

**Postpartum Psychosis: A Foucauldian analysis of women's
experiences of living with this diagnosis.**

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ABSTRACT

Postpartum psychosis is thought to affect one or two women per 1000 deliveries (Kendell, Chalmers & Platz, 1987). The construction of this diagnosis as 'rare' has served to marginalise women who experience 'psychosis' in the postpartum period. This has been demonstrated not only in policy and service provision, but also in the paucity of academic research and the development of psychological interventions. This study sets out to explore how women are able to construct their experiences of postpartum psychosis, illustrating how material and discursive practices enable or constrain the telling of their stories.

Ten women who had experienced a diagnosis of postpartum psychosis were interviewed. A discourse analytic approach, aligned with critical realist epistemology and informed by the work of Michel Foucault was used. Following analysis of the women's talk, four discursive sites were identified, namely: Institutional Framing: Constructing Motherhood and Madness'; 'Postpartum Psychosis: The Problematic Self'; 'Lived Experience of a Duality: The Fragmented Self' and 'Survivors Story: A Mad Mum Reclaiming a Sense of Self and Educating Others'. The construction of a 'survivor' position served to reframe women's experiences of postpartum psychosis, offering a more comfortable position to inhabit, other than identification as a 'mad mum'.

This study has demonstrated that the experience of postpartum psychosis is complex. The ways in which women talk about and make sense of their experience has been created and sustained through powerful institutions such as health and social care agencies that have set up the discursive positions of a mother and a mental health patient as antithetic to each other. The identified implications of this study have been highlighted for those who provide services, suggesting that they should be better informed to respond appropriately to women diagnosed with postpartum psychosis and their families.

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1.0. INTRODUCTION

The primary aim of this study is to explore how postpartum psychosis is constructed in and through the talk of women who have experienced this diagnosis following childbirth. This is with the intention of identifying the social and material practices made possible by these constructions. The secondary aim is to identify the subject positions enabled by such constructions. The identity and conduct of women diagnosed with postpartum psychosis, which may be enabled or constrained by the self-governing practices acting at the level of society, institutions and the individual will be considered (McNay, 2009). In articulating this study, I have chosen to focus specifically on women's experiences of postpartum psychosis by interviewing women who have been offered this label as an explanation of their experiences of 'madness' following childbirth. Although incidents of postpartum psychosis are relatively rare, the experience can have life altering consequences for women and their families. Women are placed in positions of tremendous stress, simultaneously negotiating their role as a new mother and as a mental health patient. How women are able to make sense of postpartum psychosis has been under researched and there is a paucity of literature concerning women's lived experience of this diagnosis, and identifying ways in which clinical psychology intervention can facilitate recovery. This study will look at the legitimisation of diagnoses in the postpartum period and how they define women in terms of their position as a mother, bringing into focus the dominant discourses about motherhood and mental illness, and ways in which women are able to construct their own experiences.

By way of introduction to this study issues of psychiatric definition will be outlined, and the medical construction of postpartum psychosis will be discussed. How women and motherhood have been constructed historically will be evaluated, bringing into focus the problematic position of women who are diagnosed with mental health difficulties in the postpartum period. In order to collate the literature supporting this introduction, systematic literature searches were conducted. For details of how these were approached please see Appendix A.

1.1. Issues of Definition

Firstly, issues of definition are considered in order to highlight the impact of language and the ways in which individual experiences can be constructed through social interaction. I will briefly refer to the title of this study; 'Postpartum Psychosis: A Foucauldian analysis of women's experiences of living with this diagnosis'. The term 'postpartum psychosis' has been widely accepted as a label that is referred to in order to conceptualise women's experience of psychotic symptomology in the postpartum period. It will become apparent from the analysis presented in this study that this psychiatric diagnosis is not well understood and can be experienced in multiple ways. However, for clarity in this thesis I will refer to the label 'postpartum psychosis' in order to form part of the language used to understand the women's reported experiences and to draw attention to components of the discursive space made available by this term. Despite not being an individual diagnostic category in either, the Diagnostic and Statistical Manual of Mental Disorders, 4th edition [DSM-IV TR] (APA, 2000) or the International Classification of Diseases [ICD10] (WHO, 1992), the term postpartum (also known as puerperal) psychosis has continued to be used by health professionals and the general public (Jones & Cantwell, 2010). A review of research on postpartum psychosis between 1966 and 2005 (Sit, Rothschild & Wisner, 2006) highlights that the DSM – IV TR allows for classification of postpartum psychosis as severe 'depression', or 'psychotic disorder', if symptoms present within four to six weeks of childbirth. The nosological status of postpartum mental health difficulties has been informed by conflicting research, causing controversy and leading to confusion, in both research and clinical practice (Jones & Cantwell, 2010). It has been argued that postpartum mental health difficulties are separate and should be identified and understood in a different way to mental health difficulties diagnosed at a different point in time (Hays & Douglas, 1984). In juxtaposition, it has been stated that mental health difficulties in the postpartum period are not separate to known psychiatric diagnoses such as 'psychosis' and 'depression', but occur coincidentally or are precipitated by childbirth (Platz & Kendell, 1988). The relationships between previous diagnoses of 'severe affective psychosis', particularly 'bipolar disorder' and childbirth, have been evidenced in recent studies (e.g. Jones & Craddock,

2005; Heron, et al. 2008); however incidence of mental health difficulties in the postpartum period, in the absence of previous history of mental health difficulties, has rarely been addressed. The positioning of women with no previous relationship to mental health diagnosis with a psychiatric label such as 'depression' or 'psychosis' could be seen to pathologise the experience of motherhood.

Jane Ussher (2011) states that:

“Representations of madness encapsulated within the DSM not only define the boundaries of what it means to have a 'disordered mind' but also function to construct the subject position 'mad woman'; legitimising the right of particular experts to speak about and treat her condition, and defining which particular 'truths' are accepted as explanations for her disordered state” (p.4-5)

What has been highlighted here is how psychiatric diagnoses as defined by the DSM inform how an individual is positioned and enabled to make sense of their experiences and how they are rendered governable. Social constructionist literature (e.g. Szasz, 1961) has suggested that diagnostic categories are constructions informed by social and cultural ideologies, highlighting beliefs about madness and sanity, in a particular place, at a particular point in time. The psychiatric label 'schizophrenia', which is intermittently and more commonly referred to as 'psychosis' has been brought into question by challenging the diagnostic category on the grounds of the distortion of research supporting the validity and usefulness of this diagnosis, and ethical concerns on imposing a diagnosis on those who resist (e.g. Szasz, 1987; Boyle, 2002; Pilgrim, 2007). The social construction of 'schizophrenia' has been a hot topic of discussion and linked to the growth of medical influence in moral management of madness in the nineteenth century (Scull, 1979); however this study does not set out to discuss the relevance and validity of 'schizophrenia' as a psychiatric diagnosis. Rather, it sets out to explore the lived experience of this diagnosis in the postpartum period. By taking the position of critical realist social constructionism, a recognition of women's lived experience of distress in the postpartum period, as

well as the material and intra-psychic concomitants of this distress, will be acknowledged by the term 'psychosis' only because of the discourses which circulate in a particular culture at a particular point in time (Ussher, 2011).

The following sections will provide an outline of how postpartum psychosis has become constructed by medical frameworks. The implications of these constructions for service provision and how this may affect a woman's ability to access support and indeed make sense of her experience will be explored.

1.2. Postpartum Psychosis: A Medical Construction(?)

There is a growing body of biomedical research seeking to identify the incidence and biological significance of postpartum psychosis. The following sub-sections summarise the characteristics, consequences and explanations of postpartum psychosis that have been identified in this research and elsewhere. By illustrating how knowledge is constructed within a medical paradigm, implications for how academics, health professionals and women themselves are able to make sense of postpartum psychosis will be highlighted. By deconstructing the dominant literature, alternative ways of understanding can be brought into focus.

1.2.1. Characteristics of postpartum psychosis

The UK government recognises that at least half of all women experience low mood, either at some point during their pregnancy, or in the initial days following childbirth. This is widely accepted but usually expected to pass with 'rest, support and reassurance' (NICE clinical guidance, 45, 2007). Postpartum psychosis, as it has been constructed through medical discourse and psychiatric symptomology, is thought to be the most severe and uncommon form of postpartum affective illness (Jones & Craddock, 2001). Medical statistics have indicated that it affects between one or two women per 1000 deliveries (Kendell, Chalmers & Platz, 1987). However, it has been suggested that the risk of being diagnosed with postpartum psychosis rises to one in seven women if this diagnosis has been experienced previously following childbirth (e.g. Brockington, 1996). The prevalence of risk is constructed as greater if a woman has been diagnosed with 'bipolar disorder' or 'schizoaffective disorder' in the past (Jones & Craddock,

2001; Robertson, et al. 2005). Brockington (1996 p.200) described a classic picture of a mother with a diagnosis of postpartum psychosis as..."an odd affect, withdrawn, distracted by auditory hallucinations, incompetent, confused, catatonic or alternatively elated, labile, rambling in speech, agitated or excessively active". Unusual experiences categorised by psychiatric symptomology in the postpartum period (as early as the first forty eight hours following childbirth), such as thought disorder, auditory hallucinations and delusions, have all been constructed as indicators of postpartum psychosis (Brockington, 1996). The collection of symptoms, defined as 'postpartum psychosis', have been observed within different ethnic groups, countries and cultures (Kumar, 1994) with consistent rates of prevalence reported transculturally.

1.2.2. Consequences of postpartum psychosis

In the absence of clear diagnostic categorisation, clinical guidelines have been set up within the UK to guide the provision of care for women who are diagnosed with mental health difficulties in the postpartum period (NICE, 2007). However, Spinelli (2004) highlighted that once a diagnosis of postpartum psychosis has been established, it has been suggested that mental health practitioners should firstly educate the woman and her family about postpartum psychosis, then administer psychiatric medication and encourage supportive therapy, while continuing to assess the woman's mental health and safety status. Whilst in the biomedical literature most cases of postpartum psychosis are described as requiring hospitalisation for treatment, the prognosis is generally favourable (Nonacs & Cohen, 1998). It is well documented that women are constructed as being able to go on to recover fully and have good social functioning (Pfuhmann, Stoeber & Beckmann, 2002). Decisions made about the provision of care for women diagnosed with difficulties in the postpartum period have been influenced by literature that has informed understanding about the consequences of postpartum psychosis. For example, controversially it has been suggested that women who are diagnosed with postpartum psychosis experience cognitive distortions that may result in unsafe practices and the possibility of a mother neglecting her child (Kumar, et al. 1995). Although the prevalence of suicide (e.g. Oates, 2003 illustrated that only two women a year complete suicide following a diagnosis of postpartum psychosis) and infanticide is extremely rare (Freidman,

et al. 2005), media representations of postpartum psychosis often focus on these cases to sensationalise the public's perceptions of mental health difficulties in the postpartum period. The stigma of mental illness has been discussed in academic literature (e.g. Sarbin & Mancuso, 1970) highlighting the public's unsympathetic attitude towards persons marked 'mentally ill'. In particular, the diagnosis of 'psychosis' or 'schizophrenia' is thought to evoke fear, with social distance encouraged from individuals who are marked as 'unpredictable' and 'dangerous' by the media (Baumann, 2007). In light of the severity of constructed consequences of postpartum psychosis, much literature to date has focused on causative factors and prevention.

1.2.3. Explanations of postpartum psychosis

Due to the observed relationship between childbirth and the onset of psychiatric symptoms, biological models of postpartum psychosis have been postulated. The rapid fall in a woman's levels of oestrogen and progesterone following the birth of a child has been proposed as triggers for postpartum psychosis (Cookson, 1982). Research has also suggested that genetic factors may be implicated (Jones & Craddock, 2001). Within positivist mainstream research however, the aetiology of postpartum psychosis still remains unclear. Psychological and social models have more recently been proposed in order to develop understanding of severe mental health difficulties in the postpartum period, which have served to highlight the demands of motherhood (e.g. Nicolson, 1998). The search for explanations of the occurrence of postpartum psychosis served to inform the construction of knowledge but has been unable to provide any definitive answers. Thus, it is currently accepted that the majority of psychotic episodes in the postpartum period are part of a wider experience of major psychiatric illness, in particular 'bipolar disorder' (e.g. Robertson, et al. 2005). Research linking postpartum psychosis to other psychiatric diagnostic frameworks is unable to offer any explanation or insight into how postpartum psychosis is experienced by women who receive this diagnosis. The medical construction of postpartum psychosis can be seen to problematise a woman's experience of becoming a mother, positioning her in need of professional support from mental health services.

1.3. The Madness of Women: The Problem of the Reproductive Body

The previous section outlined some of the structural conditions under which postpartum psychosis has come to be understood within the medical framework of prevalence and symptomology. This has offered a reductionist account of causative factors, preventative measures and treatment which has informed understanding of postpartum psychosis, but has neglected to attend to ways in which postpartum psychosis is socially constructed and how this may inform a woman's sense of self. The following sub-sections will examine the historical subject positioning of women in terms of their reproductive abilities. Literature will be used to consider how women are subject to psychiatric diagnosis and to evaluate the practices by which women have become 'problematized' by the construction of 'madness'.

1.3.1. Subject positioning of women and the social construction of 'madness'

It is thought that by examining the genealogy of current discourses and discursive practices, the culturally located nature of particular beliefs and regulatory techniques can be explored (Foucault, 1967). The medicalised constructions of 'madness' have informed understandings of mental health difficulties in a certain way. Rather than being real entities, many social constructionist writers have argued that all psychiatric diagnoses can be conceptualised as discursive constructions created by the process of expert definition (e.g. Boyle, 2002). In this view, 'madness' is a socially constructed label, based on value-laden definitions of normality, which determines how a person's future behaviour is seen and addressed. Diagnosis of mental illness has been seen to simply legitimise professional control, offering a framework for the enactment of disciplinary power in Western society. It has been argued that the practices of regulation, previously undertaken by the church, have simply been passed onto experts who monitor and regulate psychological well-being and ensure socially acceptable individual functioning (Rose, 1985). It can be understood that through defining a person as 'mad', this acts to determine what is 'normal', producing the boundaries of desired behaviour, thoughts and feelings. The fear of the stigma associated with 'madness' and mental health diagnoses has been proposed to ensure self-policing of an individual's behaviour as one attempts to avoid being

positioned as 'mad'. This suggests that the label 'mad' warrants certain sanctions, with everything that an individual says or does being judged within a medicalised mantle (Scull, 1979).

1.3.2. The feminist challenge to women as 'mad'

Feminism has a history of interrogating psychiatric diagnosis, questioning the effects of medicalised patriarchies on a woman's sense of self as a mother, wife, sister (Swartz, 2013). Historically, accounts of women's 'madness' have been well documented and still serve to define and regulate women's 'madness' today (Ussher, 2011). Accounts of 'hysteria' are present in the eighteenth and nineteenth centuries and enable the genealogy of historically specific mechanisms which provide discourses that function as true in particular times and places (Foucault, 1972), allowing an understanding of women's mental health difficulties to be traced. In the eighteenth century hysteria was defined as "...a passion (formed of womb); a disease in women, also called suffocation of the womb, and vulgarly fits of the mother" (Small, 1996 p.20). Feminism and feminist theory has highlighted the significance of reproduction in defining the characteristics of women (Martin, 1989; Ussher, 1989). Across history, women's greater propensity to madness has been attributed to the reproductive body, with women's reproductive organs deemed to be central in all aspects of her psyche and well-being. The relationship between childbirth and mental illness can be tracked historically, and has been recorded in written accounts as far back as the 1400's, where a description of what is now understood as 'postpartum psychosis' is described in a personal memoir by Margery Kempe (cited in Freeman, Bogarad & Sholomskas, 1990). Although notions of hysteria are not in such common use today, it can be seen in leading research into postpartum psychosis, in that the biomedical model of women's 'madness' still places hormones in the centre stage (e.g. Brockington, 1996). However, to attribute experiences such as postpartum mental health difficulties simply to the biological or psychological consequences of the female reproductive system has been seen to ignore the effects of a patriarchal culture on women and dismiss the possibility that women's madness is a 'normal' response to oppression (Niven & Walker, 1998).

In summary, societal perceptions about women that have been influenced by historical views of gender are likely to perpetuate assumptions about the role of women who have been defined by their reproductive abilities. An intrinsic link has been made between womanhood and the value of reproduction (Sevón, 2005), which could arguably influence a woman's sense of self if she inhabits the position of a mother. The next section will discuss the dominant discourses of motherhood and how ideas about the 'good mother' are constructed.

1.4. The 'Good Mother': A Problematic Identity?

Despite demographic and cultural changes, it continues to be the case that most people become parents at least once in their lifetime (Graham, 1993). The ambition to have children is thought to be closely related to the ways in which parenthood is socially constructed around ideologies of gender roles and family life (Phoenix & Woollett, 1991). This section will explore the cultural discourses about motherhood and how cultural ideologies inform a woman's position and sense of self as a mother, in order to create a context in which women diagnosed with mental health difficulties in the postpartum period may be able to construct their difficulties.

1.4.1. Motherhood and the construction of the 'good mother' discourse

Kaplan (1992) highlighted that representations of motherhood in popular culture play a significant role in creating myths of motherhood that women are exposed to from an early age. Women have been viewed as having children because it asserts their 'natural femininity' (Woollett & Nicolson, 1998). Motherhood is socially constructed as an idyllic time and a fulfilling experience for women, with negative responses or experiences of motherhood being pathologised (Lewis & Nicolson, 1998; Phoenix, Woollett & Lloyd, 1991). It has been suggested that 'good mothers' are always available to give children love and attention, and that they are calm and in control (Weaver & Ussher, 1997). Current ideas about good mothering in Western culture emphasise the need for mothers to be sensitive and child centred by putting their baby's needs before their own (Woollett & Phoenix, 1996). The construction of motherhood as an essentialising and central component of adult identity for women serves to discourage questioning or

resisting these constructions, encouraging women to feel guilty if they fail to live up to the ideals of motherhood (Weaver & Ussher, 1997; Choi, et al 2005). Hall & Wittkowski (2006) investigated the prevalence of negative thoughts after childbirth in mothers who had not been diagnosed with mental health difficulties and found that reports of negative thoughts are common. This study highlights evidence to reassure new mothers and reduce feelings of guilt that can be associated with negative experiences in the postpartum period.

Winnicott (1971) introduced the idea of 'good enough mothering', however, the problem has remained that many women are not satisfied with being 'good enough', with the modern world and neoliberalism encouraging the pursuit of perfection. Generations of second-wave feminists stated that women can 'have it all', embodying ideas of the perfect housewife, wife and mother, creating a 'super mum culture' (Choi, et al 2005). In a study carried out by Brown, Small & Lumley (1997), women were invited to describe their personal construction of a 'good mother'. Women described this 'icon' as having "...never ending supplies of patience, spending time with her children willingly and regularly, being able to provide her children with the right sorts of attention, stimulation and guidance, and remaining calm and relaxed at all times" (p.189). Women who experience a disparity between their own experience and the idealised representations have reported thinking that they are the only one who isn't coping and, rather than asking for help or support, put on a false mask of competence and fulfilment (LeBlanc, 1999). It has been suggested that it is the idealised discursive representations of motherhood within society that keep women silent, blaming themselves for not being a good enough mother, rather than speaking out and saying that sometimes they feel as if they can't cope (Ussher, 2006). Research has suggested that women who experience fragmentation between an idealised construction of what they thought a mother should be like, and the way in which they view themselves, are more likely to experience difficulties with a fragmented sense of ideologies and the lived experience of motherhood (Breen, 1975). Women, who are able to modify their picture of motherhood to fit the reality of becoming a mother, are thought of as less likely to experience difficulties. In terms of severe mental health difficulties such as postpartum psychosis, this research suggests that constructing an idealised view of motherhood could

increase the risk of women experiencing emotional difficulties in the postpartum period.

There is a substantial body of research that highlights the Western construction of motherhood as an 'ultimate fulfilment', providing women with a valuable and important role (e.g. Woollett & Phoenix, 1996). This appears to put mothers in a powerful and important position; but could also position women to be blamed if things go wrong. This brings into question how women are able to identify as a 'good mother' in the face of a diagnosis of postpartum mental health difficulties and how they are able to construct their position in line with dominant cultural discourses of motherhood and mental health problems. The next section considers the problematic subject position of experiencing mental health difficulties in the postpartum period.

