terrifying and surreal world of postpartum psychosis; stigma and dismissal; support needs and preferences; and process of recovery. These are described below, alongside supporting evidence from first-order data and second-order constructs.

Table 3.
Cross comparison of third order constructs

Third order *themes* and subthemes	1	2	3	4	5	6	7	8	9	10	11	12
The terrifying and surreal world of postpartum psychosis	*	*	*	*	*	*	*	*	*	*		*
Suicidal and infanticidal ideation	*			*								
Distress	*	*	*	*	*		*	*	*	*		*
Unmet expectations	*	*	*	*		*	*	*				
Stigma and dismissal	*	*	*	*	*	*	*	*	*	*		*
Support needs and preferences	*	*	*	*	*	*	*	*	*	*	*	
Postpartum psychosis seen as different from other mental illnesses	*	*	*		*							
Contact with professionals	*	*	*	*	*	*	*	*	*	*		
Contact with non-professionals	*	*	*	*	*		*	*	*	*	*	
Importance of information		*	*							*		
Process of recovery	*	*	*	*		*		*	*	*	*	
The role of the infant	*								*	*		
Regaining and developing personal identity	*	*	*	*		*		*			*	

Note: * indicates which papers contributed to each theme and subtheme.

The terrifying and surreal world of postpartum psychosis. All but one paper (11) described participants' experiences as terrifying and

distressing. A combination of confusion, fear, psychotic symptoms, and overwhelming emotions existed.

Suicidal and infanticidal ideation. Two papers (1, 4) referenced women discussing suicidal and infanticidal ideation during their experience. However, reasons for this differed between participants. One woman described contemplating "altruistic suicide."

> "[…] my own voice […] it was commanding myself to do things and if I didn't do these things then it would mean I was selfish and it would cause harm to others. So if I didn't kill myself […] then my family would die." (Chotai, 2016, p. 66)

Conversely, others stated they wished to die for relief from the hopeless darkness. Some stated that family members, but not the infant, were a protective factor. One woman described not wanting to die but feeling unable to continue living due to this new life she was experiencing:

> "[…] I knew it was not the person I really am. It just felt it was too bad. I missed the person I am and the person I recognised as me." (Engqvist & Nilsson, 2013, p. 87)

Similarly, reasons for infanticidal ideation differed between participants. For some, this thought was intrusive and attributed to the psychosis, for others the infant was strongly aversive and caused resentment. A third motivation for contemplating infanticide was to save the infant:

> "[…] it was a bad world. It was not a good place to be. I wanted to protect my children from this. Then I thought, 'Well, I'll kill them.'" (Engqvist & Nilsson, 2013, p. 86)

For some women, these intrusive thoughts were unacceptable and intolerable, which made disclosure difficult:

> "[…] I certainly wouldn't tell anyone those thoughts unless they had been through it. It's inconceivable really to think about harming your own child." (Hunter, 2013, p. 55)

Some women were unwilling to speak about the nature of these thoughts, even many years post-episode.

Distress. The experience of postpartum psychosis led to an array of distressing emotions and cognitions, particularly surrounding guilt, shame, fear, and desolation. All but one paper (6) referenced the distress associated with the experience of postpartum psychosis. Guilt appeared to

relate to the inability to care for the baby, reliance on loved ones, and 'missing out':

> "[…] all these feelings of guilt because you missed out." (Heron et al., 2012, p. 157)

Many women described fear during this period, accompanied by powerful cognitions:

> "[…] I had a fear of everything, I was scared that I was going to die and nothing was normal and I feared everything." (Chotai, 2016, p. 66)

In addition, one paper (12) highlighted the prevalence of worry about caring for the baby, which was sometimes the start of a psychotic belief or delusion:

> "[…] That was the point when I had started to say something bad is happening or happened, or, erm, I think I have done something to my baby… I was like, I get it now. I have basically done something to Baby, she's died, so I have killed her." (Wyatt, Murray, Davies, & Jomeen, 2015, p. 153)

There was a strong emotional reaction to postpartum psychosis, and women experienced a sense of powerlessness, despair, and confusion. These emotions were accompanied by cognitions regarding feeling like a "freak," attempting to make sense of what was happening to them, comparing themselves to their previous self and others, and thoughts of intentional harm. The emotional responses to infanticidal ideation differed according to intent and appraisal, with guilt and shame being responses to contemplation and planning, versus anxiety and despair in response to intrusive thoughts.

