Postpartum Psychosis: the Role of Psychosocial Factors and the Experience of Fertility Decision-Making

being a thesis submitted in partial fulfilment of the
requirements for the degree of
Doctor of Clinical Psychology
in the University of Hull

by
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MSci (Hons) Psychology
University of York
June 2024

Acknowledgements

Firstly, my sincerest gratitude goes to the women who participated in this research. Your openness, honesty, and advocacy for postpartum psychosis are inspiring. Hearing and sharing your stories through this research was truly a privilege. Thank you also to those at Action on Postpartum Psychosis, your support, particularly during recruitment, was invaluable to this research.

I would also like to thank my supervisors, Dr Anjula Gupta and Dr Chris Sanderson, for their continued support, guidance, and encouragement during this project. Thank you for trusting in my ideas and sharing your knowledge and reflections, all of which have helped me to grow, both personally and professionally, over the last three years.

To my family, thank you for always believing in me. Your unconditional love and calming reassurance have given me the strength to achieve, particularly when the road has felt bumpy on this long academic journey.

To my partner, Cam, I would not have been able to complete training or this thesis without you. You have cheered with me during the highs and lifted me up during the lows. Thank you for your endless love, patience, and faith in me.

Lastly, I would like to dedicate this thesis to my nana, Wynn - one of the strongest women I know. Thank you for teaching me kindness and compassion; values that you have passed down our family, without which I do not think I would be where I am today.

Overview

This thesis portfolio comprises three parts:

Part One: Systematic Literature Review

The systematic literature review explored the role of psychosocial factors in women’s experiences of postpartum psychosis (PP) using qualitative research. A thematic synthesis of the eight identified papers generated one overarching theme (Misogyny and Motherhood), which connected to six further analytical themes: Perinatal-specific Stress, Trauma and Stressful Life Events, Social Support, Legal Factors, Economic Factors, and Culture, Religion, and Spirituality. Findings demonstrate the extensive role of psychosocial factors across women’s experiences of PP and indicate the need for continued psychosocial engagement in future research and clinical practice.

Part Two: Empirical Paper

The empirical paper explored women's experiences of fertility decision-making after an experience of first-onset PP. Qualitative data from semi-structured interviews with nine women were analysed using Interpretative Phenomenological Analysis. Six Group Experiential Themes, associated with twelve subthemes, were identified: Decision-making as *“a bit of a process”*, Fear of recurrence, Desire to have more children, Grief, Support needs, and Accepting the decision. Findings represent the complex, emotional, and deeply personal nature of fertility decision-making after first-onset PP and indicate the need for specialist, psychologically-informed preconception support.

Part Three comprises the Appendices

The appendices contain supporting information to the systematic literature review and empirical paper, including reflective and epistemological statements.

Total word count (excluding appendices): 24,334

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Part One: Systematic Literature Review

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"I sometimes fancy that in my condition if I had less opposition and more society and stimulus—but John says the very worst thing I can do is to think about my condition, and I confess it always makes me feel bad. So I will let it alone and talk about the house."

The Yellow Wallpaper, Charlotte Perkins Gilbert (1892)

Part One – The Role of Psychosocial Factors in Women's Experiences of Postpartum Psychosis: A Qualitative Systematic Review

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This paper is written in the format ready for submission to the Psychology of Women Quarterly.

Please see Appendix A for the Guidelines for Authors.

Word count: 7, 528 (excluding abstract, tables, figures, references and appendices)

Abstract

Research into postpartum psychosis (PP), a severe perinatal mental health difficulty, has been historically dominated by the biomedical model. The literature has begun to explore psychosocial risk factors for the onset of PP. However, a gap remains regarding a deeper understanding of the influence of psychosocial factors in the broader meaning and experience of PP. This systematic review, therefore, aimed to use the growing qualitative literature base to explore the role of psychosocial factors in women's experiences of PP. A comprehensive literature search of five databases was conducted, and thematic synthesis was employed to synthesise the findings of the eight included studies. One overarching theme (Misogyny and Motherhood) was connected to six further analytical themes: Perinatal-specific Stress (including the subthemes Stressful Pregnancy, Birth Trauma, and Postpartum Complications), Trauma and Stressful Life Events, Social Support, Legal Factors, Economic Factors, and Culture, Religion, and Spirituality. The findings demonstrate the extensive role of psychosocial factors across women's experiences of PP, including highlighting the pervasive role of misogynistic narratives and patriarchal oppression. The review indicates the need for continued psychosocial engagement in future research and clinical practice regarding PP.

Keywords: postpartum psychosis, psychosocial, thematic synthesis, systematic review, qualitative

Introduction

Research suggests between 0.89 and 2.6 women for every 1,000 births globally will develop postpartum psychosis (PP; Vanderkruik et al., 2017). Whilst relatively uncommon compared to other perinatal mental health difficulties, PP is considered one of the most severe (Forde et al., 2020). PP typically develops within two weeks following birth (Osborne, 2018) and can involve a rapid onset of distressing experiences, such as confusion, racing thoughts, unusual beliefs, disorganised behaviour, and mood lability (Heron et al., 2008, Perry et al., 2021). Specialist support is considered vital (Forde et al., 2020), typically involving inpatient admission, often to a Mother and Baby Unit (MBU; Plunkett et al., 2017).

Despite its severity, PP remains significantly under-researched (Freidman et al., 2023). There is growing recognition within PP literature this is in part due to the dominance of the biomedical model which has restricted progress by creating misogynistic and reductive narratives about psychosis in the female body (Brown, 2019). For example, primary models of aetiology have focused on locating PP within women's bodies and biology, such as hormonal theories, which continue to be referenced despite limited evidence regarding their efficacy (Doucet et al., 2011; Isik et al., 2022). Similarly, clinical research has overwhelmingly focused on biomedical interventions, such as anti-psychotics and electroconvulsive therapy, despite their efficacy and suitability for this population being questioned (Babu et al., 2013; Doucet et al., 2011; Osborne, 2018). Recently, Brown (2021) emphasised the need for contemporary psychosocial and feminist perspectives in understanding PP, including the importance of centring women's voices through qualitative research.

The demand for more critical engagement regarding the PP experience sits within a wider paradigm shift that has occurred for psychosis outside the peripartum. Historically understood as a brain disease (Johannessen & Joa, 2021), with little recognition given to the influence of environmental factors (McGuffin et al., 1994), psychosis outside the peripartum is now understood through a more holistic and nuanced lens. For example, the traumagenic neurodevelopmental model

(Read et al., 2001) explains the role of psychosocial stress, such as developmental trauma, poverty, and discrimination, in predisposing, precipitating, and perpetuating experiences of psychosis (Read et al., 2009; Read et al., 2014). Changing the discourse around psychosis has had significant clinical implications, notably the increase in trauma-informed care and the development of evidence-based psychological therapies (Read et al., 2014), which are reflected within clinical guidelines (National Institute for Health and Care Excellence (NICE), 2014). Deplorably, PP has largely been left behind, with a marked absence of citation of the traumagenic neurodevelopmental model (Read et al., 2001; Read et al., 2014) within PP literature and a lack of specific and non-medical recommendations for PP within current perinatal mental health clinical guidance (NICE, 2020).

Psychosocial factors can broadly be defined as characteristics that influence individuals psychologically and/or socially, as such they describe individuals in relation to their social environment and the effects this can have on their physical and mental wellbeing (Thomas et al., 2020). Multiple quantitative studies have identified significant relationships between individual psychosocial risk factors and PP, including low socioeconomic status (Nager et al., 2006; Upadhyaya et al., 2014), history of childhood abuse (Hazelgrove et al., 2021; Kennedy & Tripodi, 2015), stressful life events (Aas et al., 2020; Hazelgrove et al., 2021), and peripartum complications (Antoniou et al., 2021; Hellerstedt et al., 2013; Khedr et al., 2023; Meltzer-Brody et al., 2017; Upadhyaya et al., 2014). Recent systematic reviews and meta-analyses have sought to assess these relationships more definitively. However, primarily due to the lack of sufficiently powered research and replication studies, robust conclusions about the role of adverse life events in the onset and relapse of PP could not be made (Caropreso et al., 2020; Nguyen et al., 2022; Reilly et al., 2023).