1.5. Psychiatric Diagnosis in the Postpartum Period: A Problematic Experience?

1.5.1. The subject position of a mother with a psychiatric diagnosis

Irrespective of the aetiology of difficulties in the postpartum period, the previous sections in this chapter have highlighted a wider on-going debate that women have been 'pathologised' by medical and scientific discourses, irrespective of whether they are ill (Nicolson & Ussher, 1992). Feminist and social science approaches point to the significance of childbirth for women's identities and relationships, as they incorporate the new baby into the network of family and other relationships and as they renegotiate the relationship with their partner as parents (Woollett & Nicolson, 1998). For women the birth of a child can present new emotional challenges which are potentially stressful and can impact on a woman's emotional well-being. The majority of women maintain positive mental health after the birth of a child; however, research has estimated that 10% to 15% of women experience depression or more serious mental health difficulties in the first year of motherhood (Cox, Murray & Chapman, 1993). Screening for change in affect in the postpartum period can be difficult given the number of physical symptoms typically associated with having a new baby that are also identified by psychiatric diagnoses as symptoms of 'depression'. For example, new mothers

frequently report disturbed sleep, reduced appetite, experiencing a lack of energy and diminished libido (Nonacs & Cohen, 1998). While severe postpartum mental health problems are generally more easily detected, less severe difficulties talked about by women can easily be dismissed as 'normal' consequences of childbirth and symptomatic of motherhood (Nicolson, 2000).

The success of transition from pregnancy to motherhood has concerned experts and lay people alike (Niven & Walker, 1998). When a mother fails to adapt to the culturally defined role of mothering the focus of the attention is often about what has gone wrong for the woman, if she has become 'depressed', or worse, if she is having unusual experiences that can be understood in terms of 'psychosis'. Concern with psychiatric indices and labels of distress, such as postnatal depression (PND) and postpartum psychosis, has more often focused on psychological factors that predict distress, rather than understanding the lived experience of mothers who are diagnosed with mental health difficulties. To date, studies examining the emotional well-being of mothers have most commonly been concerned with PND (Flores & Hendrick, 2002). The validity of 'postnatal depression' as a diagnosis has been questioned, with increasing feminist literature suggesting a possible trigger for depression in the postpartum period by highlighting the demands of the mothering role (Mauthner, 2010; Nicolson, 1998). However, literature on postpartum psychosis has previously concentrated on the biological aetiology and the links to genetic and hormonal risk factors; therefore, postpartum psychosis has been placed more firmly within a medical framework as a legitimate 'medical condition', according it status. Postnatal depression and postpartum psychosis undoubtedly have some similarities in terms of when they occur, in the context of a new parent role, and with identified symptoms such as 'depressed mood'; however, a striking difference between the two conditions has been identified in terms of lived experiences and consequences of diagnosis (Robertson & Lyons, 2003). The problematic presentation of postpartum psychosis invariably leads to hospitalisation, which positions women in extremely powerless ways: they are labelled with a psychotic illness within a patriarchal medical system at a time when they are expected to be taking on the role of a 'good mother' (Robertson & Lyons, 2003).

In the next sub sections, research and discussion will be outlined that has dealt with the institutional responses to postpartum mental health difficulties, a woman's sense of self following psychiatric diagnosis of difficulties in the context of being a mother, and consideration of the impact of these practices in terms of a woman's ability to seek help and support. By considering institutional practices this will serve to widen understanding of how women are regulated as mothers and how difficulties in the postpartum period are able to be constructed and made sense of.

1.5.2. Institutional practices: Regulating women's behaviour in the postpartum period

In Western culture childbirth usually takes place in a hospital setting and the process of medical management started in pregnancy continues into the postpartum (generally defined as twelve months following childbirth). While medical approaches continue to view pregnancy and childbirth as risky, ideas about the postpartum period are increasingly suggesting that following childbirth, women are 'fit and well'. It has been suggested that women are capable of taking responsibility for looking after themselves and their babies, requiring minimum hospital care (Niven, 1992). The postpartum period, and in particular the experiences and perspectives of women themselves, have generated less interest from health professionals, social scientists, and from consumer groups such as National Childbirth Trust (Woollett & Nicolson, 1998), compared with pregnancy and childbirth. In general, the emphasis in the immediate period following childbirth is on the physical recovery of the mother and the establishment of infant feeding (Crossley, 2009). National Health Service campaigns in the UK have continued to promote the message 'breast is best' to prospective mothers (Stanway & Stanway, 1978). Political and health controversies over breast and bottle feeding have dominated research in this area, revealing the health benefits of breastfeeding (Crossley, 2009). Institutional incentives to encourage breast feeding have also been highlighted in money saving for national health services. The promotion of childbirth and breastfeeding as natural and unproblematic would suggest that women who need to seek support may feel positioned as problematic by the wider societal and cultural

pressures of motherhood, enforced by the health service provision (Marshall & Godfrey, 2011).

Pregnancy and the early postpartum period are times of high surveillance by health care institutions, providing opportunity of early intervention for women previously diagnosed with psychiatric conditions, as well as identification of women at risk. This provides opportunity to facilitate preventive strategies and to safeguard a mother's wellbeing in the early stages following childbirth (Godderis, 2010). Governmental technologies, like screening and prevention programmes, have been introduced more recently to identify women who are 'at risk' of having postpartum difficulties. Within this framework, all pregnant women risk being positioned as "pre-symptomatically ill" (Rose, 2007 p.19), pathologising motherhood within a medical framework. Generally, health care professionals follow guidelines (NICE, 2007) to determine what constitutes a 'problem' in the postpartum period and whether a woman needs to be referred to psychiatric services. Primary care and maternity staff continue to rely on their own professional experience to determine the level of input needed for each patient. In order to determine what a 'normal' reaction to childbirth is, a 'normal experience' must be defined, taking into account cultural and social contextual factors.

Whilst there are guidelines available for the treatment of bipolar disorder, otherwise known as affective psychosis (e.g. NICE clinical guideline, 38, 2006), specific guidelines on intervention and treatment of postpartum psychosis for health professionals are less available (e.g. NICE, 2007; CEMACH, 2007). Most women who are diagnosed with postpartum psychosis are seen to need treatment in hospital, ideally being offered a bed in a Mother and Baby unit (MBU), a specialist psychiatric facility where mothers with a diagnosis of mental illness are admitted with their babies. However, if there is no access to a MBU a woman will most likely be admitted to a general psychiatric ward. If this happens, there is an expectation that a woman's family or partner will care for the baby. If there is no one to provide care for the baby, a social work professional will find a temporary carer. Generally, women are treated immediately with a combination of anti-psychotic medication and mood stabilisers (Doucet, et al. 2011). These

general guidelines serve to prioritise the safety of mother and baby (Thorpe & Elliot, 1998) and address the treatment of psychiatric symptomology, thus constructing the woman as a 'patient' and subject to medical intervention. Riley (1995) highlighted that few authors have commented in any systematic way on the methods of treatment of more severe presentations of mental health difficulties in the postpartum period, possibly reflecting the difficulty of applying a standardised treatment to something that can present so differently, for different women, with varying circumstances and systems of support.

1.5.3. Embodiment and discursive practices regulating the new mother

Nicolson (1993) suggested that the 'norms and facts' constructed about motherhood inform everyday understandings about how mothers 'should' behave and what being a mother means in Western cultures. The biomedical influence highlighted in previous literature has endorsed a positivist, hypothesis testing approach, which can be seen as reductionist and unable to capture the lived experience of mothers who have been diagnosed with difficulties in the postpartum period. Psychological approaches to the postpartum period have generally focused on the child rather than the mother and on the impact of early experiences for their later development and social relations (Kalus & Kennell, 1982). However, research such as that carried out by Gammel & Stoppard (1999), has begun to bring into focus how women experience and begin to talk about difficulties in the postpartum period. Their study found that prior to a diagnosis of postpartum depression; a significant majority of the women who were interviewed attributed their experiences of reported low mood to their everyday lives. However, after formal psychiatric diagnosis, the women were seen to reinterpret their experiences as 'symptoms' caused by chemical imbalances in the brain. The women used medicalised terms such as 'illness', and 'disease', suggesting that the dominant medical discourse had informed their construction of experience, positioning themselves as a passive patient, subject to pharmacological treatment. The function of the women's talk in this study could be seen as serving to absolve women from blame for their symptoms and to neutralise the stigma associated with postpartum difficulties. Additionally, the women in this study were seen to make a distinction between their 'real self' and their 'sick self', disowning their sick self as something over which they had no

control. Gammel & Stoppard's study brings into question how diagnosing women with a disorder in the postpartum period possibly serves to legitimise the positioning of the postpartum body as subject to medical discipline and control, with medication or hormonal treatment being prescribed as the most appropriate 'cure'.

1.5.4. Subjectification and help seeking practices

Regimes of knowledge about women's madness are implicated in self-diagnosis, or acceptance of professional diagnosis; a process that has been described as 'subjectification' (Rose, 1996). Social systems provide a context wherein women are able to negotiate the regimes of knowledge which underpin their acceptance and interpretation of motherhood. If the significant others in a woman's life reinforce and confirm the sense of failure and inadequacy that can be experienced by new mothers, through reinforcing idealistic representations of motherhood, the likelihood of a woman experiencing feelings of isolation and depression is increased (Godderis, 2010). A woman's own self-surveillance may silence these feelings, rendering her unable to express difficulties or need for support, feeling that she should be able to cope, not wanting to be perceived as a failure in the context of an idealised view of motherhood. The multiple contradictory, shifting and sometimes fragmentary identifications women adopt in taking up the subject position 'mother', and in negotiating the material discursive, intra-psychic consequences of motherhood needs to be acknowledged. This allows recognition of the complexity of women's subjectivity and the potential for agency in the subject positions women adopt in their negotiation of distress (Ussher, 2006).

Literature has highlighted how, in women's accounts of postnatal depression, they are less likely to account for their 'depression' and negative emotions in terms of individual problems and pathology, which can be identified in the discourses of health professionals (LaFrance, 2007). Rather, research has shown that women relate their accounts of mental health difficulties to anxieties around childcare. It has been suggested that women will often link their feelings to the constraints of motherhood, including feeling trapped or out of control, which could

arguably serve to offer a less pathologising position for a mother to inhabit (Woollett & Parr, 1997; Astbury, 1994). McIntosh (1993) argued that if women construct depression as related to their experiences of motherhood, they do not consider it to be amenable to medicalised or other individualised treatment and hence rarely seek help. This could be understood in terms of a limited knowledge of the treatment options to support women in the postpartum period. In the absence of alternative constructions of difficulties, the women problematise themselves, rendering them unable to inhabit the role of a 'good mother'. Women who take up the position of the psychiatric 'other', could be seen to accept 'madness' in terms of the predominant medical definition and align themselves with a diagnosis of 'mental illness'. Those who resist this position need to construct an alternative explanation that can account for their experiences in a less pathologising way (Ussher, 2013).

1.6. Postpartum Psychosis: Inhabiting a Sense of Self

Traditional views and ideas about motherhood and a woman's role of taking care of her family as a natural 'feminine' role (Lewis & Nicolson, 1998; Phoenix, Woollett & Lloyd, 1991; Sevón, 2005), constructed in Western cultures, may compound negative feelings experienced by women who are diagnosed with postpartum psychosis. Previous literature has highlighted that the experience of postpartum psychosis, and failure to fulfil these social roles, leads to increased feelings of guilt and loss which can continue after recovery as women reflect on their experience (e.g. Robertson & Lyons, 2003; Heron, et al. 2012; Engqvist, et al. 2011). Dominant views of the 'good mother' emphasise the importance of a mother putting the baby's needs before her own (Woollett & Phoenix, 1996). For women who are hospitalised in reaction to postpartum psychosis this is not always possible and could serve to add to their sense of loss and failure (Robertson & Lyons, 2003).

1.6.1. Previous research: Strategies to cope and response to seeking help

Lefley (1989) has written at length about the effects of mental health diagnoses and stigma on the family. More recently, research carried out by Edwards & Timmons (2005) has highlighted how the stigma of postpartum mental health

difficulties can lead to withdrawal, isolation and feelings of being labelled. Descriptions of the stigmatisation and isolation experienced by both women and their families were echoed in the research carried out by Robertson & Lyons (2003), a study which pioneered research into women's experiences of postpartum psychosis. This study found that women who had experienced psychotic symptoms were positioned as more likely to experience increased feelings of isolation. This extended to their families also. Recovery from the postpartum psychosis was described as a 'grieving process' where the women needed to come to terms with what they (and their family) had been through. The women interviewed by Robertson & Lyons (2003) reported that they felt they did not have the right to experience 'normal' emotions and it was reported that fluctuating moods were perceived as pathological by their families. Women were reported as frequently describing "losing themselves, their minds and even their personalities" (p.426) due to how profound and serious their experience of postpartum psychosis was. Research has begun to explore the support needs of women diagnosed with postpartum psychosis (Heron, et al. 2012; Doucet, et al. 2011), identifying that women construct their experience of postpartum psychosis as a time of disruption and incoherence. The importance of recovery in terms of regaining confidence and social functioning has been highlighted (Doucet, et al. 2012). A recent review of narratives of women's experiences of postpartum psychosis available on the internet (Engqvist, et al. 2011) found that women talked about their experiences as devastating and that they felt neglected, misunderstood and inadequately cared for. Robertson & Lyons (2003) highlighted that in contrast to women's description of 'losing themselves', there was a sense of how the experience had made them stronger. While the women acknowledged how substantially they had changed, contradictions were apparent in that regaining their 'former selves' was used as a marker for recovery and what the women aspired to. Thus, suggesting that the women in this study were able to construct their experience in a way that positioned them as strong and able to cope.

As women's experiences of postpartum psychosis have started to be explored through qualitative studies the enormity of the consequences of this diagnosis on a woman's sense of self has been illustrated. The description of experiencing

grief, loss, and an absence of a framework in which to make sense of their experiences, suggests a need for greater knowledge about postpartum psychosis and its effects on women and their families. Despite an increase in interest in postpartum psychosis and women's lived experiences, this continues to be under-researched. Thus far, I have endeavoured to highlight that there is limited research which examines the thoughts, feelings and perceptions of postpartum psychosis, and limited access to the voice of strength and resilience. Although the identified prevalence of postpartum psychosis is rare, it has serious and disabling illness effects which can impact on the mother's close relationships. Postpartum difficulties can have serious implications for the women who have experienced them, having to live with the knowledge that she may have been through what is termed as a 'psychotic illness', at a crucial stage of family life (Robertson & Lyons, 2003).

1.7. Summary and Rationale

1.7.1. Summary

This chapter has highlighted the issues of psychiatric definition present in Western society. Psychiatric diagnoses have been constructed through medical discourse, offering a framework in which to understand individual experiences of mental health difficulties. By deconstructing the diagnosis of postpartum psychosis, the identification of characteristics, consequences and explanations of this diagnosis as defined by the growing body of biomedical literature was introduced. This has served to inform a medicalised understanding of this diagnosis, with the treatment implications impacting on the way women and families are positioned by the psychiatric system. It was suggested that the medical construction of postpartum psychosis could serve to problematise a woman's experience of becoming a mother. In order to argue the problematised position of postpartum psychosis, the historical construction of women and how they have been positioned in terms of their reproductive abilities has been explored. The construction of the 'madness of women' and the early ideas of 'hysteria' introduced the problematic position of women and the practices of regulation of the reproductive body through actions of medical institutions (Ussher, 2011). This served to set a context in which to explore the position of

women who were interviewed in this study. To further explore the ways in which women diagnosed with postpartum psychosis are positioned, cultural ideas of motherhood and the construction of the idealised mother were presented. By drawing on research that has identified women's experiences of motherhood that did not match the idealised views, the ways in which women talked about and made sense of their undesirable experiences was brought into focus.

By introducing ideas of how women are pathologised through medical discourse and highlighting the Western construction of motherhood, I sought to provide a context from which to explore the experiences of women who receive psychiatric diagnoses in the postpartum period. Subsequently, I discussed other postpartum psychiatric diagnoses, namely postnatal depression, which has been the focus of literature on postpartum mental health difficulties (Nicolson, 1998). Feminist literature has highlighted environmental factors and recognises the challenges of having a baby and how this may impact on a woman's well-being and sense of self (Sevón, 2005). However, much of the research into the experiences of postpartum psychosis has remained within the biomedical framework. Institutional practices and treatment provision for women with mental health difficulties in the postpartum period were outlined and the lack of consistent guidelines for responding to postpartum psychosis has been identified. I have sought to show how women are, at least to some extent, governed in their response to mental health difficulties as a new mother, constrained in their understanding of their difficulties by the practices (material and discursive) associated with motherhood.

1.7.2. Rationale for research

Research into appropriate interventions, policies and service provision (including clinical psychology) for women diagnosed with postpartum psychosis, tends to focus on symptomology, prevalence and predicting risk. This has been in place of exploration of the lived experience of postpartum psychosis and how women are positioned in order to make sense of this diagnosis. Similarly, treatment for women who present with symptoms of postpartum psychosis is biased almost exclusively towards rapid response, including the sectioning and medication of women, with little attention paid to the family system or longer term interventions.

Due to the rarity of postpartum psychosis, women have reported finding it difficult to gain information about the mental health diagnosis, which has led to feelings of anger and frustration being reported. This has been directed towards professional services, both for their lack of provision of useful information and lack of support for families (e.g. Robertson & Lyons, 2003; Heron, et al. 2012; Engqvist, et al. 2011; Doucet, et al. 2012). Although women's lived experience of postpartum psychosis are being brought into focus, there remains a lack of information and knowledge, leaving women and their families feeling unsupported in making sense of their experiences.

Qualitative studies have started to explore the experiences of women diagnosed with postpartum psychosis (e.g. Robertson & Lyons, 2003; Engqvist, et al. 2011), developing a small body of research that offers an alternative way of understanding postpartum psychosis. However, it is arguably important not only to make sense of how these women construct their individual experiences, but also to explore how the discourses available (for example, being a good mother, femininity and stigmatisation of mental health diagnoses) will influence these constructions and the responses enabled by them. Having an awareness of the discursive and extra-discursive factors influencing woman's accounts of postpartum psychosis could be used to inform decisions about appropriate psychological interventions. Woman's perception of their ability to be a good mother could be constructed as constrained by a lack of positive references to inform self-identity and a perceived limitation of their own power to act in the best interests of their family.

This study uses the dilemmas raised as a platform for carrying out a discourse analysis of women's talk following a diagnosis of postpartum psychosis. An analysis informed by Foucauldian principles will enable consideration of the social practices sanctioned by the local and cultural discourses available to these women (Willig, 2008). The analysis seeks to address the research question detailed below:

1.7.3. Main research question:

How do women who self-identify as having been diagnosed with postpartum psychosis construct their experiences; in what ways do they use talk to describe and understand their experiences and what discursive resources do they deploy when telling their stories?

The next chapter will clarify the methodology used in this study and highlight the reasoning for the chosen method of data collection and analysis used to address the main research questions raised.

2.0. METHODOLOGY

Researchers have usefully classified the need for researchers to clarify their epistemological stance, alongside a description of the methodology and method used, to make sense of data collected as part of a study (e.g. Harper & Thompson, 2011). This chapter falls into two halves. The first half is used to discuss the epistemological position taken in this study, namely critical realist social constructionist, highlight methodological considerations and the method used by outlining the principles of Foucauldian Discourse Analysis. In the second half, details of the method in practice will be addressed, including a focus on recruitment, participants, ethical considerations and the procedure of data collection and data analysis.

2.1. Epistemology

Essentially, epistemology is the “philosophical theory of knowledge which addresses questions about how we can know what we know” (Harper & Thompson, 2011 p. 4) and whether this knowledge is reliable or not. The epistemological position taken in this study is one that has become known as ‘critical realist social constructionist’ (Harper, 2011). Underpinning this philosophical stance is the idea that an individual’s reality exists, it is material and has real effects on real bodies, but that reality is made sense of through its discursive constructs in language and therefore it is also socially constructed.

Critical realism is a complex term, made meaningful by different people in different ways. Although language can inform the ways in which social reality is made meaningful, it is inhibited by the possibilities and limitations of the material world (Sims-Schouten, Riley & Willig, 2007). Therefore, it can be understood that language does not represent reality directly. The critical realist position highlights the importance of drawing on other evidence, beyond the text being analysed, in order to support ontological claims made about human experience. In relation to this study, it is important to go beyond the language used in order to address extra discursive factors that may influence women’s experience of postpartum psychosis. In the field of clinical psychology, ideas of social constructionism are

less concerned with phenomena themselves but rather in how they are made meaningful (Burr, 1998). Researchers informed by these ideas are concerned with the nature of social reality and aim to make sense of the ways in which certain phenomena (for example, motherhood and the experience of psychosis) are constructed through language and social interaction. The social constructionist position enables the exploration of the positions made available through social interaction and how people can be 'subjectified' by them (Harper, 2011).