Unmet expectations. Multiple women felt frustrated about the mismatch between their own and others' expectations and the reality of motherhood. Seven of the studies (1, 2, 3, 4, 6, 7, 8) described participants feeling motherhood was not as expected, particularly when previously excited about the prospect:

> "[…] It's such a shock and at the time that you were expecting to be such a wonderful time." (Heron et al., 2012, p. 157)

Some women felt pressured and invalidated by societal and familial expectations. One study (6) explored this from a social constructivist perspective, considering the phrases used by the individual which suggested her experience of motherhood was "wrong." This was

particularly evident when different generations' discourses surrounding motherhood did not "allow" for mental illness:

> "[…] Pull yourself together don't you think I wasn't depressed but in 1960 we didn't allow for that. If I heard that once, I heard it a hundred times." (Glover, Jomeen, Urquhart, & Martin, 2014, p. 261)

The experience of postpartum psychosis led to women not meeting perceived societal and individual pressures and expectations of motherhood, which led to distress when these were not met due to the experience of postpartum psychosis.

Stigma and dismissal. While navigating through the complexities of postpartum psychosis, many women described experiencing or fearing negative judgments from others. All but one paper (11) described experiences of stigma or dismissal, although some did not explicitly state whether these were actual or perceived by the women. However, this review acknowledges the differences between these two experiences, while validating that both perceived and actual stigma is likely to result in distress. There was an assumption among participants that people would react negatively to women with postpartum psychosis, due to media portrayals and stereotypes:

> "[…] Everybody's worse nightmare in the world if they're very honest with you […] to be locked in an asylum or mental hospital because of the way it's portrayed on telly and the white coats and padded cells and stuff." (McGrath et al., 2013, p. 5)

Conversely, some women reported that they were able to successfully hide their mental health difficulties and appear healthy and well. This was reportedly a deliberate effort in order to avoid raising suspicion for fear of negative consequences or judgment:

> "[…] I looked the picture of health. You would not have thought I was ill. You'd go, she looks immaculate…I used to put makeup on as like my mask. I used to make myself immaculate." (Stockley, 2018, p. 155)

The reaction from friends and partners seemed to dramatically affect the trajectory of recovery. The avoidance of discussion perpetuated stigmatizing experiences and was isolating when support was vital:

> "[…] It was just something that was…um…avoided, yeah. They wouldn't ask me how I was. It's like the whole stigma of mental illness mustn't be talked about." (McGrath et al., 2013, p. 6).

Feeling dismissed and invalidated was particularly difficult when it had taken courage to disclose these experiences. Some women also felt dismissed by loved ones during a time they needed support most:

> "[…] You've only had a baby, what's wrong with you, why you acting like this?" (Glover et al., 2014, p. 261)

However, some reported feeling well-supported and understood by loved ones:

> "[…] the support of my family helped more than anything." (Heron et al., 2012, p. 161)

Many participants reported positive, integral contact with professionals who enabled a non-judgmental space to make sense of their experiences:

> "[…] Talking to the psychiatrist, cos you can tell her anything, no matter what you tell her she doesn't criticize you […] just being able to talk about how you're feeling." (Day, 2002, p. 49)

Some participants also described the importance of empathy and support, both within services and following discharge, as crucial for those experiencing postpartum psychosis.

Support needs and preferences. Considering the tremendous impact of postpartum psychosis, and the role of other people's reactions, many participants were keen to voice needs and preferences for support that could aid recovery. All papers contained accounts regarding this, which largely stemmed from both positive and negative experiences with professionals, services, and loved ones.

Postpartum psychosis seen as different from other mental illnesses. Four studies (1, 2, 3, 5) described participants' strong desire for postpartum psychosis to be seen as separate from other mental illnesses. This appeared to manifest from two perspectives: postpartum psychosis requiring specialized treatment and support, and a desire for this disorder to be seen as separate from other mental illnesses. The latter perspective was not an explicit first-order construct but inferred from language used:

> "[…] Puerperal psychosis only happens when you give birth and is different from other psychosis. It's still seen by others as though you've been mad." (Glover et al., 2014, p. 263)

Some participants framed this view in terms of the requirement for specialist help, rather than stigma towards other illnesses:

> "[…] You're classed as a mental patient, rather than someone with an illness following childbirth. I think there's a difference you need specialist help." (Robertson & Lyons, 2003, p. 419)

It was clear that participants felt strongly about the need for specialized, experienced staff treating them in a specialist unit.