In line with the shift away from the detached biomedical perspective of PP, there has been a significant increase in qualitative studies exploring various aspects of women's experiences of PP. Systematic reviews have synthesised this rich literature base, including exploring the experience of PP (Wicks et al., 2019) and recovery from PP (Forde et al., 2020). Both highlighted the importance of the social context in understanding women's experiences of PP, specifically the distress caused by societal expectations of motherhood (Wicks et al., 2019; Forde et al., 2020). Psychological and psychosocial support were recommended as part of PP recovery (Forde et al., 2020), highlighting the importance of considering these needs.

As part of an unpublished thesis, Stockley (2018a) conducted a systematic review combining quantitative and qualitative studies to evaluate how psychosocial factors are associated with the onset of PP. A range of psychosocial factors were identified including, birth characteristics (e.g., negative birth experiences), psychological factors (e.g., childhood trauma), and sociological factors (e.g., cultural pressure). However, the review lacked coherence and depth, including understanding the reliability of findings based on research quality. Studies were also excluded if they did not directly discuss ‘psychosocial factors’. Therefore, studies may have been excluded due to their lack of explicit reference to 'psychosocial factors' simply because the original authors did not interpret or label data as such, which is likely given the dominance of biomedical narratives in the area.

The present review aims to expand on Stockley (2018a) and existing quantitative reviews that have tried to assess the role of psychosocial factors in PP (Caropreso et al., 2020; Nguyen et al., 2022; Reilly et al., 2023). Drawing exclusively from the rich qualitative research base, which has significantly expanded since Stockley (2018a), the review intends to develop a deeper understanding of how psychosocial factors influence the broader meaning and experience of PP for women, not just their role in onset (Caropreso et al., 2020; Nguyen et al., 2022; Stockley, 2018a; Reilly et al., 2023). It will also seek to engage with a more holistic and critical lens regarding the PP experience, in the hope of contributing to the need for wider change in narratives surrounding PP (Brown, 2019, 2021). Significant investment is being made to improve perinatal mental healthcare within the UK and across the world (Howard & Khalifeh, 2020; NHS England, 2019). Therefore, it is a pivotal time to explore alternative approaches to understanding the PP experience and ensure women’s voices are heard through prioritising qualitative research. With the hope of facilitating investment in valued and effective developments in care and support, such as psychosocial interventions.

The current review will identify, assess, and synthesise qualitative literature regarding women's experiences of PP, to answer the following research question: "What is the role of psychosocial factors in women's experiences of PP?"

Method

The review followed the ENTREQ ('Enhancing transparency in reporting the synthesis of qualitative research') statement guidelines (Tong et al., 2012). Before commencement, the systematic review was registered on PROSPERO (CRD42023469900).

Search Strategy

Five electronic databases (Academic Search Premier, APA PsycArticles, APA PsycINFO, CINAHL Complete, and MEDLINE), accessed via EBSCOhost, were searched between December 2023 and February 2024, with a re-run before final analysis in March 2024. The databases were selected to cover a combination of psychological, medical, and more general literature bases. Manual reference checking of eligible studies was completed (Booth, 2016) but did not yield any additional papers.

The following search terms were used:

TI (Puerper* OR Postpart* OR "Post-part*" OR Postnatal* OR "Post-natal*")
AND (Psychosis* OR Psychotic* OR Psychoses* OR Bipolar* OR Mania* OR Manic*)
AND (Psychosocial* OR "Psycho-social*" OR Psycholog* OR Social* OR "Life event*" OR Stress* OR Trauma* OR Advers* OR Abus*)

Development of search terms involved reviewing existing literature to identify keywords. Interchangeable words used to describe the postpartum period and variations in medical terminology and related constructs to 'psychosis' were considered. Variants of 'psychosocial' were identified, alongside specific psychosocial factors found within relevant articles, such as 'trauma'. A title limiter was applied to the first line of search terms to narrow to perinatal-specific literature. Truncation (*) accommodated synonyms, plurals, and spelling variations. Search terms were discussed with research supervisors and a research librarian with experience in developing search strategies for systematic literature reviews.

Limiters for English language and peer-reviewed academic journals were applied in EBSCOhost, in line with inclusion and exclusion criteria (see Table 1). No restriction regarding the date of publication was applied.

Inclusion and Exclusion Criteria

Table 1 lists the inclusion and exclusion criteria, with associated rationale, applied to the review. A peer reviewer independently checked the final sample of papers against the inclusion and exclusion criteria, no disagreements were noted.

Article Selection

Figure 1 presents a summary of article selection using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram (Page et al., 2021).

Data Extraction

The first author extracted key data from the studies included in the review, using a bespoke tool (Appendix D), and collated this in a spreadsheet. A peer reviewer independently checked all extracted data, no disagreements were noted.

Quality Assessment

The methodological quality of each study was assessed using the National Institute for Health and Care Excellence quality appraisal checklist for qualitative studies (NICE, 2012; Appendix E). The checklist was selected due to its well-established acceptability (Zeng et al., 2015), and prior use in qualitative reviews within both psychosis and perinatal mental health literature (e.g., Ritunnano et al., 2022; Watson et al., 2019). The checklist comprises 14 questions and concludes with an overall assessment rating of '++', '+' or '-'. Three studies were randomly selected for inter-rater checking by a peer reviewer. Minor disagreements in checklist criteria were

Table 1

Inclusion and Exclusion Criteria and Rationale

Inclusion Criteria	Exclusion Criteria	Rationale
Empirical research using primarily qualitative methodology/data.	Studies using primarily quantitative methodology/data or studies that are not empirical research (e.g., case studies, reviews, conference proceedings).	The review aimed to explore the role of psychosocial factors in women's experiences of PP, therefore empirical studies with primarily qualitative data were deemed most appropriate.
Studies published in English language.	Studies not published in English language.	English language sources were selected so they were accessible to the researchers. Appropriate translation resources were not within the research budget.
Studies published in peer-reviewed journals.	Studies published in non-peer-reviewed journals or unpublished theses.	Peer-reviewed sources were selected to increase the likelihood of high-quality studies being included.
Studies that include women who have experienced PP (including those with a confirmed clinical diagnosis or self-report).	Studies that do not include women’s experiences of PP (e.g., only reporting partner, family, or professional perspectives). Studies exploring other perinatal mental health difficulties, such as postnatal depression or studies that do not stipulate specific difficulties/diagnosis.	Sources that had distinguished data on women’s experiences of PP were deemed most appropriate to the aim of the review. PP has a varied history regarding clinical diagnosis (Spinelli, 2021), so studies with participants with confirmed clinical diagnosis or self-reported PP were included.
Studies that explore women’s general experiences of PP (e.g.,	Studies that focus on specific aspects of women’s PP experiences (e.g., experience	It was beyond the scope to include studies that consider specific aspects of women’s PP

development, onset, course, meaning).	of recovery, care/intervention).	experience. Excluding these studies also ensured the current review was distinguished from pre-existing reviews (e.g., Forde et al., 2020).

identified and discussed until a consensus was reached, however, no changes to overall assessment ratings were required.

There is a lack of agreement within the literature regarding how quality assessment should be applied within qualitative evidence syntheses (Flemming & Noyes, 2021). However, the decision was made to exclude any studies that received a '-' overall assessment rating, due to the deemed lack of credibility (Engqvist et al., 2011), leaving eight papers in the final review.