2.1.1. Critical Realist Social Constructionism

By adopting the position of a critical realist social constructionist I have taken the view that, alongside an awareness of the importance of studying language in detail, looking beyond spoken language enables a further layer of interpretation. This allows what is being said to be set in a broader social, cultural and historical context. Willig (1999) has suggested that an individual's actions are structured by social and material realities. The ways in which these realities impose constraints on what is said and done, influences the construction of phenomena in different contexts. It has been useful to make sense of critical realism with social constructionism in terms of its position as ontologically realist but epistemologically relativist (Harper, 2011). Such, in developing an epistemological approach I have drawn on the ideas of various writers who have proposed that discursive and material practices act in relationship with each other and serve to enable or constrain subjectivity (Willig, 1999; Parker, 1992).

2.1.2. Issues of this position

The epistemological position taken in this study assumes a certain understanding of key words. In this study, the term 'discourse' will be taken to mean systems of meaning that are related to interactional and wider socio-cultural contexts and operate regardless of the speaker's intentions. The term 'language' is taken as a form of social action in specific interactional contexts, and is seen as a means of constructing one's own reality. Taking a critical realist social constructionist approach in this study will enable the exploration of women's discursive constructions of postpartum psychosis. The self-disciplining practices engaged in and with, and the subjective positions they take up will be brought into focus. The

social structures and material practices that the women are exposed to will be acknowledged and the use of the discursive constructions enabled to refer to this will be considered. Adopting the position identified in this study has been criticised however, for leading to inconsistency (Harper, 2011). For example, it has been argued that when a researcher, informed by critical realist social constructionism, conducts a discourse analysis there is a risk of selectively questioning some phenomena, while attending to others as if they exist and are real (Speer, 2007). Failure to go beyond the text presented might mean that subjectivity and embodiment of constructed phenomena that is talked into being cannot be explored fully (Nightingale & Cromby, 1999). In order to acknowledge and address this dilemma, I have taken the position that understands the socially constructed and the real as neither dichotomous nor homogeneous (Burr, 1998). By speaking of things as simultaneously constructed and real, I am accepting that a complex and intricate relationship must exist between 'knowledge' and 'practice' (Foucault, 1972). This study will adopt the idea that knowledge and practice are mutually-sustaining, and together with social structure have 'real' embodied or subjective effects on people (Burr, 1998). To illustrate the position of social constructionism, the introductory section of this study has identified literature which constructs 'the good mother' and 'psychosis' as being historically and culturally-situated and influenced by wider societal discourses. It has been previously highlighted that culturally-available constructions of motherhood and mental health diagnoses may produce, not only the discursive practices of 'psychotic mothers', but also the responses of institutional practices such as health and social services with which women may come in to contact.

The next section will detail the methodological assumptions, used to provide a framework for planning and implementing this research, in order to address the research questions identified in the previous chapter.

2.2. Methodology

'Methodology' has been defined as the study of the 'method' used to inform the research process (Willig, 1999). It has been identified as a specific technique of data collection and analysis guided by the philosophical assumptions identified by

a particular epistemological stance. This study has utilised a qualitative approach to data collection and analysis in order to enable understanding of experience and systemic processes. A Discourse Analytic method, namely Foucauldian Discourse Analysis (FDA), has been used to explore how postpartum psychosis is constructed in and through women's talk.

2.2.1. Discourse Analysis

Discourse analysis is a broad and diverse field which fundamentally offers a framework from which to study language. It relies on a variety of approaches, which derive from different scientific principles and utilise various analytical practices (Wetherell, Yates & Taylor, 2001). The analysis of discourse considers how certain issues are constructed in people's accounts, the variability in these accounts, rhetorical devices used and the functions of talk in the context of the on-going interaction (Potter & Wetherell, 1987). A commonality of discourse analytic methods is that language is seen as productive of events and experiences, rather than reflective of 'reality'. It is seen to facilitate the pursuit of, and identification with certain subject positions, actions and practices. Harper (2006) has identified two approaches of discourse analysis, Foucauldian discourse analysis (FDA) and discursive psychology (DP). FDA focuses on the wider context of discursive resources (e.g. how ways of talking about an object, event or experience are constructed by institutional contexts). DP is more concerned with the finer details of discursive practice (e.g. rhetorical devices and their use in negotiating social interactions). FDA looks to explore the influence of power, particularly how privileged discourses are legitimated, and how various subject positions and practices are made possible by discursive constructions (Willig, 2008).

The next section identifies the principles of FDA and how this method of analysis is used in this study to make sense of the ways in which the women talk about their experiences of postpartum psychosis.

2.3. Method

In developing a rationale for the method used in this study, I have been informed by the suggestion that an effective analysis of discourse may be produced through the exploration of discursive practices, discursive resources and the discursive constructions that allow various subject positions and actions to be made possible (Sims-Schouten, Riley & Willig, 2007). These factors will be considered together with the exploration of material practices that may be understood as 'extra-discursive' in their ontology.

2.3.1. Foucauldian Discourse Analysis (FDA)

This method of analysis draws upon post-structuralist themes identified by Foucault and is informed by feminism and Marxism (Arribas-Ayllon & Walkerdine, 2008). FDA focuses on discursive resources and explores the way in which discourses construct objects and subjects and create certain versions of reality, society and identity. FDA also considers the ways in which discourses maintain certain practices and institutions (Willig, 2008). The method of analysis used in this study was specifically a critical realist version of FDA. This method of FDA proposes that material conditions (possibilities and constraints) have individual meaning and provides a context in which the references of certain discourses are recognised by individuals in their talk (Sims-Schouten, Riley & Willig, 2007). Consequently, as Sims-Schouten, Riley & Willig, (2007, p.103) state: "this approach does not only map the ways in which participants use discourse to construct particular versions of reality, but it also positions their talk within the materiality they have to negotiate". Foucault suggests that discourses structure what it is possible to say through systems of exclusion, such as the prohibition of certain words and the division of mad and sane speech. It has been proposed that in any given context there may exist more than one discourse, certain discourses will be privileged, suggesting that they exist in hierarchical relations with one another (Foucault, 1985).

Understanding the ways in which a woman is able to talk about her experience of postpartum psychosis is identified in the aim of this research. Consequently, an analytic plan was developed which focussed on identifying objects and practices

on the basis of which women as mothers with mental health difficulties can be 'problematised' (Foucault, 1985). To consider how these women became positioned simultaneously as a 'mother' and as a 'mental health patient', discursive and material practices designed to exercise power over the self, are explored (Rose, 1996). Such practices have been referred to as 'technologies of power' and 'technologies of the self' (Foucault, 1988 p.18), both terms commonly used in FDA. 'Technologies of power' are understood as regulatory practices of institutions that enable the production of 'technologies of self'. These processes of governmentality are thought to be regulatory at the level of institution and disciplinary at the level of the individual. 'Technologies of self' have been defined as those practices used to make oneself a neoliberal subject, for example, the practice of self-disciplining, normalising, and engaging in ethical principles applied in the production of particular kind of self. The analytic foci that informed the analysis of the women's talk was theoretically informed by Arribas-Ayllon & Walkerdine (2008).

2.4. Method in Practice

2.4.1. Recruitment and participants

2.4.1.1. Recruitment

Ten participants were recruited using two different methods. Firstly, participants made contact in response to a research advert that was posted by an online Postpartum Psychosis Charity Network, which has a following of approximately 600 women in the UK and worldwide (see Appendix B). The Network is run by a team of women who have experienced postpartum psychosis, clinicians and researchers. Network members were able to access the research advert through the online web page and a social media site. This yielded responses from a number of women, following email contact and telephone conversations, seven resulted in interviews. Secondly, participants were recruited by making contact with a key researcher in the area of qualitative research in postpartum psychosis; the contact details of three participants who were willing to take part in research projects in this area were secured. I contacted these women directly by telephone and/or email, and following the provision of information about taking part in the study, all three women agreed to be interviewed.

Contact details were provided within the recruitment material, including an anonymous e-mail account and a telephone number where confidential messages could be left. Following enquiries, all potential participants were provided with information pack (see Appendix C), including an information leaflet and a consent letter, clarifying the details of the study. This was then followed up by a phone call conversation to discuss any further questions, verifying their willingness to participate in this study and arrange an interview. Once the interview details had been agreed, an interview guide was sent by e-mail (see Appendix D), comprising a sample of likely questions. The recruitment of ten women, who had experienced a diagnosis of postpartum psychosis, was considered to be an adequate sample size, given my intention to conduct interviews each lasting around ninety minutes (Potter & Wetherell, 1987).

2.4.1.2. Participants

The women who were interviewed in this study were aged between 25 and 45 years old and all described themselves to be from a White British ethnic background. Two participants each had one child, seven had two children and one of the participants had one child and was pregnant at the time of interview. She later gave birth to twins and did not experience any postpartum mental health difficulties¹. Eight participants were married; two of the participants defined themselves as single. Participants' employment status included Student, Tutor, Health and Social Care Administrator, PA Administrator, Freelance PR, Freelance Trainer, Policy Manager and Housewife. Two participants lived in Greater London, three in the Midlands, two on the south east coast of England, two on the south west coast of England and one in Wales. I travelled to visit all the women in their homes or in a specified location in their local area. All participants stated that they spoke English as a first or regular language. Participants had all been diagnosed with 'Puerperal or Postpartum Psychosis' following childbirth. At the time of the interviews participants deemed themselves to have 'recovered'. Recovery was measured by the woman's sense of self at the

¹ Details of the participant's pregnancy were disclosed following agreement of participation, following careful discussion it was agreed that she would remain in the study.

time of the interview, compared to when she first experienced symptomology associated with the psychiatric diagnosis postpartum psychosis.

2.4.1.3. Inclusion and exclusion criteria

Recruitment materials were produced in English due to limited resources and therefore interviews were conducted in English. This limited participation to those who spoke English as a first language. Participants were advised not to take part in the study if they were still experiencing 'psychotic symptomology' as defined by the DSM-IV TR. The majority of women diagnosed with postpartum psychosis are hospitalised and treated with psychiatric medication, which was the experience of all the women who took part in this study (Brockington, 1996). However, the experience of hospitalisation after childbirth was not an essential inclusion criterion for women to take part in the study. All of the women were living in the community at the time of the interview. Women who were still prescribed psychiatric medication following an episode of postpartum psychosis were not excluded from participation. A woman's state of fertility was not defined as one of the exclusion criteria. Following disclosure of pregnancy by one of the participants during the research process, her participation was discussed with her and her support network was ascertained to ensure that participation would not have a negative effect on her emotional well-being during her pregnancy. It was established that she and her family had a robust network of support in place from psychiatric and perinatal mental health services and due to the nature of the recruitment she was already linked in with a peer support network. The participant continued to express a desire to take part and it was felt that excluding her from the study would have more of a detrimental effect than allowing her to share her story while she was being monitored by a network of support.

2.4.2. Research and reflexivity

In this context, I will refer to reflexivity as the ability to engage in a critical understanding of the contribution my own experiences and circumstances have in shaping this study. In this sub section, epistemological and personal reflexivity will be considered (Willig, 2001). Epistemological reflexivity refers to reflecting upon ways in which my own beliefs, interests and values could shape the research. Personal reflexivity refers to an exploration of the assumptions made

throughout the course of this study which may in turn influence the analysis (Nightingale & Cromby, 1999).

My analysis was influenced by a variety of factors, external and personal, including the opportunity to undertake a more critical approach to a qualitative piece of research, inviting the voice of women who have been diagnosed with postpartum psychosis. The aim of this study is to raise questions about psychiatric services, the treatment of women and the usefulness of the contested diagnosis 'psychosis', which could be thought of as impacting on the way this study is executed. The exploration of dominant discourses about motherhood and mental health difficulties serves to highlight literature in this field which has been dominated by biomedical, 'realist' research, drawing on gender-normative paradigms about motherhood and mental health. More personally, my position as a woman in my 20's who has not experienced motherhood, is acknowledged as an extra-discursive factor, potentially influencing how each woman taking part in the study was able to talk to me about her experience. My role as a researcher, rather than my more commonly assumed position as a trainee clinical psychologist was also considered as it is understood that research interviews can mirror therapeutic encounters, as they both serve to provide a space for people to talk about their experiences with someone who is positioned to listen (Tea & Lathlean, 2004). Careful boundaries were discussed and it was agreed that any clinical issues that arose during the interviews with the women would be discussed and reflected upon with the team supervising this study. The process of reflexivity was addressed throughout the research process by the use of a reflexive research journal (Finlay & Gough, 2008). This was used to create some space away from the immediate context of the study, to structure subjectivity and reflect upon my historically embedded subject position (see Appendix E). I was mindful that in constructionist research, the researcher is considered to co-produce the data rather than being positioned as a neutral observer (Silverman, 1997). In this study the participants were invited to view a draft interview schedule and then contribute to the agenda if they chose, prior to our meeting. This enabled them to be engaged as co-authors of the discursive interview (Kvale & Brinkmann, 2009).

2.4.3. Ethical procedure

In formulating this study I considered ethical implications through drawing on a number of questions informed by Willig (2001), including: ‘in whose interests is the proposal of the research question?’ and ‘how might the findings of this research be used by women, their families and institutions?’ Although these questions were not directly addressed in the analysis of the data, they are considered in the final chapter (see section 4.2), highlighting the implications of this study for service providers, health professionals and the participants themselves. In this study, the experiences of postpartum psychosis have been explored through the examination of women’s talk, rather than studying the direct views of institutions and policy makers. Holding these questions in mind enabled issues of power evident in women’s talk to be considered more explicitly, addressing issues of power as linked to the construction of knowledge (Foucault, 1982).

This study was registered with the University of East London (see Appendix F). Ethical clearance was approved by the University (see Appendix G). In terms of recruitment, an ‘opt-in’ method was used requiring women to volunteer to take part in the study by responding to a brief description of the research detailed in the research advert, or following email correspondence. At the beginning of each interview it was ensured that the participants had read and understood the information leaflet detailing the aims of research and that they had given written consent. I ensured that participants had the opportunity to ask further questions about the nature of the study. Following the interview, the women’s experiences were acknowledged and validated and avenues for access to further support were discussed if required (see Appendix H). Participants were asked how they had experienced the interview process and, in instances where personal or potentially distressing information had been disclosed, they were asked how it had felt sharing this. It was agreed with each participant that they would receive a full transcription of the interview and would be offered the opportunity to receive feedback following the completion of the study.

It is important to highlight that care was taken to ensure that the research method was carried out in the best interests of the participants and ethical issues that

could have arisen during the course of the study were considered. The following was taken into account:

- Prior to recruitment of participants, I liaised with key researchers in the field of postpartum psychosis to discuss the inclusion and exclusion criteria for the selection of women interviewed.
- I met with a Clinical Psychologist working in a clinical setting with women diagnosed with postpartum psychosis to consider possible risk issues and safeguarding practices.
- In the application for ethical clearance from the University of East London, ethical issues were adhered to. This included ensuring that participants were given detailed information prior to taking part in the study, they were aware of their right to withdraw and that informed consent had been obtained.
- All women interviewed had independently made links with an online support network, following the interview they were given contact details of agencies where they could seek further support.
- All women were given a transcript of the interview. This was considered to be important in validating the experience of telling their story of motherhood and postpartum psychosis and offered a written record of their account.
- My personal background in training as a clinical psychologist has positioned me as competent in being able to assess risk and alert services if I felt worried about the mental health of the women throughout the interview process.

2.4.4. Data collection and analysis

2.4.4.1. Data collection

In this study, the main research question was to explore how women, who self-identify as having been diagnosed with postpartum psychosis, construct their experience. The research question identified that in order to do this, the ways in which women use talk to describe and understand their experiences, and the discursive resources they deploy when telling their stories, needed to be examined. With this research question in mind, data were collected through semi-

structured discursive interviews with the identified research participants. The interviews ranged in length with the shortest being one hour and two minutes, and the longest two hours and 38 minutes. The average length of the interviews was approximately 90 minutes.

An interview guide was developed in order to identify questions which were based on the research aims, and theoretically driven by the existing literature identified in chapter one (Kvale & Brinkmann, 2009). The guide was used to facilitate the acquisition of the participants' construction of postpartum psychosis in the context of related events (e.g. description of their experience, treatment provision and the impact of this diagnosis on sense of self and relationships). The topic areas identified broadly covered women's experiences and consequences of receiving a diagnosis of postpartum psychosis. Questions were also raised to establish an idea of a woman's interpretation of social perceptions of mental health difficulties in the postpartum period. An awareness of the potential discourses or assumptions deployed or influencing the participants' responses, as well as identification of inconsistencies and counter-discourses was maintained. Due to the nature of the interview ensured that I was an active participant, positioned to be mindful of potential factors influencing my own interpretation of women's talk. I was attentive to the respective ways of speaking and relational styles during the interview. An attempt was made to use simple, non-professional language which did not assume any particular professional stance. Assumption of knowledge of medical terminology was avoided in order to acknowledge the variety of participant backgrounds (Patel, 1999). A conversational interview style, based on Potter & Wetherell (1987), was adopted in order to allow the women interviewed to offer and elaborate on their views. All interviews were audio-recorded using a digital recorder.

2.4.4.2. Transcription

All interviews were transcribed verbatim. In order to maintain consistency with transcription, a simplified convention was used (as per Malson, 1998) which has been adapted from Potter & Wetherell (1987). This method of transcription was considered appropriate as the study of discourse was not directly concerned with the use of rhetoric and speech patterns, but focussed on broader 'global'

discursive constructions (Malson, 1998). The transcription conventions used are detailed in Appendix I.

2.4.4.3. Process of data analysis

Although there is no general agreement regarding the procedure of discourse analysis, it is widely recognised that the process of analysis begins with transcription (O'Connell & Kowal, 1995). During transcription the original aims of this study were revisited and notes were made in my reflexive journal in order to facilitate the exploration of the women's descriptions of their experience of postpartum psychosis. The steps undertaken in order to complete a Foucauldian discourse analysis of the data generated are detailed in seven stages detailed below:

Step 1: Making notes. After each interview brief notes were made regarding the process of the interview, and initial ideas for themes were detailed in a reflexive journal. I returned to these during analysis and write-up.

Step 2: Identifying what is being talked about and how. I presented the interview transcripts in tables, creating columns in which I started the analysis by focusing on the objects, events and experiences being constructed in the women's talk. This process encouraged me to refer back to the research question and to consider what each participant was talking about at different points during the interview (e.g. health care provision, childbirth, breastfeeding, motherhood) and how she was talking about it. At this stage the practices and subject positions produced in the women's talk and how they constructed individual experiences of postpartum psychosis were also considered. A worked example of the process of data analysis in Step 2 can be seen in Appendix J.

Each interview transcript was read three times, changing the sequence to ensure that the ideas generated were not influenced by the earlier or later interview(s). In the course of the initial reading the focus of analysis was refined by identifying a starting point from which to explore the research question. During this process, it seemed that the ways in which women in this study talked about their experiences were 'problematized' in the context of becoming a new mother and

identifying as a user of mental health services. This observation served to offer a starting point for more detailed analyses, in terms of the problematic position of inhabiting the role of a good enough mother and simultaneously a mental health patient (Foucault, 1985). The first reading of the transcripts suggested that the literature needed to be re-addressed in order to explore the constructions of motherhood and psychosis. At this point an initial question was hypothesised:

“Under what circumstances are women who have experienced postpartum psychosis made to be problematic. With this in mind, what discourses and counter-discourses render the problem of simultaneously being a mother and a psychiatric patient visible and intelligible?”

Step 3: Identifying analytic foci. A range of accounts and practices operating at the level of the individual, society and institutions were identified (e.g. the influence of health care system and antenatal agencies). Through the discursive and material practices brought into view by the women’s talk, the experience of regulation and systems of power were explored, highlighting the ways in which these constructions of postpartum psychosis and the consequences of this diagnosis positioned her as ‘problematic’, grounding the analysis within the women’s talk (Arribas-Ayllon & Walkerdine, 2008). In the initial stages of coding, prominent ‘discursive sites’ were identified, which seemed to coherently present the constellation of constructions identified. The process of analysis was informed by four analytic foci detailed by Arribas-Allyon & Walkerdine (2008) which served to address the identified research question:

- 1) What technologies of power (e.g. national health services, social services, governmental policies) and technologies of self (e.g. practices engaged in to enhance status as a good mother, and a user of mental health services) are evidenced in the women’s talk?
 - What institutions of power act upon women diagnosed with postpartum psychosis to govern her conduct from a distance?