Contact with professionals. One paper (2) referred to experiences of medical support while the remaining studies referenced support needs largely focused on interactions and perceived attitudes from staff. Some participants spoke of negative experiences with an emphasis on lack of control or awareness of treatment decisions or justification:

> "[…] I was saying 'no, no, no, no, no, no!' […] They wanted to give me an injection, I don't know what kind of injection it was." (Day, 2002, p. 77)

Avoiding separation from the infant while receiving inpatient treatment was emphasized, and largely influenced recovery trajectory:

> "[…] You can't logically figure out where your babies are […] The mother's state of being is usually dependent on that baby." (Doucet et al., 2012, p. 239)

Most women described feeling unprepared and unaware of postpartum mental health issues, apart from one participant who valued this discussion:

> "[…] At antenatal classes there was definitely a realism that it could be the best and the worst of times […] so that was good." (Hunter, 2013, p. 50)

It was evident that it was important for women to feel prepared for the possibility of difficulties during motherhood. Negative experiences may have been exacerbated by the severity of symptoms, which increased confusion and distress.

Contact with non-professionals. Many women described the importance of practical support following discharge, utilizing help from family members. This was connected to feeling untrustworthy in making decisions, and feeling overwhelmed:

> "[…] I couldn't trust my own judgment […] I needed someone with me 24 hours, seven days a week." (Doucet et al., 2012, p. 239)

The importance of contact with other women with postpartum psychosis was also prevalent. This served to validate, inspire, and normalize experiences:

> "[…] It was a relief to know…it does exist, other people have had it before me and there are things that can be done." (McGrath et al., 2013, p. 7)

Participants' experiences of non-professional support were variable, and possibly dependent on supporting individuals' experiences and attitudes towards postpartum psychosis. Interpersonal relationships could either positively or negatively affect the individual's experience of postpartum psychosis:

> "[…] It's interesting how the illness ... feeds off the relationships you've got and some of your delusions and things can be directly related to other relationships you've got with different people. But also, it's your relationships with your family and your spouse that will eventually help you get better." (Wyatt et al., 2015, p. 435)

Additionally, relationships could be affected positively or negatively, including improvements in trust and respect, but could also include emotional and physical barriers that were challenging to overcome, as described by partners:

> "[…] All I wanted to do was hug her ... she was in this space that you couldn't get in ... I couldn't even touch you, you just pushed me away." (Wyatt et al., 2015, p. 431)

Importance of information. Many participants talked about importance of information both before childbirth and at the time of postpartum psychosis. It was suggested that information may have assisted during recovery for both the individual and loved ones:

> "[…] Having what is going on explained to you earlier so that you can maybe help explain it to others is important." (Doucet et al., 2012, p. 239)

However, it was also highlighted that information needed to be "screened" so that women did not feel frightened or overwhelmed. Information and support for loved ones was also highlighted as critical, yet variable across accounts. "Information" also described sharing feelings

about the experience. One participant advocated shared discussion during recovery:

> "[…] If there was some system in place […] the whole family would be involved so they can understand you and you can understand them, it would definitely speed up recovery." (Heron et al., 2012, p. 160)

Conversely, one participant suggested that although information had not been easily accessible prior to or during the episode, this would not have changed the outcome:

> "[…] I don't think there is anything that can stop it if it's going to happen." (Glover et al., 2014, p. 63)

It seems that information was generally considered useful for both the patient and their loved ones, but that consideration needs to be given to how much information is delivered, by whom, and when. While information may not prevent postpartum psychosis, it may aid recovery.

Process of recovery. One second-order theme (1) succinctly describes the overall experience of postpartum psychosis—"shades of dark with a ray of light." Although recovery was often deemed impossible or intangible at the beginning of the women's journeys (reported by these women), recovery was indeed possible and experienced. All but two studies (5, 7) described the participants' process of recovery. Two aspects were consistent in the recovery process: the role of the infant and regaining and developing personal identity.

The role of the infant. The infant was considered pivotal in three studies (1, 9, 10), and participants described interactions with the infant as motivational in recovery and bonding:

> "[…] He was the key reason, he was the reason I wanted to get better." (Plunkett, Peters, Wieck, & Wittkowski, 2016, p. 4)

Increased confidence in caring for the child was viewed as a marker for recovery and improved mood:

> "[…] You just gradually start enjoying things more and more and noticing things more and more and feeling more confident in your ability to, erm, to look after the baby." (Plunkett et al., 2016, p. 6)

This particularly supported the notion by the mothers that they should not be completely or constantly separated from the infant during treatment.