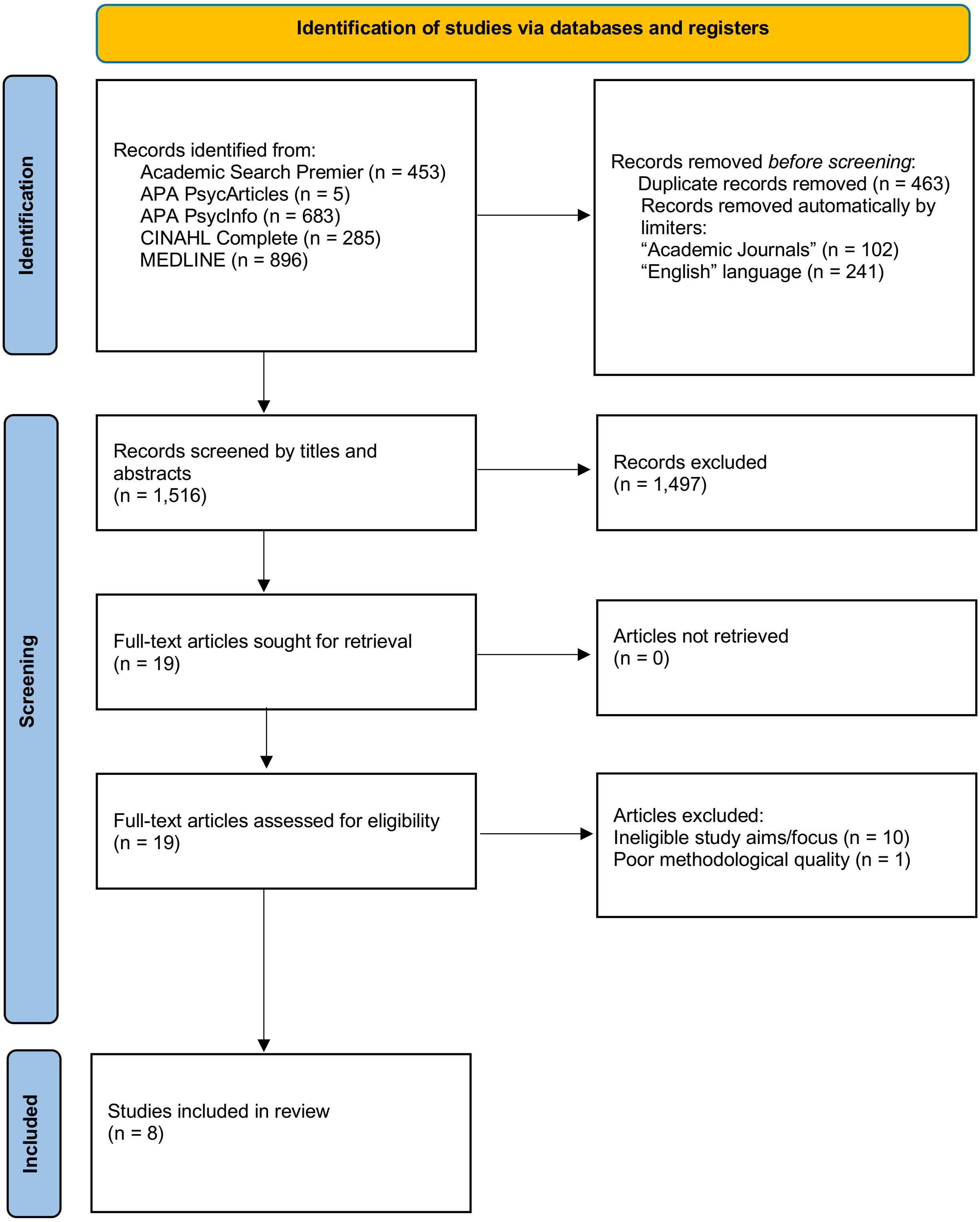
Data Analysis

A thematic synthesis (Thomas & Harden, 2008) was conducted. Thematic synthesis was selected for its suitability for qualitative evidence synthesis, specifically when seeking to describe people's experiences of illness and healthcare (Flemming & Noyes, 2021), as was the aim of the present review.

Following Thomas & Harden's (2008) guidelines, all data under the headings "findings" or "results" of the included studies were extracted electronically and imported into NVivo 14 software. The first author completed inductive, line-by-line coding of the data, developing more codes as each study was assessed. Primary codes relating to similar constructs were then grouped and refined into descriptive themes. During both stages, the first author endeavoured to put the review question "temporarily…to one side" (p. 7, Thomas & Harden, 2008) to reduce the impact of an a priori framework on initial findings. The final stage of synthesis involved generating analytical themes, by "going beyond" (p.7, Thomas & Harden, 2008) the data from included studies by identifying connections between descriptive themes and developing new interpretations to address the review

Figure 1

Article Selection Summary - PRISMA Flow Diagram (Page et al., 2021)



question. Analytical themes were discussed and refined with research supervisors.

Researcher Position

The first author identifies as a white British, female, trainee clinical psychologist with a longstanding research and clinical interest in perinatal mental health. The first author acknowledges and actively seeks to engage with feminist and psychosocial approaches to PP (Brown, 2021). It is, therefore, recognised that the researcher's lens will have influenced data synthesis, potentially obscuring data that does not align with their experiences or approach (see Appendix B for further discussion). The first author engaged in regular supervision, a reflexive interview, and used a reflective research diary throughout the research process, to maintain awareness of their position and assumptions; subsequently strengthening the credibility of the review (Tong et al., 2016).

Results

Characteristics of Included Studies

Table 2 presents a summary of the included studies. Studies ranged in publication year from 2003 to 2024. Most were based in the UK (Beck, 2020; Glover et al., 2014; Stockley, 2018b; Robertson & Lyons, 2003), however the location of the remaining studies varied internationally, including Sweden (Engqvist & Nilsson, 2013), Australia (Jefferies et al., 2021), India (Thippeswamy et al., 2015), and predominatly USA (Vanderkruik et al., 2024).

All studies broadly aimed to explore women's experiences of PP, with some studies varying in approach and focus. For example, one study used internet narratives of women's experiences of PP (Beck, 2020) and four studies had specific aims of exploring women's experiences of onset, early days, and perceived causes of PP (Engqvist & Nilsson, 2013; Jeffries et al., 2021; Stockley, 2018b; Thippeswamy et al., 2015).

All studies employed a qualitative design but differed in approaches to analysis, the most common being content analysis (Engqvist & Nilsson, 2013; Thippeswamy et al., 2015; Vanderkruik et al., 2024).

There was a total of 302 women participants across the eight studies. Two studies included next-of-kin participants (Engqvist & Nilsson, 2013; Thippeswamy et al., 2015), but in line with the aim of this review, their data was not extracted. The sample sizes of women within the included studies ranged from seven to 130. Reporting of participant characteristics varied significantly. Most studies included women who had been diagnosed or recovered from PP within the last 10 years (Glover et al., 2014; Jefferies et al., 2021; Robertson & Lyons, 2003; Vanderkruik et al., 2024). However, some included participants whose time since onset of PP was significantly longer (Engqvist & Nilsson, 2013; Stockley, 2018b).

Methodological Quality

Studies varied in methodological quality, with only three receiving the highest overall assessment rating of '++' (Beck, 2020; Glover et al., 2014; Jefferies et al., 2021). This rating indicated the study had met most or all of the quality criteria and where it had not been met, conclusions were deemed very unlikely to change. Five studies were given an overall assessment rating of '+' (Engqvist & Nilsson, 2013; Robertson & Lyons, 2003; Stockley, 2018b; Thippeswamy et al., 2015; Vanderkruik et al., 2024), indicating some of the quality criteria had been met and where it had not been met, conclusions were deemed unlikely to change. Appendix F details the specific ratings the studies received for each quality checklist criterion which informed overall assessment ratings.

All studies appropriately used a qualitative approach, had clear research aims, and defensible research designs. The common issues that led most studies to receive an overall assessment rating of '+' were: a lack of detail about data collection methods, a lack of depth in 'richness' of results, and uncertainty about the reliability of analysis. For example, Stockley (2018b) provided no detail regarding how demographic data were collected and no examples of semi-structured interview questions. Multiple studies presented shallow descriptions of themes (Engvist & Nilsson, 2013; Thippeswamy et al., 2015), and the use of non-verbatim quotes in Vanderkruik et

Table 2

Summary of Included Studies (presented in chronological order)