- What material and discursive ‘self-regulatory’ practices do the women engage in which serve to exercise power over herself and constrain or enable her conduct?
- 2) How are mothers with mental health diagnoses made to be problematic?
What discourses about motherhood and mental health render women who have experienced postpartum psychosis problematic?
- 3) How does the subject position of a mother with mental health difficulties allow women to speak the ‘truth’ about their experience of postpartum psychosis?
How does this subject position offer a perspective from which to view a version of reality and moral location?
- How are linguistic practices and discursive resources deployed (or not) in the interview to construct an experience of postpartum psychosis in conversation or dialogue?
 - What wider discursive and extra-discursive contexts (spoken about or not) are made possible?
- 4) How do women engage in practices of self-regulation in order to attain status as a good mother and a good mental health patient?
- How do woman locate themselves within their repertoire of experience?
 - What vantage point with respect to a version of the reality of postpartum psychosis are constructed and performed by their positioning?
 - What moral location is afforded within the conversation?

Step 4: Selecting extracts. Once the analytic foci had been identified (see above), extracts were selected from the interview transcripts that highlighted:

- Discussion of regulatory and self-disciplinary practices in relation to the self-governing practices talked into being by the women and acting at multiple levels.

- How these practices are constrained or enabled by the constructions of postpartum psychosis in order to provide a context in which the women were able to make sense of their experiences.
- The practices in which women who identify as a mother and as a mental health patient talked into being to make sense of their position.
- The women's interpretation of how others experienced their position in certain ways.
- The constructions of their experience of (and responses to) postpartum psychosis.
- The material and social practices warranted by these constructions as per the main research question.

Step 5: The construction of discursive sites. During this process, examples from these inter-connected constructions were identified. At this stage, decisions were made about which constructions were to be included in the final write up based on how they were depicted within the text and whether constructions were supported by extracts within and between interviews. Evidence of similar constructions across the talk of participants ensured greater representation of wider used constructions of postpartum psychosis. This served to highlight the lived experience of this diagnosis for the women interviewed in this study. Specific extracts were considered in terms of how they might exemplify this. Through choosing and contrasting specific extracts which demonstrated key constructions, coherence of analysis was sought. Presentation of discourses attempted to provide a narrative of how women experience postpartum psychosis. It was possible to identify groups of inter-related constructions which produced the experience of postpartum psychosis in four contexts. The main discursive sites highlighted how women's constructions of their experience of postpartum psychosis were presented in the interview and were articulated as follows:

- Institutional Framing: Constructing motherhood and madness
- Postpartum Psychosis: The Problematic self
- Lived Experience of a Duality: The fragmented self

Also identified, were the contradictory accounts or challenges to these constructions in the final discursive site.

- Survivors Story: A mad mum reclaiming a sense of self and educating

Step 6: Selection of extracts to support the identification of discursive sites. The analysis was written up, drawing upon collated sets of extracts to elaborate key constructions and demonstrate their effects through the use of chosen extracts. Extracts used to illustrate the four discursive sites were linked to relevant literature.

Step 7: Refining the discursive sites and presenting analysis. The overall analysis was systematically refined by integrating or separating some constructions in order to provide an overall coherence. This has been highlighted through the use of subheadings in the Analysis and Discussion chapter. My decision to stop analysing was primarily driven by time constraints; however I ensured that what had been presented seemed useful and answered the research questions.

In response to the research question and the four analytic foci identified, it was considered that within their talk, the woman seemed to be consistently 'problematised' in the subject position of mental health patient, while embodying the position of a mother. The next chapter will report and discuss the outcomes of the analysis in the context of the main 'discursive sites', namely: Institutional Framing: Constructing motherhood and madness'; 'Postpartum Psychosis: The problematic self'; 'Lived Experience of a Duality: The fragmented self' and 'Survivors Story: A mad mum reclaiming a sense of self and educating others'.

3.0. ANALYSIS AND DISCUSSION

The first chapter presented literature to show how women, who have experienced postpartum psychosis and self-identify as mothers and mental health patients, are rendered problematic. A variety of social and institutional practices, enabled and sustained through culturally-available and historically-contingent discourses and ideologies were identified. From the literature it can be argued that the identity of women, who have been diagnosed with postpartum psychosis, has been problematised by two dominant discourses and/or constructions that they inhabit: first in relation to the 'good mother', and second as a 'patient' who has been diagnosed with mental health difficulties and is subject to the regulatory practices of mental health institutions.

The opposing positioning's of 'mother' and 'user of mental health services' render the position of women, diagnosed with postpartum psychosis (i.e. neither able to fulfil the role of a 'good mother' or a 'good patient' at the same time), as difficult to make sense of and uncomfortable for society to acknowledge. By examining the talk of women who have been diagnosed with postpartum psychosis, this study begins to unpack the polarisation of the two positions that women with this diagnosis inhabit. The ways in which women are positioned by a psychiatric diagnosis, the technologies of power that influence how they make sense of their experience, and how these technologies are wielded in order to set up ways of being for the women interviewed, will be explored. In this chapter an analysis of the interviews with the women will be presented and a preliminary discussion offered. In doing this, reference will be made to the four analytic foci detailed in chapter two (section 2.4.4.3, Step 3). Extracts from the participants' transcripts will be used to evidence how constructions of postpartum psychosis are enabled (Arribas-Ayllon & Walkerdine, 2008). The social practices made possible by these constructions and the subject position of women who have been diagnosed with this condition, will also be attended to.

The analysis of the women's talk will be presented around four discursive sites which sustain certain positions inhabited by the women. These sites should not be considered independently, but more as an "interconnected network of

discursive practices producing the concept of postpartum psychosis and attendant subjectivities” (Morris, 2003 p.136). To clarify the main discursive sites before the reader engages with the complexity of the women’s talk please see Table 1 which comprehensively summarises the discursive practices.

Table 1: A summary of the main discursive sites identified in women’s talk.

Discursive Sites Identified	Description
1: Institutional Framing: Constructing motherhood and madness	This discursive site highlights the ‘technologies of power’ and ‘technologies of self’ that serve to construct women’s experiences of postpartum psychosis. In particular, this site demonstrates how women in this study negotiate regulatory institutions such as health care systems and antenatal agencies in order to position themselves as a ‘good mother’ and a ‘good patient’ in line with expectation. This discursive site also explores how regulatory institutions impact on a woman’s sense of self and engagement in self-disciplinary practices to ensure her status as a ‘good mother’. Key aspects of women’s experiences of femininity and motherhood are illustrated here, supporting contemporary literature in this area (Marshall & Godfrey, 2011; Crossley, 2007, Choi, et al, 2005)
2: Postpartum Psychosis: The problematic self	The second discursive site explores how women’s talk serves to problematise the constructions of motherhood and mental health difficulties and thus problematise the position of a women diagnosed with postpartum psychosis. The women in this study were seen to problematise their immediate experience of becoming a mother, identified in their reference to childbirth, early attachment experience and breastfeeding. The absence of

	<p>idealised description can be linked to feminist literature on motherhood (Crossley, 2009; Crossley, 2007; Niven & Walker, 1998) The consequential effects of a psychiatric diagnosis in the postpartum period can be demonstrated through women's description of their problematic position as a mental health service user and a mother, leaving the women feeling disempowered.</p>
<p>3: Lived Experience of a Duality: The fragmented self</p>	<p>This discursive site illustrates how the women talk into being their experience of postpartum psychosis as one of fragmentation. The extracts selected serve to demonstrate the challenge of finding a position to inhabit as a mother with a diagnosis of postpartum psychosis. The site explores in turn, the experience of motherhood and psychosis and an absence of a positive sense of self to inhabit, highlighting the discourses about mental health difficulties as counter to those of a good mother. Literature that has explored women's lived experiences of postpartum psychosis is referred to in order to identify how women have constructed postpartum psychosis in other research studies (e.g. Robertson & Lyons, 2003). Further in this study, some of the women explore the uncomfortable position of a 'mad mum'</p>
<p>4: Survivors Story: A mad mum reclaiming a sense of self and educating others</p>	<p>The final discursive site introduces a contradictory account of the problematised position previously articulated. This site shifts the gaze to examine the woman as a 'survivor' of postpartum psychosis, a subject position constructed through the talk of recovery. This construction draws on stories of strength and resilience to reframe the problematised position of a mother with mental</p>

	illness as someone who can educate others. The description of wanting to break down stigma of mental health difficulties is in line with key literature exploring the experiences of service users and the survivor movement (e.g. Chamberlain, 1978)
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These sites will be discussed in turn in the following sections.

3.1. Institutional Framing: Constructing Motherhood and Madness

This section will study the processes by which postpartum psychosis becomes constructed within women's talk. This will be considered firstly, through the action of institutional practices that govern a woman's conduct as a mother and as a mental health patient; and secondly, through the response to ideological accounts that serve to shape the woman's actions and identity through the obligation of self-disciplinary practices (McNay, 2009).

3.1.1. Negotiating technologies of power: Being a 'good mother'

The term 'technologies of power' refers to "any assembly of practical rationality governed by a more or less conscious goal" (Rose, 1996 p.26). Foucault (1982) mentions such technologies in terms of an approach by which individuals are able to understand themselves. In this context, 'technologies of power' are constructed as institutional practices acting upon the woman to regulate her conduct and influence a sense of identity. The institutional practices of note are those within the awareness of these women and talked into being within their accounts, and which serve to exercise power over their conduct. In the context of postpartum psychosis, the following extracts draw upon how the women focused on health care institutions, but also talked about the practices of other agencies (e.g. antenatal organisations, social services) to inform their sense of what it means to be a 'good mother'. The following extract is taken from the interview

with Hannah², and demonstrates the influence of health care systems on the practices of motherhood.

Extract 1: **Hannah:** I said that I had wanted to try and breastfeed, so we tried, one of the nurses came in to help me in the night but he [the baby] just wasn't establishing so they cup fed him with formula. They kept me in for two days to try and establish it and my assigned midwife was very pro breastfeeding, and that is where I think (.) you know, it could have started.

Catherine: Right. So you struggled with breastfeeding initially and then, when were you discharged?

Hannah: Erm, well they kept me in for two days to try and establish the feeding.

Catherine: Was it just not successful?

Hannah: No, I just *couldn't do it, couldn't latch*, so

Catherine: Which I think is the experience of other women too.

Hannah: It is but when you're told that it's the most natural thing in the world and that anyone can breastfeed, if you want to (.) you know. I hadn't slept for hours because I had been in labour. As a first time mum, you know you want to do what's best for your baby and whenever you go into these baby units you are bombarded with breast is best (**Hannah:** 65 – 78)

In this extract, Hannah constructs her early experience of motherhood in the context of breastfeeding. Ideas about breastfeeding have been informed by health care institutions and imparted by professionals, in this case Hannah's '...assigned midwife ...'. The construction of breastfeeding as best practice and the discourse of '...breast is best...' is reflected in clinical guidelines and literature made available for new mothers (WHO, 2002). In discussing her problematic experience of breastfeeding, Hannah talks into being an explicit 'technology of power'. The advice and recommendations provided to new mothers by health services enacted to regulate the behaviour of new mothers and promote

² All the participants' names have been changed to protect confidentiality. The names used are pseudonyms

breastfeeding as the best way in which to feed and nurture a baby. A similar account of the dominant medical and social discourse of '...breast is best...' (Stanway & Stanway, 1978) was discussed by all of the women who were interviewed and has been alluded to in Extracts 6, 11, 12. In this extract Hannah described feeling '...bombarded...' with information about feeding and good practice as a mum. She describes being told that breastfeeding is '...the most natural thing in the world...' and that '...anyone can breastfeed...' setting up a certain judgement about the role of a mother in the context of desirable ways of being (Crossley, 2009; Marshall & Godfrey, 2011), simultaneously positioning her as unable to be a good mother as she '...couldn't do it...'.

The constitution and enactment of regulatory institutions and the discourse about breastfeeding being 'the best', draw not only on material resources (i.e. health care guidelines and information provision), but also on gender-stereotyped social accounts of motherhood informing practice (e.g. motherhood as natural and intuitive; Nicholson, 1998). The effect of such discursive constructions is for a woman who isn't able to breastfeed to be positioned as an incompetent mother, and in this position she is called upon to accept professional help without complaint. The health care institution has created a system in which a new mother is hospitalised, or '...kept in for two days to try and establish...' breastfeeding, locating early difficulties in motherhood firmly in the women, rather than identifying her baby's difficulties in latching on to feed. Thus, enabling judgement on competence to allow, or not, the woman to carry out her role independently. Nursing and midwifery health care professionals are positioned to construct what is normal and as a consequence, what is not normal. They are agencies that provide help and support, and do so by monitoring the efficiency of breastfeeding. The construction of health care professionals as knowledgeable and powerful ensures that women do what is thought to be best for her baby, thus a woman is called upon to engage in self-disciplinary practices (Foucault, 1988), such as breastfeeding, to ensure her status as the right kind of mother.

In the next extract, Anna draws upon independent organisations outside medical health care institutions that have been set up for women in the antenatal period to promote ideas about, and create certain expectations about, motherhood.

Extract 2: Erm (.) I think at antenatal classes there was definitely a realism that it could be the best and the worst of times so there was an acknowledgement that it was nerve wrecking and amazing all wrapped up into the same bundle ... so that was good. There wasn't really any discourse about ... what if things go horribly wrong. We don't want to talk about still births or severe mental illness (**Anna:** 385 – 389)

Here, Anna talks into being an implicit 'technology of power' that is enacted through antenatal agencies to regulate expectations and inform the practices of women who are expecting a baby. From Anna's account a key aspect of this technology is that a '...realism...' about motherhood is acknowledged, on the surface, encouraging a balanced view. However, she identifies an absence of any discourse about '...less desirable realities'...' that can be experienced in motherhood. It seems that antenatal agencies have used their position to create a 'truth' about motherhood which is unable to consider the unspeakable, such as severe mental illness, and in turn acknowledge women's experience of postpartum psychosis. The effect of this 'technology of power' is for Anna to feel constrained from acknowledging difficulties that others '...don't want to talk about...'. The construction of motherhood created by agencies such as antenatal classes, have acted to silence women who have experienced things going '...horribly wrong...'. Anna highlights the inconsistency of her experience of motherhood and the description of difficulties acknowledged by the antenatal classes. In the following extract the position of antenatal agencies in the preparation for motherhood during pregnancy is discussed. The absence of an acknowledgement of possible problems in the postpartum period is highlighted.

The next extract explicitly names the practices of antenatal organisations as acting to enable and empower women.

Extract 3: Then I went to NCT classes, I did a lot of preparation, I wanted to be prepared for the birth. Nothing about afterwards though, it's all concentrated on the birth which led me to believe that you could be

in control of what you wanted to happen during the birth ... that is definitely a fallacy. They did try to empower you (**Nicola**: 34 – 37)

This extract frames an antenatal organisation (NCT) as an agency that sets up ways of being as a mother and/or parent. Antenatal classes are constructed as places that women can feel prepared, consistent with research suggesting that feeling more informed about pregnancy, childbirth and parenting can reduce feelings of anxiety (Barlow et al, 2010). Ideas about empowerment are discussed, acting with the intention of offering a mother a sense of agency and opportunity to develop the new skills expected of mothers. Nicola described the belief that a woman could be in control of childbirth as a ‘...fallacy...’ which brings into stark reality her own experience of childbirth and the onset of postpartum psychosis, suggesting her feeling a loss of control, disabling her position as a mother .

3.1.2. Negotiating technologies of power: Being a ‘good patient’

These next extracts bring into context the culturally available accounts of mental health difficulties and the enactment of ‘technologies of power’, such as mental health services, on a woman’s conduct when experiencing difficulties. All of the women who were interviewed in this study had sought support from mental health services in response to experiencing difficulties in the postpartum period. All of the women spent a period of time following the birth of a child in a mental health inpatient facility, namely psychiatric wards in a general hospital, or more specialist services such as a mother and baby unit’s (MBU). In the context of crisis, the women were diagnosed with ‘postpartum psychosis’ and positioned in the role of a mental health patient. In their talk, the women focused on the ‘technologies of power’ that informed their position, including mental health care institutions and the professionals who work within the health care systems. In the next extract, the initial contact with health services, following experience of mental health difficulties in the postpartum period, is constructed.

Extract 4: The mental health team asked questions about my childhood, my schooling, really irrelevant stuff that would only ever come out in years of therapy /**Catherine**: Mmm/;. At the end of that they still had no power to do anything and I had to wait hours for the crisis team.

It was a kick in the teeth that they were the only ones who could admit me to hospital. We arrived at A&E at two in the morning and it wasn't until six that evening that the crisis team came. The women that came just held my hand and said, "I can help you", and that was a relief. I just thought that someone will know what's wrong. She asked if I wanted to go and if I hadn't I would have been sectioned, she didn't say that but I was desperate for help so I willingly said I would be admitted. You don't realise that once you have said you will be admitted, it's not so easy to come out again
(**Nicola:** 256 – 264)

Nicola discusses positions of power as informed by the ability to exert control and make choices. The construction of the hospital system and mental health professionals is informed by their position of power in being able to '...admit...to hospital', and to '...section...'. The individual that exerts this control is not explicitly identified in a role or vocation; however they are framed as enabling; as someone who could '...help...', which seemed to provide a sense of relief. It has been suggested that the mechanism of power operates to produce knowledge about mental health difficulties and therefore informs the activities of health and social care systems (Foucault, 1972). Power is seen to act out in the relationship between Nicola as a patient and the system in which she is positioned, to make sense of her identity as a woman diagnosed with postpartum psychosis. Nicola's talk brings into focus her position as informed by the material practices of power such as sectioning with which she describes cooperating. The following extract identifies social services as operating from a position of power; the disempowered position of Nicola and the importance of cooperation is once again highlighted.

In this extract, Emma discusses her actions as a mother and a mental health patient as governed by regulatory agencies.

Extract 5: **Emma:** Well I wasn't able to fight my corner really because they had all the power. We gathered that if they decided to go for a care

order then it would happen very, very quickly, we wouldn't have a chance; well there was a big risk basically.

Catherine: It sounds like you felt vulnerable.

Emma: It wasn't worth the risk of saying no, I'm not going to do what you say, that's not cooperating with social services which you don't want to do, *you have to cooperate*. The fact that cooperating meant losing my liberty and being locked up in a psychiatric unit, apparently that's a reasonable request /**Catherine:** Right/; So, it wasn't a good introduction to the place basically. At the time when I was admitted there was this meeting that involved social services and the ward manager at the MBU [Mother and Baby Unit] and there was a question mark whether I met the clinical threshold to be admitted, if was I really ill enough (**Emma:** 195 – 204)

Here Emma talks explicitly about the construction of power within the mental health system that is enacted through practices such as detainment and sectioning. Clinical thresholds are set up by governmental bodies and act as 'technologies of power' in that they offer guidance and thresholds for professionals to inform the best pathway of care for a woman who is presenting with mental health difficulties in the postnatal period (NICE, 2007). The sense of assuming the position as a mental health patient is described by the act of cooperating with the systems in which the women find themselves. The use of the term '...they...', in a description about the distribution of power, suggests the feeling of being 'other'ed', highlighting the disparity in power between the professional and the patient. From Emma's account, a key aspect of involvement of social services is the coercive threat that she will lose custody, or access rights to her baby, unless she exercises cooperation and accepts a loss of her own sense of liberty. The effect of 'technologies of power' is for Emma to be constrained from undermining the position of a 'good mother' through cooperating with prescribed treatment and management of difficulties in the postpartum period. Thus, she is positioned as a user of mental health services, and seen to require external support in caring for her baby.

The next sub section moves on to explore how regulatory institutions impact on a woman's sense of self and how she is required to engage in self-disciplinary practices to ensure her status as a 'good mother'.

3.1.3. Negotiating technologies of self

The process by which individuals acknowledge and respond to ideologies enables the development of a framework in which they are able to recognise themselves as 'subjects'. Ideology in this sense is defined as "the imaginary relationship of individuals to their real conditions of existence" (Althusser, 1971 p.162). In this instance, the ideologies examined are the social, cultural and historical discursive practices recognised by the mother who has received a diagnosis of postpartum psychosis, as revealed in the women's talk. The women's accounts illuminated practices of self-discipline or 'technologies of the self' (Foucault, 1988) which served to exercise power over her identity and conduct, particularly help-seeking. The following extracts begin to explore how women regulate themselves and enhance their status as a mother and/or user of mental health services. Located within the interaction between the interviewer and the women, it can be seen that the women engage in normalising practices in order to conform to prevailing discourses on good motherhood (e.g. Choi, et al, 2005) and expectations of a mental health patient. In the following extract, the use of social interaction through social media fora is described as a way of self-disciplining through the careful monitoring of descriptors of behaviour that can be observed by others.

Here, Sarah's description of social interactions serves to promote a certain way of perceiving herself as a mother.