Regaining and developing personal identity. The impact of postpartum psychosis on personal identity was devastating at first:

> "[…] Your whole being, how you see yourself, the kind of person you are, and your whole sense of identity is completely devastated." (Heron et al., 2012, p. 158)

Additionally, loved ones noticing changes in the woman's personality or behavior was often the first indicator that something was wrong:

> "[…] It was about eight to ten days when my sister—and I think Robert as well—noticed that I was behaving not like myself." (Wyatt et al., 2015, p. 430)

However, a marker of recovery was the process of regaining and adapting to an adjusted personal identity, including a focus on positive characteristics that had developed as a result:

> "[…] You can sympathise, well empathise with people more because you've been there yourself. I think that has made me a better person." (Robertson & Lyons, 2003, p. 424)

This included an adjustment of priorities resulting from the experience, and many women described using their experience to support others, raise awareness, and challenge stigma:

> "[…] I would never have done this work before I was ill but now I feel I have something to offer them, and I want to give something back." (Robertson & Lyons, 2003, p.424)

Line of Argument Synthesis

The line of argument synthesis summarizes the synthesis of findings from individual research papers, to provide new understanding and interpretation (Noblit & Hare, 1988).

Themes of support needs and preferences, stigma and dismissal, acknowledging the terrifying and surreal world of psychosis, and process of recovery, are seemingly connected via the woman attempting to regain her identity, and appraisals of the experience of postpartum psychosis. It was clear that many women felt completely unprepared for the possibility of postpartum psychosis, and most participants stated that information provided by health professionals during pregnancy about potential postpartum illnesses, would have assisted. It was highlighted in one paper that it can be very difficult for personal relationships if the woman's

delusions are grounded in the context of interpersonal relationships, which was reportedly a common occurrence (Wyatt et al., 2015).

There was a strong preference for postpartum psychosis to be viewed as a separate mental illness, with purely biological etiology. Interestingly, many participants used stigmatizing language to describe mentally unwell individuals without postpartum psychosis, while also describing a stigma towards postpartum psychosis.

"Appraisal" was also key in all aspects of postpartum psychosis and accounted for some differences between individual experiences (e.g., Kelly, 1955/1991). For example, the role of appraisal was evident in relation to perceptions of failure as a mother and judgments about intrusive thoughts, which gave rise to distressing feelings of guilt and shame. To promote recovery and support women during this experience, a non-judgmental awareness is required by people surrounding women experiencing postpartum psychosis. Appropriate information should be provided, stigmatizing attitudes and language avoided, and treatment individualized with attention given to the woman's appraisal of her role as a mother and the experience of psychosis. Family interventions may be appropriate to address the views of those supporting the individual and to aid their understanding of how to promote recovery.

Discussion

This review highlighted important factors for clinical practice and in deepening understanding of the experience of postpartum psychosis via synthesis of existing research. These findings support the work of researchers suggesting that the content of psychotic experiences often reflects social and personal contexts, such as wider societal pressures, unmet expectations of motherhood, and perceived lack of control (Rhodes & Jakes, 2000).

The meaning behind infanticidal and suicidal ideation have crucial implications for formulation and risk assessment. Additionally, the evidence highlights the importance of resisting a "knee-jerk" reaction when women disclose thoughts of harming their infant, as distinctions were made between distressing, intrusive thoughts, and fantasy, and the intent associated with these. Panicked reactions are likely to result in reduced disclosure and honesty regarding these thoughts (Fairbrother & Woody, 2008).

Distress, particularly in the form of guilt and shame, were perpetuated by infanticidal ideation. This is an important consideration for services, as reduced disclosure may increase risk for both mother and infant and the level of disclosure was impacted by reactions from professionals (Dennis & Chung-Lee, 2006). Individuals felt more able to disclose when they felt safe, not judged, and were working with an experienced specialist in the field of postpartum psychosis.

It was deemed crucial by the women that they were not separated from their infant during treatment. However, managing proximity for women who resent or consider harming their baby must be carefully considered alongside perceptual difficulties and distress that seemingly accompany postpartum psychosis and could make safe, effective child-rearing incredibly difficult during acute phases. The role of the infant was reported by the mothers as pivotal during recovery, and therefore general psychiatric units which resulted in separation were deemed completely inappropriate by the mothers (1, 9, 10). Additionally, proximity assists with bonding during this critical period, and in prevention of later attachment difficulties (Plunkett et al., 2016). Access to mother and baby units and community treatment was variable across participants and locations, which is reflected in government plans to rectify this (Department of Health, 2016). However, the risk issues must also be considered by professionals, ideally involving transparency and shared decision-making with the mother and/or family.