Author(s), Year & Country	Title	Research aim(s)	Research Design and Method of Analysis	Participant Characteristics (women in sample only)	Findings	Quality Rating
Robertson & Lyons (2003) UK	Living with puerperal psychosis: A qualitative analysis	To explore women's experiences of PP and gain some understandings about living with that experience following illness.	Qualitative Grounded theory (Glaser & Strauss, 1967)	10 women diagnosed/treated for PP within last 10 years; average age at interview = 34yrs; time since recovery from PP = 6m – 10yrs; 3 women had subsequent births (unaffected by PP); 4 women had subsequent non-puerperal psychiatric episodes	2 higher order categories: (1) Living with emotions (2) Regaining and changing self 3 major categories with sub-categories: (1) A separate form of mental illness (2) Loss (3) Relationships and social rules	+
Engqvist & Nilsson (2013) Sweden	Experiences of the First Days of Postpartum Psychosis: An Interview Study	To explore descriptions of the first days of PP from different	Qualitative Content analysis	7 women who self-identified an experience of PP; age at interview = 36-60yrs; time since onset of PP = 7-32yrs; age at onset	1 theme: Shades of black with a ray of light 5 subthemes: (1) Loss of sleep (2) Being in an unreal world	+

	with Women and Next of Kin in Sweden	perspectives (women and next of kin).		of PP = 27-32yrs; no women had subsequent births	(3) From a wanted baby to an unwanted baby (4) Infanticidal ideation (5) Suicidal ideation – a complete darkness	
Glover et al. (2014) England	Puerperal psychosis – a qualitative study of women's experiences	To explore women's individual experiences of PP and the context in which they make sense of it, in order to consider the possibilities for a more holistic understanding of PP.	Qualitative Inductive thematic analysis (Braun & Clarke, 2006)	7 women diagnosed with PP in last 10 years; age range at interview = 25 – 45yrs; total number of children = 1 – 4 (4 primiparous, 3 multiparous); all lived in North of England (4 lived in a city, 3 lived in rural areas); 2 women had changed partners since their illness	4 themes: (1) The path to puerperal psychosis (2) Unspeakable thoughts and unacceptable self (3) 'Snap out of it' (4) Perceived causes	++
Thippeswamy et al. (2015) India	What is in a name? Causative explanatory models of postpartum psychosis among	To explore explanatory models of PP among women and their family members.	Qualitative Content analysis	123 women diagnosed with PP (8 interviews answered by women only, 44 interviews answered by women and a family member together, 71	In 69% of interviews, the explanatory model participants gave for PP could be broadly classified into 4 categories:	+

	patients and caregivers in India			interviews answered by family members only); average age at interview = 25.42yrs; 61% were primiparous; 49.6% were from a rural background; 99.2% were married; socioeconomic background - 61% were low and 31.7% were middle; average number of years in formal education = 9.88yrs; 77.2% belonged to Hindu religion	(1) Specific to postpartum period (2) Mental illness (3) Psychosocial factors (4) Supernatural (5) Physical factors	
Stockley (2018b) UK	Women's Experiences of Postpartum Psychosis During Onset and Early Days	To explore women's experiences of 'out of the blue' PP during onset and early days.	Qualitative Interpretative phenomenological analysis (Smith et al. 2009)	7 women who self-identified an experience of PP; time since experience of PP = 2 – 22yrs; areas of living included Midlands, North West England and North Wales	4 superordinate themes: (1) What's happening? (2) Lack of recognition of the seriousness (3) Breast is best? (4) Trauma	+
Beck (2020) UK	Pentadic Cartography:	To conduct a narrative analysis of	Qualitative	8 women who had posted narratives about their	Total of 52 scenes described.	++

	Mapping Postpartum Psychosis Narratives	stories of PP women had posted on the Action on Postpartum Psychosis (APP) website.	Narrative analysis (Burke, 1969)	experience of PP on the APP website; 5 were primiparous and 3 were multiparous; 6 were married and 2 were partnered	Frequency of scenes: Agent: Act = 32 (appeared most prominently on the pentadic map); Scene: Agent = 13; Act: Agency = 7	
Jefferies et al. (2021) Australia	The river of postnatal psychosis: A qualitative study of women's experiences and meanings	To explore women’s experiences of PP and address the following questions: (1) How do women recognise that they are experiencing symptoms of PP? (2) What are women’s experiences of seeking assistance for these symptoms? (3) What do women perceive to be contributing factors	Qualitative Inductive thematic analysis (Braun & Clarke, 2006)	10 women who had recovered from PP in the last 10 years; age at first episode of PP = 28 – 25yrs; 4 were primiparous and 6 were multiparous; 8 had PP after first birth and 2 had PP after second birth; 3 had experienced 2 episodes of PP; area of living covered 4 states of Australia; all partnered at time of interview	5 key themes using the allegory of a river: (1) Banks of the River: *Family history or pre-existing mental illness after a previous pregnancy* (2) Muddy Waters: *Problems during pregnancy, childbirth or the early postnatal period* (3) Gathering Momentum: *Subtle changes in thoughts or behaviour* (4) The Rapids: *Symptoms of psychosis*	++

		that may have led to the development of PP?			(5) The Misty Pool: *Recovery*	
Vanderkruik et al. (2024) International (predominately USA)	The lived experiences of individuals with postpartum psychosis: A qualitative analysis	To explore women's self-reported lived experiences with PP, including the context of the episode in their lives, treatment experiences and recovery.	Qualitative Content analysis (Hsieh & Shannon, 2005; Mayring, 2021)	130 women diagnosed with PP within the last 10 years; average age at interview = 34yrs; race: 5 black or African American, 112 white, 1 native Hawaiian or other Pacific islander, 5 Other, 3 no primary race; geographic location at interview: 114 = USA, 16 = outside USA; education during pregnancy: 84.2% = Bachelor's degree or post-graduate training; 89.5% married during pregnancy; 77.4% employed during pregnancy	4 overarching categories: (1) Broad psychosocial experiences (2) Impact on the mother-baby dyad (3) Treatment experiences (4) Recovery experiences	+

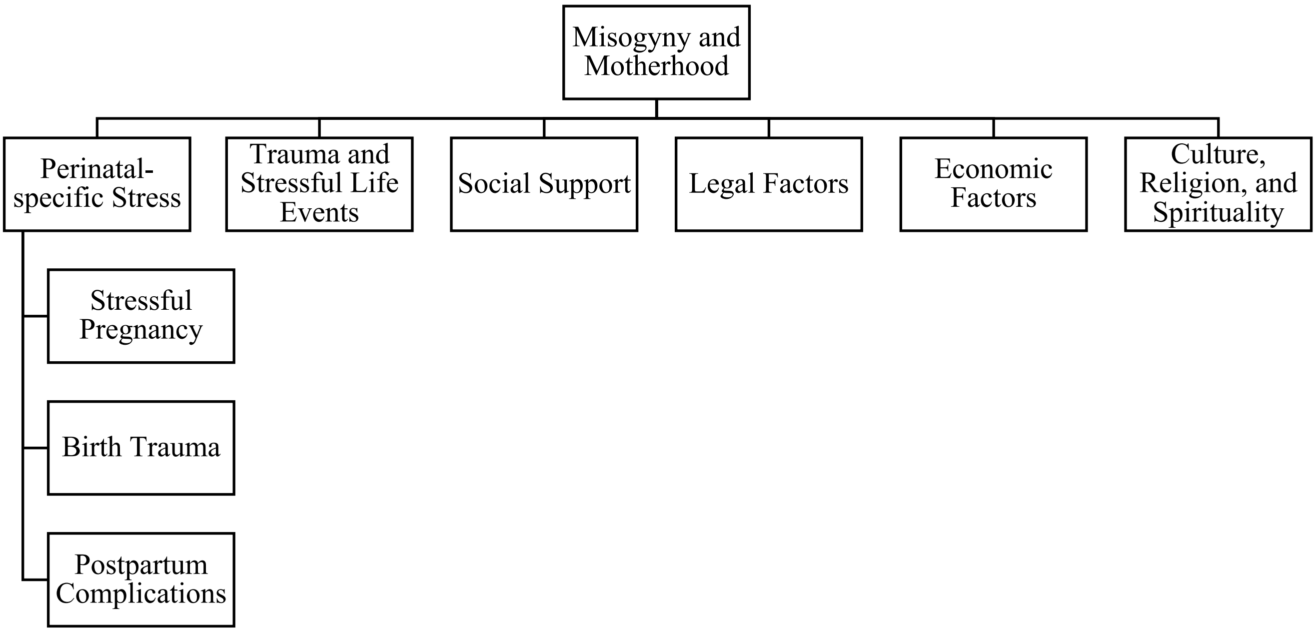
al. (2024) lacked richness when presenting participants' experiences. A few studies only used one coder (Beck, 2020; Stockley, 2018b) or were unclear about how many coders were involved in analysis (Engqvist & Nilsson, 2013). Several studies utilising multiple coders lacked clear descriptions of how differences between them were resolved (Engqvist & Nilsson, 2013; Robertson & Lyons, 2003).