Extract 6: Then I got a bit obsessed with Facebook, I was always putting photos and stuff up because I thought that it appeared like I was a good mum. Erm, and I became the same about breastfeeding, I had to breastfeed. It was like if I didn't do that they would know that I had taken no interest in all the other stuff (**Sarah:** 155 – 159)

Sarah articulates an awareness of her idealised status by dominant social accounts that place mothers in a position of being identified in a certain way (Lewis & Nicolson, 1998). She talks into being the socially conditioned ability to nurture and provide for her baby through focusing on ‘...breastfeeding...’ and by ‘...putting photos...’ of her baby on Facebook. In doing this, the construction of a good mother as someone who breastfeeds and takes an interest in her baby serves to problematise Sarah’s position as a mother who was experiencing mental health difficulties. She describes her behaviour in the role of a mother as governed by what others thought she should be doing in order to appear in a certain way, reducing the role of a ‘...good mum...’ to the ability to be able to successfully breastfeed. By engaging in self-disciplinary practices she resists exposing the difficult experiences as a new mother. It might be speculated that Sarah seeks to publically position herself as a ‘good mum’ via Facebook in order to avoid the less favourable alternative, suggesting that she is performing good mothering, but not really engaging with it (Butler, 1990). In order to regulate the social perception of Sarah’s position as a mother, she is able to action control over how she is perceived by choosing not to disclose thoughts and behaviours that are incompatible with the idealised view of motherhood.

In the next extract, Nicola’s talk frames her experience of a motherhood that does not fall in line with culturally acceptable discourses.

Extract 7: I don’t think I thought that far, I think at that point it was more desperate just to survive and to keep him [the baby] safe, I don’t think I got as far as I can’t tell them otherwise I am going to be a bad mum. It certainly stopped me revealing once I was well. I hadn’t realised that I hadn’t told my husband that I had attempted to kill myself, and had thoughts of harming him [the baby]. I didn’t realise I had attempted to slit my wrists until I had a flash back, and 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. Even intrusive anxious thoughts are hard to understand if you have not had them (**Nicola:** 364 – 370).

Here, Nicola constructs herself as a mother with ‘...intrusive anxious thoughts...’ and through her talk identifies as a member of a marginalised group experiencing the ‘...inconceivable...’. She describes stopping herself from revealing her thoughts of harming herself and of harming her baby in order to protect her identity as a good mother. In doing so, she constructs an apparent ‘technology of self’ that acts to silence sharing her thoughts that would risk her being exposed as ‘...a bad mum...’; a mother who thinks about harming her own child. She refers to her experience of psychotic symptomology as ‘...hard to understand...’ suggesting that pathologised thoughts and feelings, that do not fit with the idealised view of motherhood, are difficult to communicate. Nicola describes not telling her husband about her thoughts in the context of postpartum psychosis, although she identifies that this was an unconscious decision, it serves to isolate her in the experience of postpartum psychosis. This is consistent with literature that suggests that the experience of fathers and husbands has been neglected or dismissed (e.g. Robertson & Lyons, 2003).

The ‘technologies of self’ that operate through interaction seemed to enable the women who were interviewed to enhance their status and make sense of their position as a woman with a diagnosis of postpartum psychosis, in a way that is socially accepted. In the following extract, Mary describes that challenge and her ‘...struggle to find a way of describing...’ her experience as a mother. Mary constructs her experience of mental health difficulties by highlighting the relational component of being a mother.

Extract 8: Catherine: What was your relationship like with your daughter; did you feel like you bonded with her?

Mary: I did yeah, very much. I always struggle to find a way of describing this, I think about while I was ill and while I was depressed as two separate things. While I was psychotic or manic or mad, I don’t know, I call it ill /**Catherine:** Okay/; that’s how I do it in my head. While I was ill with the manic thing, I was very much bonded and felt very attached to her, but once the depression kicked in that’s when I felt very detached. As that came about I

started to believe that she wasn't my baby, she couldn't be my baby because I didn't feel right towards her (**Mary:** 471 – 477)

This extract highlights Mary's constructed experience of postpartum psychosis. She uses the term '...ill...', a well-used euphemism, which could be seen as more neutral than psychiatric terminology. This serves to replace the word psychosis which is laden with negative connotations and stigma informed by historical constructions (Boyle, 2002). It could be understood that Mary is separating incidents of being '...ill...' and '...depressed...' in order to help make sense of her experience. Her ideas about being a '...good mother...' are informed by the social practices of motherhood, namely the process of attachment or bonding with her baby (Kalus & Kennell, 1982). In this framework, she is able to identify a sense of connectedness through her experience of postpartum psychosis, however she problematises '...depression...' as preventing her from fulfilling her role. She talks about denial of her role as a mother in the face of not feeling '...right...' towards her baby. She describes feeling '... detached...'. This could be suggestive of an attempt to preserve her sense of self, or offer a realist view of her symptoms. It is possible that she is distancing herself from her experience of mental health difficulties in the postpartum period as there is an absence of a positive dialogue about mental health and motherhood to refer to. She describes postpartum psychosis as a '...manic thing...' suggesting that it is tangible and not part of her. Through her description of postpartum difficulties, in the context of an interview, self-disciplinary practices can be seen to be in operation to highlight the different positions which Mary talks into being. This included the more desirable sense of self as a mother who was able to feel '...bonded...' and '...attached...' to her baby.

This section has served to illustrate the ways in which the women's talk constructed certain institutional practices as 'technologies of power' (Foucault, 1982) acting on the woman from a distance to constrain her identity and conduct as a mother with a diagnosis of postpartum mental health difficulties. In so doing the women talked into being two 'technologies of power'. Firstly, health and social care institutions which were identified as promoting idealised views of motherhood through the actions of mental health professionals and social

services. Secondly, antenatal organisations, namely NCT, that are set up to encourage women to be prepared for motherhood, but without an acknowledgement of less desirable realities of motherhood. The technologies of power, talked into being by the women, served to render the women as inexperienced and less knowledgeable about motherhood and mental health and therefore positioned them as disempowered. The effect of this was to produce the women as compliant with the requests of institutions in order to fit in with idealised expectations. Furthermore, the women's apparent 'interpellation' (Althusser, 1971) by ideologies about motherhood as natural and intuitive, was indicated by constructions of 'technologies of the self' (Foucault, 1988) and the exercise of self-identity and conduct perceived by others, namely promoting themselves in the role of the 'good mother' through social interactions and silencing undesirable thoughts and feelings associated with psychotic symptomology.

The next section will discuss the second discursive site identified in the previous chapter, namely 'Postpartum Psychosis: The problematic self', bringing the way women have constructed postpartum psychosis into focus. The consequences of ideologies set up by 'technologies of power' and 'technologies of self' (Foucault, 1982) will be explored, considering the position of women who have experienced postpartum psychosis and how women's talk renders them marginalised and problematic.

3.2. Postpartum Psychosis: The Problematic Self

In constructing the experience of postpartum psychosis various accounts were deployed, which served to produce the presence of a diagnosis of 'psychosis' and becoming a new mother, as problematic in terms of both the immediate experience and its consequential effects on the woman. These constructions had different implications for the subject positions of the women as both a mother and a mental health patient. The women's talk constructed their immediate experience of motherhood as a site of challenge in terms of coping with their problematic experiences of childbirth, attachment with the baby and breastfeeding. In this section, the woman's accounts are presented to highlight

the woman's problematic experience of becoming a mother and being in receipt of mental health services. The way in which women problematise their experiences brings into view the polarisation of these two positions.

In this extract, Mary's talk problematises her experience of childbirth by highlighting the disparity between her own experience and the representations of childbirth portrayed in the media.

Extract 9: Yeah and the baby gunk is all over you, it's not like on the telly <both laugh>. And the thing is then, erm ... she was born and then he [woman's husband] was straight on his phone, then he left quickly and didn't hang about. I was wheeled, well they put you into a wheel chair because they are born on a labour ward then you go off to the maternity ward. So I was just taken there and nobody was around and I thought I should get some sleep because it was nine in the morning and been in labour through the night. I just couldn't sleep at all, not even resting. I was really traumatised by the birth. The thing is I think you would normally be really traumatised by that kind of thing but I had a really difficult birth with my first and I had nothing like that. I didn't have that, every time I shut my eyes, I was in labour again. It was like a haunting thing, and it was really vivid
(Mary: 117 – 126)

Mary constructs her experience of childbirth in terms of an event by which she was '...traumatised...' by using symptomatic language such as '...haunting...' and '...vivid...'. This rhetoric is consistent with the symptomology of post-traumatic stress disorder (PTSD) as defined by the DSM – IV. She does not draw on traditional, idealised social accounts, which construct 'normal' childbirth experiences as natural and fulfilling (Woollett & Nicolson, 1998), rather Mary reports '...baby gunk is all over you, it's not like on the telly...'. In describing her own reality, Mary acts to isolate herself from the dominant view, she describes feeling isolated and alone '...nobody was around...'. The role of her husband is minimised '...he left quickly and didn't hang about...', consistent with previous research into postpartum psychosis where a husband's role is often dismissed

(e.g. Doucet, et al. 2012) As Mary is taken from the labour ward in a ‘...wheel chair...’ the position that seems to resonate with her at that time was one of a patient. This could be understood in terms of in the absence of an ‘idealised’ experience of childbirth and motherhood (Crossley, 2007). Through Mary’s talk, she constructs an account of a positive birthing experience, positioning her own experiences as problematic. In the following extract, the woman’s position of a mother is problematised by referencing idealised views of attachment and bonding with the baby following childbirth.

The next extract highlights how Nicola constructs her emotional experience of motherhood.

Extract 10: I thought, I should be sitting here gazing at him and loving him but I couldn’t look at him [the baby]. I remember turning away and feeling that something was wrong. I thought I needed to get some sleep, but it was different to how I felt with my second child, but I didn’t know at the time. I didn’t feel right. I didn’t feel lots of love towards the baby I was holding. I actually just wanted someone to come and take him from me so I could recover (**Nicola:** 78 – 83)

Nicola refers to motherhood by using idealised terminology such as ‘...gazing...’ and ‘...loving...’. These actions and emotions are constructed as something that she felt should have defined her immediate lived experience, but rather she ‘...couldn’t look at him...’, ‘...didn’t feel lots of love...’. Nicola seeks to emphasise that she recognised that her emotional reaction to motherhood was ‘...wrong...’ and that she ‘...didn’t feel right...’. She talks about the importance of needing to ‘...recover...’ from having a baby, needing to sleep and wanting someone to take him so she could recover. The construction of the ‘good mother’ has been defined by the availability of a woman to care for and nurture her baby (Weaver & Ussher, 1997), serving to problematise the beginnings of motherhood for Nicola.

Further to the description of problematic childbirth and developing an attachment with the baby, the practice of breastfeeding informs how women feel able to position themselves as a ‘good mother’. How the practice of breastfeeding is

constructed by technologies of power, such as health services, was discussed in the last section (e.g. Extract 1). However, this extract highlights the consequences of expectations of breastfeeding and how this practice of motherhood can serve to problematise a mother.

Extract 11: Claire: Yes, yes, because you've got the anxiety of this child that you are trying to keep alive and you can't get the milk from your body into her body, which is a major frustration, so you've got frustration, anxiety, on a level that you have never experienced before.

Catherine: The stress of motherhood I suppose?

Claire: Um hum ... yep, yep, and the stress of trying to breastfeed because it's the best <laughs> I really wish I had given her formula sooner or tried to mix feed or something, rather than get really, really, really, blistered and infected nipples that you couldn't feed through and that were unbelievable painful to cure. You know I mean, mastitis is the worst, they put cows down because *it's so painful*. It's so unbelievably bad <laughs>, and you get flu with it, so you get fever (.) you're very ill, it was a very bad case (**Claire:** 272 – 281)

In this extract, once again the role of a good mother is defined by the experience of breastfeeding which is constructed as a process with which to '...keep [the baby] alive...' yet for Claire, her experience of breastfeeding is constructed as '...frustration...anxiety...unbelievably painful...you get the flu...fever ...ill...'. In the absence of idealised language, Claire creates a stark comparison to the practice of breastfeeding constructed as part of the 'good mother' discourse (Niven & Walker, 1998). She focuses on a physical description of symptomology offering her own crude reality of breastfeeding. Claire's reality is of inhabiting a body that is dysfunctional by reasons of mastitis, described as '...really, really blistered...', '...so painful...'. She describes symptoms of a diseased body, suggesting that the physiological consequences of breastfeeding can be constructed as rendering someone to be '...put down...'. The medicalisation of motherhood is evidenced by the use of symptomatic language; which is seen in

other accounts of women's experiences of motherhood, serving to problematise their positions. The detachment from emotional experience could be seen as a protective strategy in the absence of alternative discourses about motherhood and problems encountered. Claire's talk clearly suggests that the sense of expectation that is informed from culturally available discourses about practices, such as breastfeeding (Crossley, 2009), positions her in a place of responsibility to ensure that she is seen to be providing the best for her baby, with little consideration about what may be best for her.

The construction of motherhood as the enactment of a relationship in which a woman cares for, protects, and provides for her baby (Woollett & Phoenix, 1996), brings into stark reality the complexity of the position of a mother as a mental health patient. The role of a mental health patient within the health care system requires the individual to comply with treatment programmes, removing a sense of individual responsibility and disempowering the individual patient's ability to position themselves as a carer for others. The next extract highlights the problematic position of a mental health patient, and how Laura's adherence to prescribed medication impacts on her ability to fulfil the role of a 'good mother'

Extract 12: Yeah, but I think I was in the hospital a week or two before they actually sorted out proper medication, erm (.) but, one of the medications they put me on, I don't know if it was the wrong one? I couldn't sit still, I'd be feeding [names baby], I had to stop breastfeeding, and I would just put him down and go off somewhere because I had to keep walking round all the time (**Laura:** 104 - 108)

Here, Laura discusses her position as a mental health patient and a mother. Her position as a patient requires compliance with treatment plans and the administration of medication; however, this is met with the challenge of being unable to fulfil her role as a 'good mother' due to difficulty with breastfeeding because of the experience of taking medication and its identified side effects (needing to go off, walk around). A mother with mental health problems is made to be problematic by provision of treatment, such as medication, in which a woman's ability to carry out the expected roles of a mother are put under strain.

There is an expectation of looking after one's self and being removed of other responsibilities in the position of a mental health patient, which contradicts ideas of togetherness that informs the good mother discourse (Weaver & Ussher, 1997). Winas (2001) discusses the side effects of antipsychotic medication, highlighting that there are minimal guidelines regarding the use of medication while breastfeeding, positioning mothers with mental health difficulties as problematic within the mental health system.

In the next extract, social work professional's construction of a problematic mother with mental health difficulties is highlighted, rendering the position of women with a mental health diagnosis as disempowered.

Extract 13: Rachel: Social service said quite openly that they will always treat me with a high index of suspicion because I have had mental health problems.

Catherine: How does that feel?

Rachel: (.) I understand why they do it. I have got the GP to write a letter about what postpartum psychosis is, the fact that I have recovered and that I am functioning as a normal person, that they have no concerns about me other than what they would have about any other mother. People don't get it. I know that they are trying to protect [names baby] but in a way they put us through so much stress. It's my husband it affects more, because he remembers the very first time round and how awful that was, whereas I don't remember as much (**Rachel:** 500 – 508)

Rachel positions herself as a mother in the context of having once inhabited the position of a patient, highlighting how she is always, already now seen as problematic by social services which act to govern the behaviour of parents and serve to protect the well-being of infants. Following a diagnosis of postpartum psychosis, Rachel constructs her changed identity as a mother, describing herself as someone who will be treated with a '...high index of suspicion...'. She acknowledges her position as someone who has experienced mental health problems, and is stripped from her identity as a '...normal person...' who is able

to protect her daughter. Rachel is seen to be problematised and disempowered, having to rely on a health professional, namely her GP, to attest to her status as a mother. She suggests that she is positioned by the label 'psychosis' and others are unable to see past this, informing judgement of her reputability as a 'good mother'. The psychiatric label postpartum psychosis is seen to dehumanise Rachel (Rosenhan, 1973). Previous research into women's experience of postpartum psychosis has suggested that due to the bizarre nature of acute symptoms of postpartum psychosis, fear and anger can be provoked in mental health professionals (e.g. Engqvist, 2007). Here, the diagnosis of postpartum psychosis can be seen to instigate an external body, in this case social services, to take responsibility for what would be expected to be a mother's role in protecting her daughter. This extract brings into context the wider effects of postpartum psychosis on family members. She positions her husband as someone who has experienced postpartum psychosis alongside her and acknowledges the effects of the memories he holds of this time. She suggests that her husband holds different memories, and in a sense he is positioned as more affected as she is protected by not being able to remember.

The construction of an idealised mother and a mental health patient who is compliant with treatment has illustrated the complex conditions surrounding these women. Using symptomatic language as a rhetorical device to highlight their problematised position, creates a distance between idealised constructions and lived experience of motherhood. The next section discusses the third discursive site, 'Lived Experience of Duality: The fragmented self'. How the women construct their immediate problems as negotiating 'discursive dilemmas' in how to respond to their position as a mother diagnosed with postpartum psychosis, will be explored. These dilemmas include 'Motherhood with psychosis: No sense of self to inhabit' and 'The uncomfortable position of a mad mum'.

3.3. Lived Experience of Duality: The Fragmented Self

The lived experience of motherhood and the onset of psychosis have been problematised in the women's talk, addressing incongruence between the fantasies and the reality of motherhood. The onset of postpartum psychosis

seems to serve not only as a challenge to a woman's sense of self, but also as a call to action to respond appropriately in her role(s) of mother and mental health patient. Ways in which the women talked about their experiences are identified in this section. The first concerns the ways in which the identity of a mother and a patient are separated in the talk of women. The second concerns how the women make attempt at positioning themselves as a mother alongside the diagnosis of postpartum psychosis, creating a new discourse in order to describe their experience as a 'mad mum' (e.g. **Claire:** 405 – 419). These positions will be addressed in turn.

This extract highlights the challenge of finding a position to inhabit and identify with as women with a diagnosis of postpartum psychosis. This 'discursive dilemma' was difficult to articulate and make sense of, which is seen in the rhetoric Jess deployed in responding to questions about her experiences.

Extract 14: Jess: It was the middle of the night so he [husband] was going to go home and thought everything was okay, but for me it was instant, as soon as I gave birth I felt that I was not me. Obviously this psychosis had happened.

Catherine: Okay, how did you feel like not you?

Jess: I suddenly felt (.) I'm not sure, at the time after the baby, it's hard to articulate, I didn't have the elated things after the baby. I was taken to the ward and I then started to become really paranoid, it's really hard to explain, I can really visualise it (**Jess:** 74 – 80)

In this extract, Jess describes her lived experience of becoming a mother and the challenges of 'psychosis'. Her difficulty in articulating what happened can be understood on the level of her being unable to make sense of her experiences in the problematised position of a woman who experiences 'psychosis' in the context of becoming a new mother. Jess is rendered speechless, literally; she is unable to use talk to produce a construction of postpartum psychosis that makes sense to her '...it's hard to articulate...it's really hard to explain...'. Jess reports that she is unable to put words to her experience, but she can '...visualise it...' giving her description of postpartum psychosis a dream like quality. It could be

seen that when she tries to put this 'dream into words' it gets lost and becomes more difficult to make sense of. With the absence of other people's accounts and the limited information about postpartum psychosis made available to women, she appears to find it challenging to make sense of her position with no helpful discourse about 'motherhood with psychosis' to relate to. It might be speculated that the theme of absence is evident also when she describes '...I felt that I was not me...' suggesting an absence of a sense of self as 'me' (Robertson & Lyons, 2003). Jess shares, '...I didn't have the elated things after the baby...' proposing an absence of positive affect following the birth of her baby. In the context of postpartum psychosis, Jess is seen to articulate an absence in her identity as a 'good mother'. She positions herself as passive in the process of psychosis which '...had happened...' removing her from a position of control and agency expected from a woman who is a mother according to social discourse (Woollett & Phoenix, 1996).

The absence of women's descriptions of their sense of self as a mother in the context of experiencing 'psychosis' brings clearly into focus the problematic position of postpartum psychosis and the reality of women finding it difficult to articulate their experiences. The next sub section will explore the absence of a sense of self to inhabit.

3.3.1. Motherhood with psychosis: No sense of self to inhabit

In the following extracts, it becomes clear that the problem encountered in the women's talk is that there is no subject position in which they are able to make sense of their status as a mother and a mental health patient. In the next extract, Jess discusses her experience of being a mother compared to the reported experience of others.

Extract 15: Jess: I think that's probably the main reason why you don't want to tell people. Because, the initial ... you do feel like a terrible mother and feel such guilt, still now.

Catherine: Where has that come from? Is it social perceptions of what mums should be doing?