Both personal shame and stigma from others were often associated with incongruence between expectations of motherhood and mental illness, particularly regarding "failure as a mother" (4, 6, 9). It is important that discourses surrounding the potential reality of motherhood are openly discussed during the perinatal period. Results indicate that stigma perceived from society and family members was prevalent and affected recovery, which supports existing research regarding precipitating factors leading to postpartum psychosis, including pressure from the social context (Rhodes & Jakes, 2000). Interestingly, some participants also used stigmatizing language to describe mentally unwell individuals without psychosis, perhaps indicating cognitive dissonance in reducing guilt or shame, and/or evidencing how these narratives are perpetuated. Subsequently, explicit communication from professionals describing the continuum theory of psychosis (Mannion & Slade, 2014) may be beneficial in tackling both guilt and shame and reducing stigma or judgment regarding mental health difficulties generally. It was highlighted that the way loved ones reacted to noticing a change in the woman had a big impact on the woman's experience of postpartum psychosis; this may suggest that adequate information for loved ones is equally important and consideration should be given to this being provided antenatally before distress escalates (Wyatt et al., 2015).

Differences were noted between perceived and actual stigmatizing experiences, which were perhaps due to the individual's learning history and experiences of the world thus far (e.g., Ellis, 1957). Tangible stigmatizing reactions from others may be explained by the stereotypes and lack of current knowledge surrounding mental illness, which is perpetuated by reluctance to openly discuss this (Pescosolido, Martin, Lang, & Olafsdottir, 2008). Fear of stigma or other negative consequences

also led women to purposely mask their distress and experiences (Wyatt et al., 2015).

There appeared to be a discourse surrounding professionals holding all power, while the women felt out of control and powerless over their own lives and bodies. This emphasized the need for appropriate information, rationale, and shared decision making (Ramon, Zisman-Ilani, & Kaminskiy, 2017) throughout treatment. Further anxiety arising from ineffective support (professionals and non-professionals) is likely to contribute to further distressing symptomology, which supports the stress-vulnerability model (Zubin & Spring, 1977). Additionally, only one paper (2) described the importance of medical support, which may suggest acknowledgement of the need to prioritize development of psychological treatment guidelines, which currently do not exist.

Limitations

Studies were geographically diverse—spanning continents—and included recruitment from a range of settings. Participants across papers were recruited at different time points, ranging from 1-32 years since the episode. Subsequently, synthesized experiences may not accurately represent specific contexts or reflections of different time points. Although heterogeneity (the range of demographics and settings) ensured inclusivity of differing experiences, generalizability of study findings may be limited. However, including a wide range of studies is considered vital in forming higher order interpretations within meta-ethnography (Britten et al., 2002).

Most studies did not adequately consider reflexivity, researcher bias during the research process, or epistemology. Therefore, formulation of third-order constructs were dependent upon researcher reports, lacking clarity on how second-order constructs were derived from data.

Although the review was limited to inclusion of qualitative studies, it was not felt that quantitative researcher papers would answer the research question and aims, where understanding the personal experience was focal. However, the importance of measurement of distress and relationships is noted, and future quantitative reviews would be encouraged in deepening understanding of this phenomenon. Additionally, first-person perspectives were considered integral to answering the research question and ensuring that women's perspectives were communicated. However, postpartum psychosis is not a solitary experience, and has a profound impact upon family, friends, and partners. This review did not include these perspectives but acknowledges the validity of these experiences.

Despite potential limitations, this review offers new understanding and insight beyond individual research papers alone, including clinical and research recommendations.

Conclusion

Crucially, consideration of personal appraisals, including the woman attempting to regain her identity, may assist with the recovery process and experience of postpartum psychosis. The importance of appraisal was evident throughout the review, particularly considering the continuum theory of psychosis (Mannion & Slade, 2014). It is essential that treatment, and support from non-professionals, are embedded within a non-judgmental, informed stance, so that stigma is not perpetuated. Within service provision, appropriate information must be readily available to both the woman and her family, while treatment preferences are discussed wherever possible. As a wider societal issue, discourses surrounding postpartum psychosis and mental illness require adjustment so that women feel more able to talk openly about their experiences and seek help as soon as possible. One way of informing and influencing wider society's views of postpartum psychosis is through conducting and disseminating research to aid understanding and challenge preconceptions. This starts from conducting further research in the field of postpartum psychosis. The quality appraisal in this review leads to recommendations for researchers to include careful consideration of the following: researcher reflexivity, bias and epistemological position; detailed information regarding ethical issues and procedure; recruitment strategy; and consideration of time elapsed between illness and recall. Comparisons between inpatient and community experiences and different cultures would further inform practice. The facilitation of qualitative research is, in combination with quantitative methods, vital for specific guideline development.

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