Synthesis of Findings

One overarching theme and six further analytical themes, including three subthemes, were generated by the researcher (Figure 2).

Figure 2

Analytical Themes Generated from the Thematic Synthesis



Misogyny and Motherhood

This theme describes the presence of misogyny and misogynistic discourses within society and how these impacted women's experiences of PP. Misogyny is defined as the hatred of and prejudice against women and expressions of femininity, which is rooted in and enacted by patriarchal ideology (Walker, 2024). Across all studies, misogynistic discourses were significantly present and found to impact women directly, in terms of how they make sense of themselves and their experiences, and indirectly, in terms of how others relate to women generally and when they experience PP. This theme is presented as an overarching analytical theme as it was found to permeate all other analytical themes.

A significant discourse informing women's experiences of PP relates to the idea that the identities of 'mother' and 'person experiencing mental health difficulties', specifically, those labelled as 'psychosis' are incompatible. This discourse could be particularly present in other women who identified as 'mothers' within the woman's family system (Glover et al., 2016). This narrative was associated with stigma regarding PP, which played out in how women related to themselves and their experience of PP, often using self-stigmatising words such as *"freak"* (Jefferies et al., 2021, p.5; Robertson & Lyons, 2003, p.419), *"weird"* (Stockley, 2018b, p.155), *"crazy"* (Vanderkruik et al., 2023, pp. 374-375), and *"mad"* (Glover et al., 2014, p.263). Stigma was also enacted, primarily through the misbelief and dismissal of women's distress, by both family members (Glover et al., 2014) and healthcare professionals (Beck, 2020; Glover et al., 2014; Stockley, 2018b; Vanderkruik et al., 2023), which presented with echoes of discourses around female hysteria.

> *"I think they thought I was just being a bit of a drama queen and that there was nothing wrong with me." (Glover et al., 2014, p. 262, participant quote).*

The dismissal and misbelief of women's distress often led to delays in accessing and receiving the correct care (Glover et al., 2014; Jefferies et al., 2021; Robertson & Lyons, 2003; Stockley, 2018b; Vanderkruik et al., 2023). This could further increase women's distress and often combined with additional unhelpful narratives regarding new motherhood.

> *"I think if they had have taken the lack of sleep seriously in the first place. Everyone was like 'Oh, you're a new mum. You don't sleep.' I'm like 'You don't get it. I literally haven't slept, not even an hour, not at all.' Excuse me, they didn't seem to get the urgency of the*

> *whole lack of sleep. You shouldn't go 10 days with none." (Jefferies et al., 2021, p.5, participant quote)*

Stigma often led to guilt and shame about the experience of PP (Engqvist et al., 2013; Glover et al., 2014; Stockley, 2018b; Robertson & Lyons, 2003). This was particularly prevalent when women spoke about negative thoughts and feelings they experienced towards their baby during PP and the potential impact PP may have had on their baby. Guilt and shame created by stigma were found to uphold misogynistic discourses, as women described being fearful to speak about their experiences, self-censoring details (Glover et al., 2014) or noting the study as the first time they had truly shared their experiences (Stockley, 2018b).

> *"It's really odd. I have never told anyone any of this. It's really weird stuff." (Stockley, 2018b, p. 155, participant quote).*

Misogynistic discourses around pathologising and medicalising women's distress were found to play a significant role in women's experiences of PP. For example, Robertson & Lyons (2003) described that after receiving a label of PP, expressing a full range of emotions became a *"luxury"* (pp. 423). Expressions of emotions were more likely to be perceived as pathogenic and result in medical intervention. This had an enduring effect, such as during further pregnancy after PP.

> *"I was really conscious that you're allowed…the blues…and I was thinking God even if I have that will they think I'm going downhill and put me on drugs." (Robertson & Lyons, 2003, p. 423, participant quote).*

The medicalisation of women's distress was further present when women spoke about the cause of their PP. Across multiple studies, specifically those with Western samples, women described predominate beliefs in biological causes of PP (Glover et al., 2014; Stockley, 2018b; Robertson & Lyons, 2003). Women used descriptions such as, *"chemical imbalance"* (Glover et al., 2014, p.261), and *"brain misfiring"* (Glover et al., 2014, p.262), as well as discussing hormonal changes and childbirth as the precipitant (Robertson & Lyons, 2003). These biological understandings often seemed to originate from healthcare professionals.

> *"...biological, some imbalance, that's what [doctor] used to say it was." (Glover et al., 2014, p.262, participant quote).*

Despite seeming to accept PP as heavily located within their bodies and biology, Glover et al. (2014) noted dissonance within women as they described various other factors as part of their stories. Some of these factors will be explored within subsequent themes.

Perinatal-specific Stress

All studies featured stress and stressors related to the perinatal period, which women shared as part of understanding the cause and context of their experience of PP. Three subthemes, tracking the chronology of the perinatal period were noted: Stressful Pregnancy, Birth Trauma, and Postpartum Complications.

Stressful Pregnancy. This subtheme included the experience of stress around the circumstances of pregnancy, such as unplanned or unwanted pregnancy (Engqvist et al., 2013; Glover et al., 2014; Vanderkruik et al., 2023).

> *"Well the baby wasn't really planned ... my career was going really well, I'd just been promoted again ... but we decided to make a go of it ... I feel that we went along with it like we were rushed along on something we didn't have any say in." (Glover et al., 2014, p. 259, participant quote).*

It also included stress about the wellbeing of the pregnancy; for some women, this was related to previous perinatal trauma, such as miscarriage and child loss (Glover et al., 2014; Jefferies et al., 2021; Stockley, 2018b; Thippeswamy et al., 2015).

> *"... it was ectopic, which was fortunate that I was seen by the consultant ... because if I had not had any previous problems I would have not have known it was ectopic and that could have been life threatening. Eventually when I got pregnant again, I was petrified." (Glover et al., 2014, p. 259, participant quote).*

Furthermore, it included women's stress about their own health and wellbeing, including antenatal mental health difficulties and physical complications of pregnancy, such as hyperemesis gravidarum, gestational hypertension, and preeclampsia (Beck, 2020; Glover et al., 2014; Jefferies et al., 2021, Stockley, 2018b; Vanderkruik et al., 2023).

> *"I had hyperemesis. I was vomiting constantly. I think I lost seven kilos. I was at the hospital getting IV fluids. Yeah, it was horrible" (Jefferies et al., 2021, p.4, participant quote).*

Birth Trauma. Evident across all studies, the subtheme of birth trauma, describes the high level of distress many women experienced during labour and delivery. Circumstances around birth trauma differed, such as preterm labour, obstetric intervention, fear for baby's life, and fear for own life, but a commonality was around feeling out of control (Glover et al., 2014; Stockley, 2018b; Vanderkruik et al., 2023). This appeared related to the dismissal and medicalisation of women's distress identified in the Misogyny and Motherhood theme.

> *"It was a really difficult birth… I kept saying, my head's blowing up…And everybody ignored me…and they put a wet towel over my head…they did the ventouse. That didn't work. They did forceps, they got her out. They had to cut me…out she came…I didn't get to see her... They had whisked her off…it was like I was completely irrelevant." (Stockley, 2018b, p.157, participant quote).*

Postpartum Complications. Finally, the postpartum complications subtheme describes stressful postpartum circumstances, such as concerns about the baby's health and wellbeing, including admissions to Neonatal Intensive Care and Special Care Baby Unit's (Beck, 2020; Stockley, 2018b; Vanderkruik et al., 2023).

> *"I suddenly realized there was something not right and she had actually stopped breathing…I was left thinking, I've killed my baby." (Stockley, 2018b, p.158, participant quote).*

It also included difficulties feeding the baby (Beck, 2020; Jefferies et al., 2021; Stockley, 2018b; Thippeswamy et al., 2015; Vanderkruik et al., 2023). Difficulties with breastfeeding were found to be particularly distressing due to societal pressure to breastfeed, as demonstrated by the *"Breast is Best?"* theme identified by Stockley (2018b).