Jess: It's social perceptions, but it's also how you feel ... physically. You have had a baby, but you can't care for it. Also, this kind of animal instinct of trying to protect them, and that you protect them so much that you go the other way. It makes me question how come I couldn't look after her [the baby], what would have happened if no one had been there to feed her because I was off being mental. You feel really like that's not what you are meant to do. You do see pictures of mums and buggies and I feel that I missed out on that this time. It's something that you don't discuss in your mother and baby groups. It's a horrible women's nature that we just compete, who did this and who did this best. I think that people who become poorly never get help from the network because they are so embarrassed (**Jess:** 509 – 520)

As a result of discourses about mental health difficulties that are counter to those of a good mother, Jess positions herself as a '...terrible mother...' in the public domain by being unable to ...'care for...' her child, which suggests an inability to be a good mother as defined by idealised constructions of a mother as a carer. Jess talks into being the construction of motherhood as natural and intuitive '...how you feel physically...', '...this kind of animal instinct...' (Woollett & Nicolson, 1998) highlighting her agency in being able to protect her baby to enable her to make sense of her position as a mother. A version of reality is constructed here in which if a woman is unable to care for her baby she is unable to inhabit the identity of a mother. In the context of postpartum psychosis, she is '...off being mental...' dismissing her abilities to be a mother, constructing a new role of 'being mental'. On having to negotiate multiple identities, and the need to regulate behaviour to conform to idealistic views, Jess suggests that the complexity of the effects on sense of self and societal judgement may constrain her agency to respond to her experiences of postpartum psychosis and seek help. Shame and embarrassment are used as tools to prevent help seeking, highlighting the use of negative emotions as regulatory tools. To feel '...embarrassed...' is a powerful tool of exclusion (especially in the middle classes), regulating those who can seek help by constructing certain conditions in which one can voice, or not voice, their lived experiences and emotional

response. The perception of ‘...horrible women’s nature that we just compete...’ is not normally referred to in Western culture, where men are competitive and women are gentle and caring (Bulter, 1990). By constructing women in this way, Jess is subverting ideas of femininity.

The following sub section addresses the separation of experiences of motherhood and ‘psychosis’ and explores how the women who were interviewed made an attempt at positioning themselves as a mother who has been diagnosed with postpartum psychosis.

3.3.2. The Uncomfortable Position of a Mad Mum

It was evidenced in the women’s talk that they found it difficult to merge their experience of motherhood and mental health difficulties and found it challenging to comfortably inhabit either position, because in each position they brought in the problematised construction of the other. This serves to highlight the disparity in social constructions of motherhood and madness. In their talk, a separation between these experiences can be observed. The following extracts begin to explore the uncomfortable position of a ‘mad mum’.

In this extract, Claire brings together her experience of motherhood and psychosis by highlighting how others construct her reality through their talk and actions. Greater integration of experience was evident throughout the interview with Claire. She had been diagnosed with mental health difficulties prior to her experience of postpartum psychosis and it seemed that her sense of being able to identify as a mental health patient was already constructed as more integrated into her sense of self.

Extract 16: ... trying to make friends through NCT, and it was dreadful, because I’m very open about my illness. I’m very open about my experience, and only had one actually bad experience, when a mum agreed to meet me for coffee and then definitely stood me up, I’d say (.) you know, I rang her and she was like “oh, had we arranged to meet?”, and you could tell she probably didn’t want to get involved with a mad mum, so to speak. But it was the level of

banality, around being a new mum, talking about nappies, discussing which stupid club you were going to go to next <inaud> the level of conversation, erm (.) <tuts> I don't know why it did my head in so badly (.) because they are nice people, but I certainly didn't make any lifelong friends in that time, apart from a really good nanny friend (.) I guess, you know, people say, I haven't seen you around, and you know, you explain, I've been in the mother and baby unit because I want psychotic, but nobody knows what psychosis is <laughs> They just think psychotic killer in the street, that's the level of understanding of psychosis, that's what they see in the news (**Claire**: 405 – 419)

In this extract, Claire labels herself as a '...mad mum...'. She refers to dominant discourses about psychosis that are depicted in the media, describing sensationalised ideas about '...psychotic killer [s]...' highlighting a lack of knowledge and understanding about the nature of psychosis (Sarbin & Mancuso, 1970). She described the realities of motherhood, the '...banality...' of routines and expectations '...level of conversation...did my head in...'. The use of rhetorical devices such as pauses and tut'ing emphasise her exacerbation with the construction of motherhood as 'fulfilling' and her view of motherhood as banal. Reference to her lived experience and the expectation of motherhood offers an interesting contrast. Claire distances herself from other mothers as she feels unable to be involved. The absence of a shared reality of motherhood is seen to be a consequence of 'psychosis', a diagnosis understood within a framework of medical symptomology as a loss of touch with reality (Bentall, 2004). Claire talks about her experience of being actively shunned because she was open about her experience of postpartum psychosis as '...dreadful...'. In the absence of words, but rather actions of others were used to position Claire outside the group of mothers, highlighting the uncomfortable position of being a 'mad mum'.

Here, Anna talks about her own construction of postpartum psychosis by acknowledging that it is not a homogenous 'disorder' and constructs an account of what may shape a woman's experience.

Extract 17: I do think that a lot of people, it seems to go down one line of things being very frightening, common anxieties about having a baby magnified or it goes down the road of this is so incredible, this new life I have brought into the world, and there must be something more significant. I find that interesting, what about the experience of just becoming a new mum and the terror of not knowing what to do, or this is the best thing that's ever happened to me, and how that shapes psychosis (**Anna:** 367 – 372)

By attempting to make sense of her position, as a mother who has experienced mental health difficulties in the absence of culturally acceptable discourses, Anna appears to engage in a 'truth game' to take responsibility for her position and create a more integrated position. In doing so she draws on other people's accounts of their experiences of postpartum psychosis, seen in her comment '...it seems to go down the line of...' Anna articulates different ideas about how '...common anxieties... shapes psychosis...' this could be seen as a method of deploying a practice of sense making. She acknowledges the gravity of having a baby and the multiplicity of emotions that becoming a mother may evoke and frames psychosis as a magnifier of the emotions that are generally seen as acceptable in wider society (Nicolson, 1998). Anna has connected her experience of motherhood and psychosis by introducing the radical idea that motherhood shapes the experience of psychosis. This seems to place her in a position of greater control by enabling a less blaming dialogue and a reduced sense of guilt and responsibility, serving to construct the position of a 'mad mum' as less uncomfortable. By referring to '...common anxieties...' of motherhood, Anna is constructing the experience of postpartum mental health difficulties as 'normal' and expected, removing the stigma that has come to be associated with psychosis (e.g. Boyle, 2002, Pilgrim, 2007).

In the next extract, Claire talks about her experience of postpartum psychosis and her interactions with her daughter. In her talk, Claire makes sense of her role as a mother being able to protect her daughter; however, with the disparity of psychotic symptomology, her position as a mother sits uncomfortably with the 'good mother' discourse.

Extract 18: I remember loving being a mum and I never had any problems bonding with [names daughter] that others have talked about, you know at the end of the day, I was protecting her when I was sectioned, because I had put her in a cupboard to protect her from the dog ... but probably from me as well. I always felt very protective, even when I look back and think I may have tried to smother her. I don't think I could have. Because your love is so strong when you give birth, yeah, even the anti-psychotics couldn't take away that strong feeling of love (**Claire:** 433 – 439)

The discursive dilemma of maintaining status as a good mother and mental health patient is addressed by Claire in this extract. In seeking to make sense of her sense of self and reclaim an identity as a mother following postpartum psychosis, she appears to avoid positioning herself as a bad mother by aligning herself with the role of a mother as a protector. Claire describes her role in protecting her daughter, but in the position of a 'mad mum', she identifies the need to protect her daughter from herself '...I had put her in a cupboard to protect her from the dog ... but probably from me as well...', '...I may have tried to smother her...'. Claire grapples with an uncomfortable construction, namely a '...mad mum...', as someone who is able to bond with her child, to love and protect her, falling in line with the expected position of a good mother. Although Claire has reframed her experience of placing her daughter in a cupboard as an act of protection, this would not be considered good practice for a mother within the Western culture and acts as a juxtaposition to the 'good mother' discourse. Claire suggests that in spite of her experience of psychosis, love is prevailing and she continues to position herself as a good enough mother. Holding feelings of love for her baby seems to preserve her sense of self as a mother, '...even the anti-psychotics couldn't take away that strong feeling of love...'.

The accounts presented in this section, draw on threats to being a 'good mother' and the women's fear of 'embarrassment' of being unable to fulfil the expected role. By pathologising the experience of psychosis and motherhood, the women's talk seemed to accomplish the action of separating their experiences of motherhood and mental health in order to retain some status and sense of self as

a 'good mother', as defined by idealised constructions. Furthermore, one of the women was seen to construct her position as a 'mad mum', using rhetorical devices in order to minimise the problematic experience of being a mother with mental health difficulties. In the women's talk they were seen to try and make sense of their position by highlighting the retention of positive attributes of a mother, in being able to connect with and protect their baby, despite the experience of 'madness'. However, this was done in an unconventional way and thus rendered the position of a 'mad mum' as an uncomfortable one.

The strength and resilience of the women interviewed in this study was highlighted in their wanting to reframe their experience of postpartum psychosis in a way that preserved their identity as a 'good enough mother' (Winnicott, 1971). The next section addresses the final discursive site 'Survivors Story: A mad mum reclaiming a sense of self and re-educating others', within which the women's talk created a narrative of resistance and survival.

3.4. Survivor's Story: A Mad Mum Reclaiming a Sense of Self and Educating Others

The label 'subject positioning' refers to identifying what types of person ('subject') are talked about by the women, who in relation to the constructions of their experiences and responses to surviving postpartum psychosis. In so doing, the extracts presented position the woman within a structure of reframing and resistance to the 'problem'. In the context of talking to a female interviewer, the women are seen to engage in a process of reflecting on a sense of empowerment and to build up an alternative position that is present and bearable, creating a more positive and socially desirable position to inhabit in their talk. This section aims to consider the operation of a negotiation of their problematised subject position that is evidenced in the woman's talk. By creating a story of survival and placing themselves in a position to educate others, these women are offering a contradictory account which challenges the problematic constructions, and engaging in practices of self-regulation in order to ensure their status as a good mother.

In the following extract, education and social perceptions of mental health difficulties are addressed.

Extract 19: I would talk about it to anyone if I knew that they were interested and not too prejudice and scared. I would talk to anyone about it if I thought it would be helpful. Half the time, they are the ones that need the conversation not you. Because people are scared of mental health, because one in three of us have a problem (**Claire:** 814 – 817)

Foucault (1972) has suggested that movement of social change should focus on the arena of speech as a central locus of power. In this extract, Claire described talking as a way of making sense of her experience; however, she identifies a caveat with talking only being helpful in the context of others being ‘...interested...’ and ‘...non-prejudice...’. She constructs the social perceptions of mental health difficulties as unhelpful, naming others as ‘...prejudice and scared...’. Claire draws on statistics as a way of claiming expertise to indicate the prevalence of mental health difficulties and in doing so acts to place the blame externally, suggesting that it is others that ‘...need the conversation...’, rather than talking about experiences in order to address her own sense of self. In displacing the blame, and repositioning the problem in others, arguably Claire is creating a more acceptable account of postpartum psychosis. She described being willing to ‘...talk to anyone about it...’ in the hope that this would raise awareness. She constructs her own talk as a way of raising awareness, which is consistent with literature on the ‘survival movement’ in psychiatry, which has encouraged the users of mental health services to speak out about difficulties in the hope of breaking down stigma (Chamberlain, 1978). Claire brings into question ideas on recovery and suggests that talking can be helpful in making sense of mental health difficulties; also she seems to suggest that talking about postpartum psychosis and raising awareness could help to challenge social constructions of postpartum mental health difficulties.

In the next extract Anna also addresses social interaction as a way of increasing understanding of postpartum psychosis, placing herself in a position to educate others.

Extract 20: It's weird really because I still think that I find the psychosis easier to talk about, possibly because it was shorter lived, and also I guess because I tend to be a person who likes to break down stigma and educate people, I guess I find it easier to talk about that bit. I think because the depression is so much more, for me it was so much longer and also kind of seems to (.) I don't know how to describe it? The psychosis was so wrapped up with how amazing it was to have this new life, the psychosis almost made me feel more of a unit with [names baby], whereas the depression really distanced me and made me feel like I was doing a crap job as a mum (**Anna:** 232 – 237).

Here, Anna identifies her sense of self as a person who '...likes to break down stigma and educate people...'. Anna is seen to construct her experience of difficulties in the postpartum period by a proposed taxonomy of symptoms of illness and creates a division between the psychiatric classifications of 'depression' and 'psychosis'. In Anna's talk, she suggests that her experience of psychosis was informed by her positive feelings about having a baby and despite, or in spite of her experience, she reflects on the preservation of her relationship with her daughter, stating that psychosis was an agent in making her feel '...more of a unit...' and '...wrapped up...' with her baby. This is consistent with other research into women's experiences of postpartum psychosis (Noorlander, et al. 2008). In contrast to the enabling effects of psychosis she frames depression as disabling her ability to be a mother. She describes her experience of depression as '...distanc[ing]...' and positioning her as doing a '...crap job...' as a mother. Previous research has identified women's reports of perceiving themselves as a failure when their perception of being a 'perfect mother' is altered by their experience of postnatal depression (Berggren-Clive, 1998). Feelings of guilt following postnatal depression are thought to be commonplace and linked to expression of feeling as though one is a 'bad mother' (Mauthner, 1998). In the

context of reframing her experience of postpartum psychosis, Anna reports that through the chaos of psychosis her role as a mother, in the context of her relationship with her baby, remained intact. In continuing the idea of educating others, Anna talks about being able to talk about her experience of postpartum psychosis, ‘...possibly because it was shorter lived...’ She also acknowledges different experiences of mental health difficulties in the postpartum period and a chronology of onset.

In the next extract, Claire talks about her experience of postpartum psychosis, acknowledging her strength as a mother and her resistance to difficulties.

Extract 21: Catherine: Are you able to describe your experience of postpartum psychosis?

Claire: Well no ... my daughter just asked that cause I said you were coming round, and she said “what you going to say?” and <sigh> I was saying that something along the lines of it was traumatic, it’s not something you would ever choose to go through, but, erm, I don’t know? It did make me stronger; it makes you stronger as a person <inaud> but more flawed for having been that far, close to death <deep sigh> because it’s, I don’t know, you come out appreciating your health, and life, and the people around you more. It must be up there with a rite of passage of, you know, having a child. It’s not quite as intense, but it’s (.) not as life changing, obviously, cause its *very sudden* and it’s very short but my goodness it puts things in perspective (**Claire:** 56 – 69)

Claire’s talk serves to reframe her experience of postpartum psychosis as a ‘...rite of passage...’. In the context of recovery and, from a position in which she can reflect back on her experiences, Claire’s choice of terminology evokes something that is transformative in anthropological terms. ‘Rites of passage’ (Van Gennep, 2004) in terms of cultural rituals are conceptualised as something that happens in key moments in a lifetime. The reframing of her experience as transformative seems to have enabled Claire to ‘...put things in perspective...’. Although she acknowledges that postpartum psychosis was ‘...traumatic...’ and that ‘...it’s not

something you would ever choose to go through...’, she suggests that it was an experience that has made her feel ‘...stronger...’. It has enabled her to take a different and life altering perspective and suggests a position of greater agency by highlighting a more balanced view. The suggestion of post-traumatic growth seen in this extract is consistent with literature that suggests that following traumatic experiences an individual has the capacity to experience growth, which is transformative and goes beyond coping (Tedeschi & Calhoun, 2004). It is interesting to consider Claire’s positioning as ‘...stronger [as a person]...’ in the context of talking to her daughter and her position as a mother. This story of survival and post-traumatic growth highlights the empowered position of coming through difficulties. Nietzsche (1988) cited in Ridley & Norman, 2005 p.157, professed that ‘what doesn’t kill me makes me stronger’ which seems to highlight Claire’s position in the context of this extract. Although she acknowledges that the experience has made her fundamentally different she feels able to put her experience into ‘...perspective...’. Claire’s sense of strength and re authoring of postpartum psychosis offers a more positive social account of a difficult experience that challenges her sense of self.

The final extract in this section offers Mary’s description of an interaction with a health professional to illustrate how others can reframe a woman’s experience of postpartum difficulties. This final extract highlights a different kind of educating, in which a survivor of postpartum psychosis is constructed by an external body, positioning her in a different way to how she sees herself.

Extract 22: I said to my doctor ... “what have you got on there then?” you know how they are always on their computer, “Have you got me down as bipolar then, is that what you think I am?” She looked it up and actually, she said, “it doesn’t say that on here, it just describes you as somebody who has had two children which you delivered naturally” It must have something in the fine print. But she said, “that’s not how I see you Mary, you’re *just you*” (**Mary:** 610 – 615)

In this extract, Mary makes reference to a psychiatric diagnosis to label herself as ‘...bipolar...’ reducing her sense of self to a single description of symptoms. Her

talk offers a descriptor of herself in the context of her experience of postpartum psychosis, and highlights how this position informs her identity. Her construction of self by the health professional draws on her position of a mother and that she gave birth to her daughter ‘...naturally...’, which is reminiscent of how women have historically been constructed by their reproductive abilities (Ussher, 1989). Mary reports the doctors positioning of her as ‘...just you...’ offering a different perspective in which to view herself outside of the mental health diagnosis. This extract describes the different ways of constructing people and the scope for variability in the construction of identity. The ‘technologies of self’ are constructed through interaction, and how one is perceived allows the formation of an identity (Foucault, 1982). Mary understands that she is ‘mad’, however she suggests, through the description of the doctor, that this construction of her identity is not articulated by everyone. For Mary, the idea of being seen for who she is seems to offer a sense of freedom to make sense of herself as a survivor of postpartum psychosis, giving her the agency to construct a new subject position that is not reduced by social perceptions of motherhood and mental health diagnosis.

The identity as a survivor serves to reframe the women’s experience of postpartum psychosis and identify a more comfortable position for the women to inhabit. The women in this study referred to their position in being able to educate others, highlighting their acquired knowledge gained through experience and positioning themselves as empowered. Although it was recognised that the experience of postpartum psychosis was traumatic and life changing, there was a sense of building strength and allowing different perspectives of mental health difficulties. The discourse of a ‘survivor’ was seen to be employed as an act of resisting the problematic construction of a mother with mental health difficulties, and to help make sense of and reframe the experience of postpartum psychosis accessed, through women’s talk.

This concludes the analysis and discussion chapter. The next chapter will summarise the analysis of the ways in which the women in this study constructed their experiences of postpartum psychosis. An evaluation of the research will be offered and a suggestion for the implications of the analysis will be outlined.

4.0. CONCLUSIONS AND CRITIQUE

In this section, the original aims of the study will be revisited and discussed in the context of the analysis. Implications for research, policy and clinical services will be presented. This section will conclude by critically evaluating the research project.

4.1. Research Questions and Aims Re-visited

The primary aim of this study was to explore how the psychiatric diagnosis, referred to as postpartum psychosis, was constructed in and through women's talk and to identify the social and material practices authorised by these constructions. The women in this study constructed 'technologies of power' (Foucault, 1988), which were seen to constrain the women's identity and conduct as a mother. Reference was made to the role of social services and antenatal organisations in constructing and governing the behaviour of women and families, consistent with previous research (Edwards & Timmons, 2005). 'Technologies of self' (Foucault, 1988) informed the women's sense of self and identity, encouraging them to endorse themselves as a 'good mother', for example, seen through promoting positive mothering through social interaction (e.g. through Facebook) and silencing undesirable thoughts and feelings. As pregnancy and childbirth has been identified as a time of increased surveillance of women (Godderis, 2010), it is not surprising that women in this study referred to regulatory agencies in order to construct their experiences in the postpartum period. The practices that govern how women are able to talk about and make sense of postpartum psychosis have not been explored in detail previously. However, research into the discursive construction of PND has served to highlight the positioning of women as responsible and structure their subjectivities in gendered ways (Godderis, 2010), which is relevant to draw upon in exploring the discursive constructions and subject position of women diagnosed with postpartum psychosis.

There seems to be an absence in recognition of the difficulties that can be encountered in the transition to motherhood, particularly the major psychological

and social changes experienced following childbirth (Hall & Wittowski, 2006). The consequences of idealised constructions of motherhood and the concomitant constructs of mental health difficulties were seen to problematise the position of all of the women in this study. The women all talked about their positions as a mother, with each constructing a difficult experience of the beginnings of motherhood. For example, by making reference to feeling 'haunted', feeling that they were doing things 'wrong' and experiencing a sense of 'frustration or 'anxiety'. The construction of emotional difficulties as a barrier to performing the role of a 'good mother' was similar to that illustrated in other studies in which women had talked about feeling fear, shock and loss following postpartum psychosis (Robertson & Lyons, 2003; Heron, et al. 2012). The construction of failure, by reason of inability to fulfil the social roles of motherhood evident in all of the women's talk, was consistent with women's reported experiences of PND elsewhere (e.g. Beck, 2002). Some of the women positioned themselves as passive in receipt of anti-psychotic medication and constructed postpartum psychosis as warranting others to treat them with 'suspicion'. The collapse of boundaries between health and illness constructed a reality in which the women's bodies become actionable sites for health and social care systems; this passive position has been highlighted in literature on PND and constructed as being linked to a continuum of risk and perception of a need for medical intervention (Godderis, 2010).

The lived experience of postpartum psychosis was constructed in the talk of all of the women interviewed in this study, but at times it served to fragment their experience of motherhood and psychosis, constructing an uncomfortable sense of self. Some of the women talked about feeling 'embarrassed' and 'guilt', common emotions that have been expressed in other studies (Robertson & Lyons, 2003; Heron, et al. 2012). One of the women interviewed in this study talked into being the position of a 'mad mum', in which she warranted actions of others as serving to isolate and marginalise her. The sense of the experience of postpartum psychosis as being unique (Robertson & Lyons, 2003; Doucet, et al. 2012), and one that affronts one's sense of reality and personal and social identity (Heron, et al. 2012), highlights the problematic position of a diagnosis of mental health in the postpartum period.

Finally, the construction of a 'survivor' position enabled all of the women in this study to identify as strong and resilient, gaining strength in being able to resist 'psychosis' and realise their coping mechanisms. The construction of a position of strength and resistance was consistent with other women's descriptions of recovering from postpartum psychosis (Robertson & Lyons, 2003), however, this study served to further highlight the discursive constructions available to the women that enable identification as a 'survivor'. The construction of the 'survivor' position and recognising their unique role in being able to educate others about the lived experience of postpartum psychosis, seemed to empower the women interviewed in this study. The transformation of self and experiencing a 'rite of passage' constructed by one of the women in this study is consistent with the idea that language is an important site of struggle in which domination and resistance is played out (Foucault, 1978). The construction of 'survivor' can be seen as re-claiming power and inhabiting a position of resistance.

The main research question has been addressed through the presentation of constructions of four main discursive 'sites', which are inter-penetrated by social practices and regulatory agents acting to control conduct (Foucault, 1982), which sustain certain subject positions, and silence others. The implications of the fragmentation of a woman's sense of self following recovery from a diagnosis of postpartum psychosis will be considered further in the next section.

4.2. Implications

4.2.1. The concept of postpartum psychosis and future research

The dominant biomedical research which constructs an understanding of postpartum psychosis as medically defined has been valuable in beginning to think about service provision for women who have been diagnosed with postpartum psychosis (e.g. Doucet, et al. 2011). However, the socio-political context and how women are understood, in terms of their relationship with themselves and their individual circumstances, also need to be considered. The social and cultural conditions in which women's lives occur have been neglected in the area of postpartum psychosis to date (Edwards & Timmons, 2005). Most of the women interviewed in this study talked about feeling 'embarrassed' to tell

their stories for fear of rejection and concern about their abilities to be a good enough mother. This compares to the discursive formation of PND which has governed the surveillance of mothers within a neo-liberal context and placed emphasis on locating blame in the woman for difficulties in the postpartum period (Godderis, 2010). The construction of mother's having a negative impact on their children could be seen to neglect the social, cultural and economic context of mothering, locating the blame wholly within the mother. The usefulness of a label to define the difficulties being experienced by a woman in the postpartum period has been seen as a 'relief' (Edwards & Timmons, 2005). The women who participated in this study had mixed ideas about the usefulness of the label postpartum psychosis. Further research into the way women construct difficulties in the postpartum period, particularly looking at how they make sense of the label 'psychosis' in the context of governing agents that inform ideologies about motherhood, would be helpful in exploring the construction of postpartum psychosis.

The lack of research in the area of postpartum psychosis has started to be acknowledged in the past ten years and there are now a handful of published studies which are beginning to explore the experiences of women diagnosed with postpartum psychosis (e.g. Robertson & Lyons, 2003; Doucet et al. 2012; Heron, et al. 2012; Engqvist, et al. 2011; Edwards & Timmons, 2005). These studies have focused on women's stories of the lived experience of postpartum psychosis, experiences of professional care and stigma of mental health diagnoses in the postpartum period. However, it seems that the views of those within the systems in which women exist are still rare, with the stories of significant others, such as fathers, remaining for the most part, untold (Doucet, et al. 2012). The future research I would recommend would continue to explore the construction of postpartum psychosis by promoting the voice of women and their families. By taking a post-modern epistemological perspective the discursive resources available to make sense of experience would be brought further into focus. Specifically, this study has indicated a potential value for researchers to move from medicalised conceptions of postpartum psychosis and begin to think about the consequences of such a diagnosis, at such a critical time, on a woman's sense of self. A more systemic approach to future research, that gives

weight to the voices of women historically excluded from having a public voice and from all parts of our multi-cultural society, would have a value in offering different perspectives on mental health difficulties in the postpartum period. By highlighting women's stories of survival and resilience, a more positive and hopeful discourse of postpartum psychosis can be offered. The analysis of discourse facilitates exploration of interactional processes and how they operate in regulating subjectivity. By rendering visible historical and cultural processes of dominant discourses about mental health difficulties in the postpartum period, the constraining effects of these discourses for women diagnosed with postpartum psychosis could be considered further.

To date, there has been no long term research into the consequences of postpartum psychosis on a woman's sense of self, how she constructs her role as a mother through different stages of child development, the on-going consequence on relationships with family members and the prospect of future pregnancies. The position of a mother who has experienced postpartum psychosis is already stigmatised (Edwards & Timmons, 2005) and a woman is positioned to construct her future plans as a mother in a different way. There is an absence of research into longer term health care intervention for women who have been diagnosed with postpartum psychosis. This study has drawn upon Foucauldian principles of power and knowledge which could inform thoughtful intervention and consideration of the ways in which women are able to construct their experience of postpartum psychosis. However, it would be useful to construct evaluative measures to measure the efficacy of intervention provision. Epistemologically realist research, drawing on mixed methods and the provision of statistics to evidence intervention outcome, would serve to offer a different set of tools, presenting research in line with a discourse that is more acceptable to the commissioners of services.

4.2.3. Institutional practices

The repositioning of postpartum psychosis by institutional practices, to raise professional and public awareness, could serve to inform and empower mothers who are experiencing severe mental health difficulties and start to de-stigmatise social perceptions. Front line services should be trained to conceptualise

postpartum psychosis as informed by dominant cultural and social discourses about motherhood and mental health, and respond to it in ways that do not automatically make assumptions about a woman's ability to be a good (enough) mother. Previous literature has suggested that acute symptoms of 'psychosis' provoke fear and anger in professionals (Engqvist, et al. 2007) which could affect the support given to mothers with this psychiatric diagnosis (Wan, Moulton & Abel, 2008). The professional response to postpartum psychosis could reflect the paucity in evidence based information available to professionals about postpartum psychosis, thus suggesting that education for professionals may help in reducing stigma and addressing constructions of 'psychosis' in a less stigmatising way. By encouraging mothers who experience symptoms defined by 'psychosis' to talk about their experiences, rather than avoid them, a more accepting attitude to postpartum psychosis could be constructed (Romme & Escher, 1993). Increasing feminist literature, highlighting the reality of demands of motherhood, has served to de-stigmatise 'depression' in the postnatal period and offer alternative ways for women to understand their own lived experience of motherhood and make sense of difficulties (Mauthner, 2010). Most of the women in this study talked into being the detrimental effects of a lack of social knowledge about psychosis and a more accepting view of depression in Western culture. A few women constructed the need for increased awareness of postpartum psychosis through a greater presence of survivor stories in the media, demonstrating the power of constructions of mental health difficulties made possible in the media.

Previous research into the lived experience of postpartum psychosis has highlighted an expressed need for more information about postpartum psychosis being made available for women and their families to facilitate the recovery process (Robertson & Lyons, 2003; Doucet, et al. 2012). Lack of information was seen to equate to a lack of power and sense of agency for the women interviewed in this study, consistent with other reported experiences (Robertson & Lyons, 2003; Heron, et al. 2012). It has been suggested that a lack of information given to patients indicates a lack of knowledge and/or teaching skills in mental health professionals (Engqvist, et al. 2007). Equipping women and families with information about postpartum psychosis as soon as possible could

serve to empower women, and ensure that the information is available when it is needed. Antenatal organisations were identified as employing regulatory practices (e.g. the importance of preparation highlighted in Extract 3) suggesting an absence in the recognition of things going ‘horribly wrong’ in the postpartum period. The provision of information at antenatal classes could construct knowledge about the ‘less desirable realities’ of motherhood, something that was talked about in this study as unavailable and silenced. In the talk of some of the women in this study, antenatal agencies were constructed as positioned to encourage a less blaming discourse by acknowledging difficulties with breastfeeding and the uncertainty of childbirth (Engqvist, et al.2011). The desire to educate and increase awareness constructed by most of the women through their identification as a ‘survivor’, could be utilised, encouraging ‘survivors’ of postpartum psychosis to talk to other women during pregnancy, offering a narrative about survival and resistance and highlighting a position from which they could ‘recover’ from postpartum psychosis.

4.2.4. Service provision

Although there is limited professional guidance for the provision of health and treatment of women who are presenting with symptoms of postpartum psychosis, it is generally acknowledged that treatment must be adjusted to the type and severity of the psychotic symptomology reported by the women (Engqvist, et al. 2007). An emphasis has been placed on medication and ensuring the safety of mother and baby (Spinelli, 2004). In terms of services, I welcome the provision of treatment facilities for mothers with severe mental health difficulties which allow mothers to stay with their babies (e.g. in MBU’s). However this is something that is not available to all health care localities, creating a ‘postcode lottery’. In this study, the talk of a few of the women suggested that although initially a desire to ‘recover’ from childbirth in the absence of their baby was constructed (e.g. Extract 10); they had not benefited from being sectioned in a general psychiatric unit without their baby in the long term.

Previous research has constructed the role of MBU’s in providing social support and normalisation for women who are experiencing postpartum psychosis (Howard, et al. 2006). Feeling safe has been identified as important for recovery

(Heron, et al. 2012). Within MBU's women are able to maintain their status as a mother, addressing the duality of a mother with postpartum psychosis, suggesting that those who commission and manage services should broaden their perspective on motherhood and mental health difficulties and offer a greater provision of this service. It has been reported that women constructed their experience of postpartum psychosis as unique, and there was a need to be treated in a different environment than a psychiatric ward (Robertson & Lyons, 2003; Doucet, et al. 2012). In this study, an MBU was positioned as being able to provide unique support. One woman constructed her experience of interacting with her baby when she was experiencing postpartum psychosis through the use of a video camera. She illustrated the value of videoing her interaction in enabling her to discover another image of herself, through the lens of a camera, in her role as a mother. This unique support could serve to be helpful in nurturing a woman's sense of self as a mother in a psychiatric institution.

4.2.5. The profession of clinical psychology

In terms of the role of clinical psychology, it is important to consider key issues that arose from participants' constructions of postpartum psychosis. In this study, some of the women's talk served to fragment their experience of motherhood and mental health difficulties, with the incongruence rendering them speechless (e.g. Extract 14). In the women's talk, a position of survival and resilience was a more bearable subject position to inhabit. Consequently, women's presentation to psychological services needs to be considered in terms of how they are able to engage with services and the right time to begin to make sense of their experiences in a safe and supportive way. The idea of loss has been illustrated in other studies and the sense of recovery from postpartum psychosis could be constructed as a grieving process, in the sense of loss of what should have been. Literature has highlighted the sense of loss following other psychiatric diagnoses (Miller, et al. 1990), thus suggesting the importance of addressing feelings of sadness and loss joined with a sense of survival and resistance, integrating a story of postpartum psychosis which can be constructed in multiple ways (Heron, et al. 2012). Recovery has been constructed as not just reducing symptoms, highlighting a holistic approach to recovery bolstering self-esteem, mothering confidence, social functioning and family functioning (Heron, et al. 2012).

Recovery has been talked about by women in other studies as 'feeling like their old self' (Robertson & Lyons, 2003); this could be augmented by thinking through the positions they inhabited following a diagnosis of postpartum psychosis and addressing possible feelings of duality and fragmentation.

Robertson & Lyons (2003) highlighted the need for emotional and affirmational support to aid the recovery described by the women interviewed in their study. Most of the women in this study constructed postpartum psychosis as experiencing 'ups and downs', hitting their lowest point following their experience of postpartum psychosis and reflecting back on the 'intensity' of the experience and the impact on others. Talking has been identified as having value in the recovery process; however there is no research which has explored the best ways of working within a therapeutic model. Narrative therapy (White & Epston, 1990) sees problems occurring when the stories people have available about themselves do not accord with their lived experience, taking a non-pathologising approach and considering the influence of dominant discourses on an individual's sense of self. Working in this way with women who have recovered from postpartum psychosis may offer a non-blaming framework to begin to explore their experiences, offering a less problem saturated description of themselves as a 'mad mother'. Noorlander, et al. (2008) found that due to the onset and duration of difficulties, women diagnosed with postpartum psychosis report less difficulties with bonding with their baby than in incidences of PND, a finding that is consistent with my study (e.g. Extract 8, 20). This suggests that individual or group work that focuses on the discursive dilemmas constructed by the experience of postpartum psychosis, would possibly be more beneficial rather than parent-infant therapy. Although the benefits of individual therapy have been identified, Stewart (2000) has highlighted that social support can reduce the harmful effects of stressors, and this has been supported by literature in the field of postpartum psychosis (Doucet, et al. 2012). The joining of women and/or families of women with shared experiences may serve to promote outsider witnessing and strengthen women's sense of self as a good (enough) mother. Groups may be helpful for women and partners in the immediate time following discharge when feelings of isolation and lack of knowledge have been reported (Robertson & Lyons, 2003). The practicality of a postpartum psychosis support

group needs to be considered due to the rarity of the condition and the possible difficulty in travelling due to the demands of a new baby. The way in which women constructed support in terms of talking to others, suggested that online or telephone group support could be useful (Caramlau, et al. 2011).

4.3. Evaluation and Critical Review

In this section, the study will be evaluated and critiqued in terms of a range of matters including epistemology and methodology, quality of the research process and usefulness of this research. The criteria have been informed by Georgaca & Avdi (2012), who have defined the importance of internal coherence, rigour, transparency, reflexivity and usefulness of qualitative research.

4.3.1. Epistemology and methodology

The epistemological position adopted in this study was aligned with critical realism and informed by social constructionism. By taking this stance, an account of how women used particular discursive constructions was provided. The material conditions and practices were highlighted in the talk of women who have experienced postpartum psychosis. The constructions of postpartum psychosis enabled certain subject positions in line with discourses about the 'good mother' and 'compliant mental health patient' to be brought into view. These constructions were considered to be simultaneously material and discursive as they highlighted the relationship existing between 'knowledge' and practice (Sims-Schouten, Riley & Willig, 2007). This was demonstrated in the provision of social accounts of motherhood, femininity and mental health; and mental health policy and procedures such as the treatment of 'psychosis' through the administration of medication and sectioning. These accounts served to regulate the women's role as a mother and patient.

In this study, a critical realist version of discourse analysis informed by Foucauldian principles was undertaken (Parker, 1992). Qualitative methods such as this have been criticised. However, such criticisms are thought to arise from a difference in naïve realist paradigms which draw on normative, positivist and empiricist assumptions. This can be compared to relativist epistemologies of

qualitative research, where it is more readily accepted that alternative readings and analysis of data are possible. It has been suggested that this can be accounted for by acknowledging the subject position embodied by the researcher (Willig, 2008). I acknowledge that the configuration of the discursive 'sites' identified in this study were produced as a result of my readings of the interview transcripts and process of meaning-making. As such, they should be considered as subject to my own constructions of mental health difficulties and positioning as a woman. The analysis presented in this study should not be considered an exhaustive account of women's experience of postpartum psychosis, but as one, psychologically informed, way of representing it. Willig (2008) argues for the need to consider validity of interpretation in qualitative work. The analysis of women's talk in this study and articulation of discursive sites can be understood as one of multiple readings.

4.3.2. Internal coherence and rigour

In this study, the population of women interviewed represented those who were articulate in accessing support and enthusiastic about engaging in research projects. The women who were interviewed in this study were bright, articulate and had a strong sense of recovery. They were all located within a social and economic context which enabled support and access to resources during periods of crisis. It was felt that women in different sub cultures would possibly be influenced by the availability of different discourses and would have different ways of talking about their experiences. The group of women who were interviewed in this study were homogenous in terms of background. The absence of the voice of women from less privileged backgrounds could be representative of the way in which the participants were recruited and the assumption that they already had access to a support network. This study makes no claims of representativeness beyond reasoning that if such discourses about experiences or practices in relation to postpartum psychosis are possible, then it could be suggested that they are more widely available within a culture or society (Willig, 2008). Findings from other research were identified to support the claims made in this study. Throughout the presentation of this study, attention has been paid to illustrate internal coherence, demonstrated through the presentation of extracts

from the transcription of interviews with the women, making transparent the crafting of an account of how the data was analysed.

4.3.3. Transparency and reflexivity

Harper (2003) has highlighted the importance of developing a critically reflexive position when undertaking discourse analysis. A number of principles to ensure this position have been proposed: firstly, that attention needs to be critically applied to the practices by which the researcher constructs knowledge in relation to their own contexts; secondly, that researchers should be accountable for their analysis by explicitly identifying these contexts; and lastly, that the likely effects of power and its influence on the research process need to be addressed. My position is informed by the reality that I am not a mother and I have not received support from mental health services. I do, however hold a set of agendas and ideas for research. My personal contexts included my gender, culture, ethnicity and age, my professional status as both a researcher attached to an academic institution and an employee of the NHS. I made it explicit to the women interviewed that I was interested in how they constructed their experiences of postpartum psychosis in conversation. I attempted to address some of the potential imbalance through inviting participants to be 'co-authors' of the interview (Kvale & Brinkmann, 2009), and by visiting participants at their own homes or chosen locations. During the interviews I sought to establish a rapport with participants by asking them to clarify some general information and then, by adopting a conversational approach, inviting them to share their own story in their own words, in their own way.

4.3.4. Usefulness

The usefulness of this study has been addressed in greater detail in the section titled 'Implications' (4.2). However, who decides what is useful has been questioned in the past (Harper, 1999). In my view, it is the women themselves and the organisations with which they may come into contact, who determine this. I hope that this research may serve to empower the women who took part, either through listening to and validating their experience, or through contributing to the broader knowledge in the area of lived experience of postpartum psychosis. This study has sought to contribute to the literature on the

conceptualisation of mental health difficulties in the postpartum period from a mother's perspective, including women's constructed responses, consequences and sense of recovery from postpartum psychosis. I have sought to highlight possible ways of working with women in a psychologically minded way.

This study has demonstrated that the experience of postpartum psychosis is complex. The ways in which women are able to talk about, and make sense of, their experiences has been created and sustained within powerful institutions that set up discursive positions of a mother and a patient as antithetic to each other, and in practice have proven to be difficult for mothers with mental health difficulties to inhabit. The women in this study constructed a narrative of survival and resilience, suggesting that there is a space for resistance, with the recognition of the strength to negotiate a fragmented sense of self.

I think your question about how you define yourself after postpartum psychosis was interesting ... it will always be in the back of my mind that I survived and it's something to be proud of, once you get past an initial feeling of shame ... I think surviving super mum culture makes you feel proud (**Nicola:** 760 -768)

5.0. REFERENCES

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6.0. APPENDICES

APPENDIX A: Literature Review

To review literature for this study, I searched EBSCO, an international online database resource. The following databases were selected: PsychINFO, PsychARTICLES, Medline and CINAHL and all years of publication made available. Articles reviewed were those that focused on the psychiatric diagnosis of psychosis in the postpartum period, although some papers on more general mental health following childbirth and women's experiences of motherhood were used. Papers adopting qualitative methods were prioritised given the nature of this research. Papers were excluded if they were not written in English or were not relevant to the research question.

Variations of the following search terms were used to locate relevant literature using the online databases:

- (women) OR (woman) OR (female) AND
- (mother) OR (motherhood) OR (childbirth) OR (postpartum) OR (postnatal) OR (puerperal) AND
- (mental health) OR (psychiatric diagnoses) AND
- (psychosis) OR (schizophrenia) OR (madness) AND

After refining the focus of the study, additional searches included the following terms:

- (accounts) or (talk) or (construction) AND
- (discourse) or (discursive) or (analysis)

The abstracts of studies were reviewed and the full text of those articles that seemed particularly relevant were obtained. I also conducted a hand search from the references of the most relevant papers. In addition, I searched Google Scholar using similar terms, which I found useful for directing me to relevant books, websites, and journal articles. Other literature included in this study has

been made familiar to me via my university teaching or recommended by academics from other universities.