> *"She felt a lot of pressure to breastfeed and was not producing enough milk. Her baby had dehydration soon after birth. They had to go back to the hospital and her baby was admitted." (Vanderkruik et al., 2023, p.375, non-verbatim participant quote).*

Trauma and Stressful Life Events

Traumatic and stressful life events, that were not directly related to the women's pregnancy, birth, or postpartum, were shared as part of many women's experiences of PP. This included discussion of childhood trauma, which some women shared as part of how they made sense of PP (Stockley, 2018b).

> *"I was a victim of abuse as a child, erm, and I relived that." (Stockley, 2018b, p. 158, participant quote).*

Interpersonal trauma, such as domestic violence, was perceived as part of the cause and context of some women's experience of PP (Stockley, 2018b; Thippeswamy et al., 2015). Again, highlighting the role of misogyny in women's experiences of PP, as identified in the Misogyny and Motherhood theme, through the perpetration of gender-based violence.

> *"My husband would beat me every day. He would pull my hair, kick and hit on head. I am now having these problems because of those incidents." (Thippeswamy et al., 2015, p.820, participant quote).*

Some women shared incidents of community violence and trauma, such as the murder of George Floyd and the COVID-19 pandemic, as part of their story of PP (Vanderkruik et al., 2023). For example, the COVID-19 pandemic was discussed as both providing context to the onset of PP and as an additional stressor during women's experiences of PP.

> *"Especially because during the pandemic, in a state of psychosis, when she thought she might have been hearing voices, she couldn't tell if people might have actually been talking due to masks. No visitors were allowed in the hospital due to COVID-19 as well. This was very isolating and scary." (Vanderkruik et al., 2023, p. 373, non-verbatim participant quote).*

Finally, multiple studies noted the discussion of loss, bereavement, and concerns about the health of relatives, particularly during pregnancy, as playing a role in women's experiences of PP (Engqvist et al., 2013; Jefferies et al., 2021; Vanderkruik et al., 2023).

> *"Her sibling died suddenly during her third trimester. This was very traumatic. Six months before that, her partner's sibling died of cancer, and two months before that, her grandparent died. In the span of her pregnancy, she lost three family members." (Vanderkruik et al., 2023, p.373, non-verbatim participant quote).*

Social Support

The importance of social support in shaping women's experiences of PP was highlighted across all studies. The stigma created by misogynistic discourses, as described in the Misogyny and Motherhood theme, appeared to lead many women to feel unsupported by family members and healthcare professionals (Beck, 2020; Glover et al., 2014; Jefferies et al., 2021; Vanderkruik et al., 2023). Stigma surrounding PP could lead people around women to retract their support, meaning women had subsequent difficulty seeking help.

> *"The midwife responded by telling Debbie to pull herself together, but this comment was not helpful at all and it stopped Debbie from asking for help from anyone." (Beck, 2020, p.1855, author quote).*

The internal experience of PP was described as isolating and lonely (Engqvist et al., 2013; Robertson & Lyons, 2003). For some, this seemed further compounded by the external environment of inpatient admission, which often involved extended separation from family and baby, particularly if an MBU was not available (Beck, 2020; Vanderkruik et al., 2023).

> *"Participant says they didn't see their husband for the first three days. It felt like it was even harder to be delusional and not see family…" (Vanderkruik et al., 2023, p. 376, non-verbatim participant quote).*

Women also described how the experience of PP could strain relationships with people around them, such as friends and family (Thippeswamy et al., 2015, Robertson & Lyons, 2003, Vanderkruik et al., 2023). In some cases, this led to relationship breakdown, particularly with partners (Robertson & Lyons, 2003; Vanderkruik et al., 2023).

> *"after I had been discharged my focus was on looking after [daughter], but I wasn't actually taking much notice that my relationship was sort of drifting apart. I still think to this day we would still be together if I hadn't been ill." (Robertson & Lyons, 2003, p. 421, participant quote).*

Finally, multiple studies highlighted the desire for and value of peer support as part of women's experiences of PP (Jefferies et al., 2021; Robertson & Lyons, 2003; Vanderkruik et al., 2023). Women described how meeting and hearing the stories of peers reduced feelings of isolation and stigma and helped sense-making of their own PP experience.

> *"…I do like talking about it, because it's a big thing to just keep inside. …our stories are, apart from maybe the treatment, … are all very similar from what I've heard from the others. We've all been through very similar things, and it was really good to know that I wasn't the only one, and not a total freak." (Jefferies et al., 2021, p. 5, participant quote).*

Legal Factors

Across multiple studies, women described an intense fear about their baby being legally removed from their care during their experience of PP (Beck, 2020; Glover et al., 2014; Stockley, 2018b; Vanderkruik et al., 2023). This appeared closely linked to the stigma surrounding PP, as described in the Misogyny and Motherhood theme. Women described fearing being seen as an 'unfit' mother (Vanderkruik et al., 2023) if they shared their internal experiences of PP with others.

This fear led some women to try and hide their distress, particularly from healthcare professionals (Beck, 2020; Stockley, 2018b).

> *"Paula did not tell the doctor of her intrusive thoughts because she feared that her baby would be taken away from her and she would be committed to a psychiatric ward." (Beck, 2020, p.1855, author quote).*

Some women described feeling criminalised by their experience of inpatient admission during their experience of PP, describing the environment as *"jail-like"* (Vanderkruik et al., 2023, p.370) and feeling like a *"criminal"* (Vanderkruik et al., 2023, p.376) due to the use of legal mental health detainment frameworks, such as section 5150.

> *"The room had open spaces that felt like cells. She changed into hospital clothes as people in the cells were freaking out and screaming and hitting the walls. The security guards were there. It felt like a jail situation. It did not feel like a medical situation." (Vanderkruik et al., 2023, p.376, non-verbatim participant quote).*

Some women, within Vanderkruik et al.'s (2023) predominately US-based sample, discussed criminal legal involvement as part of their experiences of PP, such as being arrested and charged for *"child endangerment"* (p. 368), which could lead to imprisonment and reduced contact with their children.

> *"She was arrested, then incarcerated for three weeks in a segregated unit. She was kept on medicine that didn't work, had mug shots taken, and was dragged through the mud…She was facing very serious jail time and didn't get to see her baby for the first three months of her life." (Vanderkruik et al., 2023, p.376, non-verbatim participant quote).*

Economic Factors

Stress related to economic factors, such as unemployment, low income, and having a demanding job, were discussed by some women as part of understanding the onset or context of their PP experience (Thippeswamy et al., 2015; Vanderkruik et al., 2023). Some also described wider impacts of financial concerns. For example, struggling to manage the mental strain of working alongside parenting (Thippeswamy et al., 2015), which relates to societal pressures described within the Misogyny and Motherhood theme.

> *"I have to do house hold work, look after the baby and have to work at a garment factory. I feel very tired, don't feel like interacting with others." (Thippeswamy et al., 2015, p.820, participant quote).*

One woman discussed how a lack of financial stability impacted her access to formal support (Vanderkruik et al., 2023).

> *"She got herself counseling, but during that time her partner lost their job, so the counseling sessions ended abruptly, and she wasn't able to continue." (Vanderkruik et al., 2023, p. 375, non-verbatim participant quote).*

Culture, Religion, and Spirituality

Some women described how culture, religion, and spirituality played a role in their experience of PP (Thippeswamy et al., 2015; Vanderkruik et al., 2023). Most notably, Thippeswamy et al. (2015), the only study to use a non-Western sample, identified the importance of culture, religion, and spirituality in how women made sense of their PP experience. Most of their participants held non-biomedical beliefs about the cause of PP.

> *"Somebody has done maata mantra (black magic) because of which all these problems have started." (Thippeswamy et al., 2015, p. 820, participant quote).*

Culture, religion, and spirituality were also found to impact the specific narratives about mental health difficulties and motherhood, as discussed in the Misogyny and Motherhood theme, that women were exposed to. These, in turn, influenced women's experiences of PP. For example, one woman shared how her family dismissed her distress, which she described being due to them being *"very religious"* (Vanderkruik et al., 2023, p.374). Another woman described how patriarchy within her culture caused pressure to have a male baby, which she believed to be significant to the onset of her PP.

"I cried after realizing that I have given birth to female baby. I wanted a male child. My family also wanted a male child." (Thippeswamy et al., 2015, p. 820, participant quote)

Discussion

Overview of Findings

This review synthesised qualitative findings, from eight papers, regarding the role of psychosocial factors in women's experiences of PP. The review identified one overarching analytical theme (Misogyny and Motherhood) which connected to six analytical themes: Perinatal-specific Stress (including the subthemes Stressful Pregnancy, Birth Trauma, and Postpartum Complications), Trauma and Stressful Life Events, Social Support, Legal Factors, Economic Factors, and Culture, Religion, and Spirituality.

The overarching analytical theme of Misogyny and Motherhood corresponds with findings from systematic reviews of the PP experience (Forde et al., 2020; Wicks et al., 2019). Consistently highlighting how societal expectations regarding motherhood and the stigma associated with PP can worsen experiences, by creating barriers to accessing support and increasing distress through feelings of guilt and shame. However, the current reviews findings go beyond this, providing evidence for the extent of harm that can be created by patriarchal power and oppression in predisposing, precipitating, and perpetuating experiences of PP. For example, demonstrating how a history of gender-based violence can backdrop PP (Thippeswamy et al., 2015), how birth trauma, rooted in the dismissal and medicalisation of women's distress and bodies, can be a catalyst to PP (Glover et al., 2014; Stockley, 2018b; Vanderkruik et al., 2023), and how the threat of or actual legal consequences of PP can maintain long-term psychological harm (Beck, 2020; Glover et al., 2014; Stockley, 2018b; Vanderkruik et al., 2023). These findings align with Brown's (2021) recognition of the importance of acknowledging how power operates within the socio-political-cultural context for women, to truly understand, support, and potentially prevent experiences of PP. The breadth and depth of this theme across all included papers, particularly those of the highest methodological quality (Glover et al., 2014; Jefferies et al., 2021), offers credibility to these findings. Therefore, this topic warrants further specific enquiry, such as qualitative research exploring PP stakeholders' views of the role of misogyny within the PP experience.

Findings regarding the Perinatal-specific Stress theme contributes to the evidence base from systematic reviews that have explored peripartum complications and stressors as risk factors for the onset of PP from primarily quantitative studies (Caropreso et al., 2020; Nguyen et al., 2022; Stockley, 2018a; Reilly et al., 2023). This theme was evidenced across all included papers, and the three subthemes were represented by studies of high and medium methodological quality, suggesting robustness in findings. In line with suggestions from previous systematic reviews (Caropreso et al., 2020; Nguyen et al., 2022; Stockley, 2018a; Reilly et al., 2023), the role of perinatal-specific stress warrants further investigation with well-powered, cohort studies. However, results from the current review would emphasise the importance of adopting a psychosocial approach to this research, including gathering data on the psychosocial impact of peripartum complications and stressors for women, instead of viewing their role in PP through a purely biomedical lens.

The theme of Trauma and Stressful Life Events largely aligns with the expanding quantitative research base regarding the role of traumatic and adverse life events in predisposing, precipitating, and perpetuating experiences of PP (Aas et al., 2020; Hazelgrove et al., 2021; Kennedy & Tripodi, 2015). Together, potentially indicating the value of exploring the traumagenic neurodevelopmental model (Read et al., 2001) in future PP research. Findings regarding the role of loss and bereavement contradict a recent large-scale cohort study that found no significant relationship between the death of a close relative before/during pregnancy and PP (Warselius et al., 2019). However, when balanced against the study's limitations, regarding lack of sufficient power and population diversity, this relationship remains worthy of further investigation. Vanderkruik et al. (2023) offered a broader definition of trauma within the present review's findings, with the consideration of community-level incidents. Given that quantitative research has evidenced the direct psychological impact of events such as George Floyd's murder and the COVID-19 pandemic (Eichstaedt et al., 2021; Iyengar et al., 2021), it would appear important for future research into trauma and PP to retain this wider lens regarding the definition of trauma. Overall, this theme was well supported by a mix of high and medium-quality studies, supporting its credibility. However, many of the specific types of trauma and stressful life events were based on only one or two studies. Therefore, as implicated by previous systematic literature reviews (Stockely, 2018a; Reilly et al., 2023), there is a distinct need for replication. This replication would, however, appear to benefit from a mixed-methods approach, allowing for depth regarding the psychosocial meaning and impact of trauma, as captured by this review.

Findings regarding the theme Social Support align with previous reviews (Forde et al., 2020; Stockley, 2018a; Wicks et al., 2019) by highlighting the importance of social support across the PP experience, including social support as a risk factor to onset, social stigma and relationship breakdown as perpetuating factors, and the value of social support in recovery, particularly peer support. Furthermore, this theme was evidenced across all studies, including those of the highest quality, strengthening conclusions. Moreover, this theme illuminated how the inpatient environment can be a barrier to social support, in turn perpetuating experiences of PP (Beck, 2020; Vanderkruik et al., 2023). Whilst based on only two studies, this novel finding is strengthened by research highlighting the importance of the baby and family within PP recovery (Lever Taylor et al., 2019; Plunket et al., 2017; Wicks et al., 2019) and specialist MBU facilities, in place of general psychiatric units (Roxburgh et al., 2023).

The theme of Legal Factors represents new findings regarding how the literal and threatened power of the legal system can shape women's experiences of PP. Findings regarding the fear of the baby's removal provide evidence for Forde et al.'s (2020) hypothesis that the anticipated threat of legal power may act as a barrier to women with PP accessing timely treatment. Moreover, women's experiences of feeling criminalised by the inpatient environment aligns with research evidencing the unsuitability of general psychiatric facilities for women experiencing PP (Roxburgh et al., 2023).

Vanderkruik et al. (2023) evidenced the experience of women who have been criminalised during their PP experience, which corresponds to a recent *"call to action"* (p.1, Feingold & Lewis, 2024) to update US law to prevent incarceration in these circumstances. Whilst this latter finding relates specifically to the US legal system, it appears to represent a widespread, underlying, harmful discourse regarding the overstated risk of infanticide associated with PP (Brown, 2019). Elements of this theme were well-supported by high-quality studies; however further research is needed to increase understanding regarding the role of legal factors within PP. In-depth qualitative enquiry exploring women's experiences of feeling or being criminalised during PP would appear an important next step to give further voice to these stories.

Whilst only supported by two medium-quality studies, the Economic Factors theme aligns with multiple quantitative studies identifying low socioeconomic status as a significant risk factor for PP (Khedr et al., 2023; Meltzer-Brody et al., 2017; Nager et al., 2006; Upadhyaya et al., 2014), increasing credibility of this finding. The present review also revealed the role of economic factors in perpetuating experiences of PP, such as the role of financial security in impacting access to care, which supports findings from PP recovery literature (McGrath et al., 2013). However, the overall limited evidence for this theme means further research is needed. Adopting a longer-term view to better understand how economic factors, such as poverty, may influence the experience of PP beyond onset would appear valuable, as identified for psychosis outside of the peripartum (e.g., Warner, 2008).

The final theme of Culture, Religion, and Spirituality was limited, with evidence provided by only two studies. However, this seems to reflect a wider issue within the field. Minimal exploration of socio-cultural factors within the PP experience in qualitative research since Stockley's (2018a) review appears strongly related to the lack of studies with non-Western samples. The paucity of culturally diverse research within PP literature is a significant issue, particularly given the known impact of systemic racism within perinatal health care (Birthrights, 2022; Pilav et al., 2022) and the experience of psychosis for women outside of the peripartum (Keval, 2019).

Further research exploring the experience of PP in culturally diverse samples, including women who are ethnically minoritised within Western cultures, will increase understanding of how cultural factors influence the meaning and experience of PP, particularly for those who are racialised.

Strengths and Limitations

A strength of the present review was that included papers drew from different sampling methods, including interviews and online narratives. This should have supported different types of participant voices to be explored. However, despite Beck (2020) achieving the highest overall quality rating, the type of analysis applied to online narratives within their sample and style of dissemination meant limited data could be drawn for the current review. Therefore, the possible diversity offered by the alternative online narrative sampling technique was potentially missed due to the limited usability of findings.

The large sample size (n = 302) was a strength of the review, given that only eight studies were included. Whilst this large sample size was mostly attributed to the Vanderkruik et al. (2023) study, it provides additional credibility to findings. However, a significant limitation is that most of the sample represented Western, assumed predominately white participants due to poor reporting of ethnicity. The lack of reporting of ethnicity and general cultural diversity within the review, means findings are unlikely to reflect the experiences of non-white, Western women. As aforementioned, the paucity of research exploring these women's experiences is a significant issue within the PP field and must be prioritised.