This study does not attempt to provide a systematic review of the literature but uses the most relevant material for this study. The table below illustrates an example of the process undertaken to find relevant literature. The screening measures used and the number of items found and reviewed through entering variations of the term 'postpartum psychosis' are shown in the tables (original numbers are shown in brackets).

"Postpartum Psychosis"

Search Items	Screened	Final number reviewed
Postpartum OR Postnatal OR Puerperal (19,842)		
AND		
Psychosis OR Madness OR Schizophrenia (131,407)	(1,167)	
	Reference to postpartum psychosis in the title or abstract (385)	
	Academic Journals (314)	
	Qualitative (15)	167

APPENDIX B: Research Advert

The description of the research study posted on the online Postpartum Psychosis Charity Network Facebook page is pictured below. Details of the study were also posted on the Network site, available to be accessed by all on the internet.

The screenshot shows the Facebook interface for the 'Action on Postpartum Psychosis (APP)' page. The page header includes the Facebook logo, a search bar, and the user 'Cat Hunter' with a 'Home' button. The page name 'Action on Postpartum Psyc...' is visible, along with a 'Timeline' dropdown and the year '2012'. A 'Like' button and a 'Create Page' button are also present.

The main content area features a post from 'Action on Postpartum Psychosis (APP)' dated May 28. The post text reads: 'Can You Help with a Research Project on Postpartum Psychosis? I would really like to chat with you about your experience of PP. What was it like for you & your family following your diagnosis? And what types of services/support were made available to you? This should take no more than an hour & I'm happy to meet wherever is most convenient for you. If you are willing to take part in the study or would like more information, please email me, Catherine on u1037626@uel.ac.uk or phone Claire Wickham on 0208 223 4174 to leave a message.'

Below the text is an image of a stack of colorful books. To the right of the post is a sidebar with a 'Now' section showing 'October', '2012', '2011', and 'Founded'. Below this is a 'Sponsored' section for 'Tassimo UK' with a logo and text: 'Now TOSSIMO brings you COSTA at home. Now you can enjoy your Costa favourites at home with Tassimo. Like · 34,009 people like this.'

On the left side of the page, there is a section titled 'Magazines @ The APP Network' with a link to 'www.app-network.org'. Below this is a post from 'Action on Postpartum Psychosis (APP)' dated May 16, which includes a link to a research paper: 'http://www.ncbi.nlm.nih.gov/pubmed/22526403'. The post text mentions 'Free open access to recovery research paper during mental health awareness week only!' and 'Temporary access to the research paper produced by APP, Information & Support Needs During Recovery from Postpartum Psychosis'. It also mentions 'The study was conducted as a collaboration between women who have experienced PP & perinatal / research experts. Available free 18th to 31st May only.'

At the bottom of the page, there is a section titled 'Information and support needs during... [Arch Womens Ment Health. 2012] - PubMed - NCBI' with a link to 'www.ncbi.nlm.nih.gov'. The text states: 'PubMed comprises more than 21 million citations for biomedical literature from MEDLINE, life science journals, and online books. Citations may include links to full-text content from PubMed Central and'.

APPENDIX C: Information Pack

Dear [Name of participant],

RE: Participation in Research Project

Thank you for expressing an interest in this research project.

I have enclosed/attached some information for you to read in relation to the research project. It includes the following information:

- Information leaflet: This will give you information on what the research entails, what you will be required to do, your confidentiality rights and a list of sources of support and advice.
- Consent form: You will be required to sign the consent form prior to the interview.

If you would like to take part in the research or have any questions about the enclosed information please contact me via e-mail or telephone:

E-mail: u1037626@uel.ac.uk,

Telephone (University of East London, Doctorate in Clinical Psychology office):
020 8223 4174/4567

Yours faithfully,

Catherine Hunter

Trainee Clinical Psychologist
University of East London

Information:

Invitation to the study

You are invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being carried out and what it will involve. Please read the following information carefully and then decide if you wish to take part.

Background to the study

It is widely recognised that at least half of women experience low mood either at some point during their pregnancy or in the initial days following the birth of their child. Postpartum psychosis affects between 1 to 2 women per 1000 deliveries and can have serious consequences for the mother and her family. In general, this seems to be an under-researched area, and to date, studies of postpartum psychosis have been conducted almost exclusively with a focus on clinical symptoms and risk factors, with comparisons with non-postpartum episodes of psychosis being made. There is limited research which examines the thoughts, feelings, views and perceptions of postpartum psychosis with the women who have received a diagnosis after childbirth. Although the identified prevalence of postpartum psychosis is rare, it can have serious implications for the women who have experienced it. This study is interested in understanding how women who have been diagnosed with postpartum psychosis make sense of and begin to talk about their experiences, and manage the consequences of postpartum mental health diagnosis and in some cases hospitalisation.

Why is there a specific selection criterion for participants?

I am recruiting women who are over 18 who have had direct experience of postpartum psychosis following childbirth and deem themselves to have 'recovered' from any episodes they have experienced. Women are advised not to take part in the study if they are still experiencing psychotic symptomology, identified as being linked to postpartum psychosis. Women who are prescribed

psychiatric medication in reaction to an episode of postpartum psychosis will not be excluded from participation in this study.

Do I have to take part?

It is your decision as to whether you take part in the study or not. You are free to withdraw at any time and you will not be asked to give any reason. If you chose to withdraw from the study information you have provided to the researcher will not be used in the final publication of the research.

What will happen if I take part?

You will be asked to read and sign a consent form. You will then take part in an interview with a female researcher. The interview will probably last around one and a half hours. This interview will take place on a date and time that is convenient for you. The interview will be digitally recorded and transcribed (typed into text). The transcribing will be done by the researcher, all identifying names and other material will be omitted for confidentiality purposes.

Will my confidentiality be respected?

Your participation will be kept confidential. All material will be stored in a locked cabinet. Any information identifying you (i.e. consent form) will be stored separately from the typed copy of your interview. Comments that you make in the interview will be used in the write up of the research however all identifying information (names and places) will be removed. The recording of your interview and the transcript will be kept in a locked cupboard. The recording will be destroyed at the end of the research. Transcripts will be destroyed after 5 years. Only the researcher, supervisor of the project and examiners will have access to the tapes and transcripts. Your participation in the research will remain anonymous. Only the researcher will know the identity of those involved.

What will happen to the results of the research study?

The results of the study will be written up and submitted as a research project as part of a Doctorate in Clinical Psychology.

Has the research obtained ethical approval?

The research has been properly registered and obtained ethical approval from the University of East London's Ethics Committee.

Thank you for taking the time to read this information sheet. Please do not hesitate to contact me if you have any further questions.

Yours faithfully,
Catherine Hunter

Consent Form

The 'Information leaflet' provided outlines information about the confidentiality and the anonymity of your interview. You should have read it carefully. If you do not understand something then please ask the researcher.

In order for you to participate in the research you will need to sign this form to give your consent. You can withdraw your consent at any time without giving a reason.

Declaration:

I have read and understood the Information leaflet, and am fully aware of what the research entails. Any questions have been answered to my satisfaction and I am participating with full understanding. I agree to be interviewed, for my interview to be transcribed by the researcher and for the responses to be included in the research and any future publications.

Please tick and sign if you agree to take part in the research.

Yes

☐

Name:

Date of Birth

Signed:

Date:

APPENDIX D: Interview Guide

Prior to the interview:

- Following introductions, what you may expect in terms of the timing, structure and style of the planned interview will be outlined.
- It is anticipated that the interview will last approximately 1–2 hours and there will be opportunities to take a break.
- You will be then be asked to sign a consent form (a sample is provided with information leaflet).
- Next, you will be invited to 'co- author' the interview. This means that at the start of the interview you will asked if you would like to add relevant themes to the interview agenda; and then at the end you will be asked to provide feedback on your experiences of the interview process.

During the interview (which will be digitally recorded):

The interviewer may take some notes to assist with memory during and after the interview. You will be asked questions around the following themes:

- a)** What was it that interested you in taking part in this research project?
- b)** Can you describe your experience of postpartum psychosis:
 - What happened; describe your experiences?
 - What were the consequences of this diagnosis for you (e.g. hospitalisation, sense of self)?
 - What were the consequences for others, including your baby and other significant relationships?
 - How did you cope with receiving a diagnosis of postpartum psychosis, what were your strengths and resources?
 - What was your experience with other people following your diagnosis? Did you tell anyone else?
- c)** What were your material circumstances during this period (e.g. hospitalisation, medication, motherhood and other relationships, opportunities

for subsequent childbirth) Do you believe that they impacted on your experience of postpartum psychosis?

- d)** What is your perception of services? Do you think professionals/services are accessible to mothers who are experiencing/have experienced postpartum psychosis? What might prevent mothers from accessing services?
- e)** How do you define yourself? How has your culture impacted on your understanding of postpartum mental health difficulties?
- f)** How do you believe society perceives women who are diagnosed with postpartum psychosis?
- g)** Is there anything else you think is pertinent to this topic that you have not had a chance to talk about?

After the interview:

- You will be asked to reflect on your experiences of the interview process and what was discussed.
- Confirmation of your consent to the material recorded and its use within the analysis and write-up will be sought.
- The researcher will explain next steps and offer advice about sources of on-going support (if required).

APPENDIX E: Extract from Reflexive Journal

Following each interview, I wrote notes in my reflexive journal. Many of these were in note form, and I referred back to them during analysis and write up. The following are example extracts.

Notes made following the interview with Mary:

'Interview felt long and intense, it was difficult to finish as she went into lots of detail about her experiences and had a lot to say. I came away feeling emotionally exhausted. Mary had planned what she had to say and made a mind map to help organise her thoughts – reminded me of the enormity of the task she faced in terms of telling her story. It has made me wonder if I need to be clearer about range of topics I hoped to cover or would that be positioning myself as more powerful and in charge? She expressed a real sense of wanting to be coherent, to make sense and for me to be able to follow her story. What she talked about seemed really relevant to my research question; she offered a lot of context/social factors/relationship issues, drawn on to make sense of experience of postpartum psychosis. I found it difficult to interject while she was talking, this felt appropriate to let her tell her story but maybe I wasn't as discursive or questioning as I could have been. Think about this next time! She was really reflexive and I felt like I came away with a real sense of her experience of mental health services and feeling disempowered. It was clear that she had thought about the different stages of her story and had started to make sense of her experience of 'psychosis' and social perceptions. She had a real sense of how life changing her experience had been and the huge impact of this diagnosis. Positioning self as 'good mother' in spite of or despite (?) her experiences. I came away with a real sense of 'survival', I got the feeling that she wanted to be seen as strong and capable. I think she was so aware in her talk of how postpartum psychosis is understood by others. I hope I remained non-judgmental – I really need to hold onto how my position as a woman who doesn't have children affects how I understand things.

Notes following initial reading of the transcript of interview with Mary:

'Very dense material and seems like few comments from me at times. There are so many issues to think about when identifying possible themes, not sure where to start. She uses brilliant language/imagery to construct a story of her experience – pull out some good quotes already?? Think I need to work out my 'analytic foci' more tightly and the best way of ordering this to tell a coherent story. I am noticing times when she refers to being regulated by others but not sure what I really need to focus on – maybe I should re-read some Foucault?? I noticed that my questions are more for clarification, the provision of draft interview schedule seems to develop interview well, enabling Mary to bring in and talk about themes. Do I need to make sure I am more directed to how the women are constructing their stories rather than clarifying narrative? I noticed that I was picking up ideas and possible from previous interviews and referencing the literature which had developed a biomedical understanding in some of the questions I ask; this is a bit realist so need to watch that in coding. I remember feeling a real alliance with her sense of survival, maybe as women with shared identification as assertive and strong? I think it was nice ending on question about strengths and resources, ended difficult interview on a positive.

Notes made in journal during writing up analysis and discussion:

I need to be more thorough with analysis, making sure I stick to the level of the language used in constructing experience – I think it might be a bit circular. I really need to make sure that each discursive site that I have identified has a clear distinction from the others and the extracts chosen reflect this. I am feeling really frustrated by word limits, there is so much data and I want to do justice to the women's stories. I have started to realise that am not describing terminology and just using it without clear definition, Pippa suggested that I need to explain terms e.g. technologies of power and technologies of self and expand on ideas. Seems my analysis is on the right track, but need to be really careful of realist language and going beyond the text. It feels good to be writing now and getting thoughts on paper, after slightly daunting process of picking out extracts. Next time through I need to cut down my words (again) - have Foucault in mind for thinking about implications of this study!

APPENDIX F: Thesis Registration Letter

Catherine Hunter
516 Lexington Building
Bow Quarter, Fairfield Road
London E3 2UF

6 June 2012

Student Number: 1037626

Dear Catherine,



Registration as a Candidate for the University's Research Degree

I am pleased to inform you that the Research Degrees Subcommittee on behalf of the University Quality and Standards Committee, has registered you for the degree of Professional Doctorate.

Title of Professional Doctorate: Professional Doctorate in Clinical Psychology

Director of Studies: Dr Pippa Dell

Supervisor/s: Dr Kenneth Gannon

Expected completion: According to your actual date of registration, which is **1 September 2010** the registration period is as follows:

Minimum 18 months maximum 48 months (4 years), according to a full time mode of study.

Your thesis is therefore due to be submitted between:

1 March 2012 – 1 September 2014
--

I wish you all the best with your intended research degree programme. Please contact me if you have any further queries regarding to this matter.

Yours sincerely,

A handwritten signature in black ink that reads 'James J. Walsh'.

Dr James J Walsh
School Research Degrees Leader
Direct line: 020 8223 4471
Email: j.j.walsh@uel.ac.uk

Cc: Pippa Dell

APPENDIX G: UEL Ethical Approval Letter

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



APPENDIX H: Thank you & Further Support

Thank you for participating in my research project. As you are aware, following the interview the audio recordings will be transcribed and analysed. The findings will be written up as a thesis and potentially in other forms such as a journal article. A summary of the findings will be offered to all participants.

Further support:

The researcher will have offered time to share your experience straight after the interview. If you feel that you would like to talk about your experience of taking part in the interview further then the researcher will be available for a one off session at a later date over the phone. Alternatively, if you should need further support or advice then the following organisations may be helpful:

Action on Postpartum Psychosis (APP)	www.app-network.org APP is a network of women across the UK and further afield who have experienced PP. It is a collaborative project run by women who have experienced PP and academic experts from Birmingham and Cardiff Universities.
Mind Info Line	info@mind.org.uk tel: 0845 766 0163
NHS Direct	www.nhsdirect.nhs.uk tel: 0845 4647 24 hour nurse-led helpline providing health advice.
Online PPD Support Group	www.ppdsupportpage.com This is a site run by women who have suffered from post-natal illness.
PNI Org UK	www.pni.org.uk An information site for sufferers and survivors of post natal illness.
Bipolar UK	www.mdf.org.uk tel: 020 7793 2600 Bipolar UK is a national user-led organisation for people whose lives are affected by bipolar disorder. It aims to enable people affected by bipolar to take control of their lives through the services offered, including self-help groups, information and publications.

APPENDIX I: Transcription Convention

Full transcription conventions were not used in this study. The analysis used in this study was concerned with global discursive resources employed by the women interviewed, rather than rhetoric and discursive practices. The transcriptions conventions used draw on Malson (1998), and stressed readability of content rather than detailed reproduction of the features of speech.

The convention followed in order to present extracts of women's talk in chapters three and four:

Pauses in speech were not timed. Noticeable breaks were denoted by the use of a full stop in brackets (.)

Ellipsis were used to show unfinished sentences or utterances. This was also used to show breaks in the speech presented.

Brief interruptions were denoted using forward slashes e.g. /CATHERINE: Mmm/; Chevrons <inaud.> indicated that material from the text had been omitted due to inaudibility or other significant doubts about its accuracy.

Chevrons were also used to provide <other information>, such as to indicate gestures. E.g. laughing, sighs, tuts.

Where words were noticeably emphasised they were typed in *italics*.


Square brackets [] were used to provide descriptive information when names or identifying details had been removed for reasons of confidentiality.

The interview extracts were numbered in the order they appear in the analysis and discussion section, and in each case, the participant name was given using a pseudonym (HANNAH, EMMA etc.) together with the line numbers as they were coded during transcription.

Punctuation was added in the extracts presented to facilitate reading.

APPENDIX K: Example of analysis of transcript (Step 2)

Research Question: How do women who self-identify as having been diagnosed with postpartum psychosis construct their experiences; in what ways do they use talk to describe and understand their experiences and what discursive resources do they deploy when telling their stories?

What are they talking about? (objects, events, experiences)	Interview with Nicola (256 – 283)	How are they talking about it?
Health Care Professionals	<p>Nicola: The mental health team asked questions about my childhood, my schooling, really irrelevant stuff that would only ever come out in years of therapy. At the end of that they still had no power to do anything and I had to wait hours for the crisis team. It was a kick in the teeth that they were the only ones who could admit me to hospital. We arrived at A&E at two in the morning and it wasn't until six that evening that the crisis team came. The women that came just held my hand and said, "I can help you", and that was a relief. I just thought that someone will know what's wrong. She asked if I wanted to go and if I hadn't I would have been sectioned, she didn't say that but I was desperate for help so I willingly said I would be admitted. You don't realise that once you have said you will be admitted, it's not so easy to come out again</p> <p>Catherine: No</p> <p>Nicola: If I had known that I may not have said yes, so I got to the hospital, we drove ourselves. All the time our parents are waiting to hear what's going on, they had the baby. I couldn't give any thought to him really because my situation felt like I was on the brink. I had to not think about him. It was just</p>	Positioned to 'therapise' – provision of treatment
Role of professionals		Allocation of <u>power</u> – agency to act Regulatory agency
Care Provision		Place to go in crisis – Team of people to "help" Place to offer "relief"
Needing help – Positioned as a patient		Help – ability to do so constructed by <u>knowledge</u>
Sectioning		<u>Power</u> to section – ultimate control/regulation Position woman as problematic
Experience of health care provision – position as a mental health patient		"desperate", "willing", compliant with being admitted – 'construction of good patient'
Construction of parent		Lack of knowledge – didn't "realise" Positioned as disempowered
Identifying position as a mother  Incompatible? The onset of postpartum psychosis & role of patient		Waiting to hear, supportive, available "the baby" – does not feel like hers, lack of connectedness? "on the brink" – tipping over into madness. Not thinking to protect sense of self

Research Question: How do women who self-identify as having been diagnosed with postpartum psychosis construct their experiences; in what ways do they use talk to describe and understand their experiences and what discursive resources do they deploy when telling their stories?

<u>What are they talking about?</u> (objects, events, experiences)		<u>How are they talking about it?</u>
Postpartum psychosis		
Experience of postpartum psychosis & position as patient	<p>mad, literally. We got to hospital, during the assessment I was gone into the delusions. It came over me, I stood up and from that point on I have 2 weeks of memories of being in a psychosis that's quite vivid but I can't really say consecutively how it panned out. At one point I remember thinking I was in a sleep clinic. Everything was exaggerated, at one point my husband and the doctor was laughing, for me I thought that's okay, I'm in a sleep clinic. I will have a sleep then be back home. I had a sleeping pill but that night it took ages for that sedative to work and to turn my brain off. I could hear people screaming; whether that was an audio hallucination I don't know. I thought it was my mum screaming because I had gone to hell, I remember texting the pastor saying, well I sent a few not making much sense about getting me out of there basically. The next morning I felt like I had to start all over again to get help and go through it all again in my mind, almost like working through Dante's stages of hell to get some help. I kept hearing pops in my head when I went through each level. That went on for 2 weeks. There was sometimes when I was euphoric.</p>	<p>Rhetorical devise - "mad" in literal sense. Humour? Less stigmatised /emotive than psychosis? Problematises her situation</p> <p>"vivid" - Symptomology to describe experience of PP – Language used in description of PTSD – trauma. Medicalised speech as descriptor</p>
Inpatient facility to 'treat' postpartum psychosis		
Medication		
Experience of postpartum psychosis		<p>Making sense of experience – needs sleep following childbirth. GOAL - recovery</p> <p>Place to provide medication - To provide sleep - To "turn brain off" – betrayed by faulty brain</p> <p>Loss of trust in oneself could hear "screaming" – explanation sought through experience of symptomology "audio hallucination"</p> <p>Unable to "make sense" of experience</p> <p>Reference to own mum "screaming" – recognition of position as mother as in tune with child</p>
Postpartum psychosis – as psychotic symptomology		<p>PP constructed as "hell"</p> <p>"euphoric"</p>