Whilst the review identified the role of multiple psychosocial factors within women’s experiences of PP, it remains limited by the lack of qualitative research specifically exploring psychosocial perspectives and factors. The review had to sample from studies exploring the broader experience of PP, therefore it is unlikely the full depth and breadth of the role of psychosocial factors within women's experiences of PP will have been captured. Furthermore, the lack of researcher reflexivity within included papers additionally complicated the ability to evaluate whether psychosocial factors were likely to have been unreported due to researchers holding a more biomedical lens of PP. Increasing reporting of researcher reflexivity and more specific engagement regarding the role of psychosocial factors will be valued steps for future qualitative PP research.

Clinical Implications

The findings of this review suggest the clinical value of adopting a psychosocial approach to identifying, understanding, supporting, and preventing PP. The omnipresence of patriarchal oppression and misogyny within this review indicates the need for critical psychosocial engagement at all levels of the PP experience. Clinical application should not stop at simply identifying women at risk of PP because of isolated psychosocial risk factors. System-level change is needed, including recognising and taking action to address the harm created by misogynistic narratives and practices within healthcare services during the perinatal period. One way this could be addressed is the implementation of trauma-informed practice across maternity and perinatal mental health services (Law et al., 2021). A trauma-informed approach could help better support the needs of women who may be at risk of PP due to historical trauma, as well as women currently experiencing PP. It could also potentially reduce the rates of perinatal-specific trauma (Simpson & Catling, 2016), which may preventatively reduce some women’s risk of developing PP.

On a more individual level, the findings of this review indicate the potential value of developing psychosocial interventions to support women experiencing PP. For example, drawing on the Power Threat Meaning Framework (Johnstone & Boyle, 2018) could support women to make sense of their PP experience within the wider socio-political-cultural context, and assist in the identification of potential perpetuating psychosocial factors, such as financial insecurity. Systemic therapeutic interventions, such as family therapy (Darwin et al., 2021) and peer support (Jones et al., 2014), may also help address stigma by supporting family’s understanding of PP and connecting women to those with similar experiences. Future research should focus on establishing the efficacy of psychosocial interventions for PP.

Conclusion

The present review reveals psychosocial factors play a complex role across women's experiences of PP. This extends findings of previous reviews that have focused specifically on understanding their role in onset. The review also highlighted the extent of harm caused by misogyny and patriarchal oppression within women's experiences of PP. Together, these findings indicate the value and importance of employing a comprehensive psychosocial approach to PP, including engaging with the socio-political-cultural context that these experiences are undeniably shaped by.

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Time for Another *by Jenny*

It must be time for another,
You can't have just one son.
He'll have no one to play with, be all alone,
And that would be no fun.

It must be time for another,
Sticking at one's not fair.
He'll be spoilt and selfish, demanding and rude
And won't know how to share.

It must be time for another,
Do you not love being a mother?
You should think about him and not about you,
He'd adore a sister or brother.

It must be time for another,
How old is he, nearly three?
Time's ticking on, your chance will be gone,
You'll really regret it, you'll see.

But another might drive me to madness,
Another could tear us apart.
We are three now not two, what would happen to you
If my mind broke? The thought breaks my heart.

This time you'd know, you'd be ready,
This time you'd plan, we'd be here.
But the horror of it all, the spiralling fall,
The hell of it, you've no idea.

Yet the thought of another is tempting,
That it might all be well, all be fine.
It could heal what has passed, lay the ghosts down at last,
The decision to try is all mine.

I'll get there, but the choice isn't simple,
The answer not easy to find.
I just hope if we do decide to have two
It doesn't mean losing my mind.

Action on Postpartum Psychosis. (2015). *Jenny's poem: 'Time for another'.* https://www.app-network.org/ourstories/jennys-poem-time-for-another/

Part Two – Fertility Decision-Making After an Experience of First-Onset Postpartum Psychosis

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This paper is written in the format ready for submission to the Psychology of Women Quarterly. Please see Appendix A for the Guidelines for Authors.

Word count: 10,462 (excluding abstract, tables, figures, references and appendices)

Abstract

Fertility decision-making has consistently emerged as a key aspect of longer-term recovery for women who have experienced postpartum psychosis (PP). However, there remains a paucity of research regarding an in-depth exploration of the experience of fertility decision-making after first-onset PP. Women who have experienced first-onset PP have no prior history of mental health difficulties but have a significantly higher risk of recurrent PP during subsequent postpartum periods. The study aimed to explore women's experiences of fertility decision-making, including the meaning of decisions and experience of support, after an experience of first-onset PP. Nine women were recruited through purposive sampling. Qualitative data was gathered via semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA). Six Group Experiential Themes (GETs), associated with twelve subthemes, were identified: Decision-making as *"a bit of a process"*, Fear of recurrence, Desire to have more children, Grief, Support needs, and Accepting the decision. Findings represented the complex, emotional, and deeply personal process of fertility decision-making, that was considerably shaped by the experience of first-onset PP. Future research and clinical implications, such as the need for specialist, psychologically-informed preconception support, are discussed.

Keywords: postpartum psychosis, fertility decision-making, qualitative, Interpretative Phenomenological Analysis

Introduction

Postpartum psychosis (PP) typically occurs within two weeks following childbirth (Osborne, 2018). Early experiences often involve feelings of excitement and energy (Heron et al., 2008), which can rapidly decline into distressing and unusual beliefs and experiences, and thoughts of harm towards self and sometimes the infant (Friedman et al., 2023). Around one woman for every 1000 births globally (Vanderkruik et al., 2017) experiences PP and one in three report no prior history of mental health difficulties (Osborne, 2018). Women within the latter group are often termed as experiencing ‘first-onset PP’ (Bergink et al., 2016).

Following an experience of first-onset PP, research suggests women are at a significantly higher risk of recurrent mental health difficulties, particularly during subsequent postpartum periods (Bergink et al., 2016; Wesseloo et al., 2016). Risk estimates for recurrent PP in subsequent pregnancy are cited as 50% within key patient information leaflets, such as those by the Royal College of Psychiatrists (RCP, 2018) and Action on Postpartum Psychosis (APP, 2014). However, this estimate is based on research assessing recurrent PP in women with varied mental health histories, including pre-existing bipolar disorder, of which there is increasing evidence that first-onset PP represents a distinct nosology (Di Florio et al., 2021).

A recent meta-analysis, using a sample of 954 women who had experienced first-onset PP, found that only 35% had a subsequent pregnancy, and of these women, 27% experienced a severe recurrence of PP following the pregnancy (Gilden et al., 2020). These data foremost provide a specific risk estimate for recurrence of PP after first-onset PP. Whilst significant, Gilden et al. (2020) note that previous research non-specific to first-onset PP may have led to an overestimation of postpartum recurrence risk within this group. Moreover, Gilden et al. (2020) highlight the potential significance of only 35% of women having a subsequent pregnancy after first-onset PP. They shared potential reasons for this relatively low rate of subsequent pregnancy. This included being advised against further pregnancy by healthcare providers, based on research regarding the experiences of women with bipolar disorder (Viguera et al., 2002). This suggestion is particularly important given that the risk of postpartum recurrence may have been overstated for women with first-onset PP. However, to date, there remains a paucity of research regarding women's views and experiences of deciding whether to have a further pregnancy after first-onset PP.

Fertility or reproductive decision-making are terms used within research literature to describe the decisions one makes about parenthood, including whether, when, and how to become a parent and the number of children one may wish to have (Philipov et al., 2015). The Theory of Planned Behaviour (TPB; Ajzen, 1991) is a psychosocial theoretical framework that has been applied to fertility decision-making to support understanding of this process (Dommermuth et al., 2011). The theory proposes that intentions, such as wanting a child, always precede behaviour and that these intentions are influenced by three major factors. Firstly, the 'positive and negative attitudes' one has towards the behaviour, for example having a child. Secondly, the 'perceived norms' related to the behaviour, for example, perceived social pressure to have a child. Thirdly, the 'perceived control' one has over the behaviour, for example, the perceptions and beliefs about the resources one has available to have a child. The theory also acknowledges the role of background factors, such as age, gender, ability, culture, and values, in influencing all three factors. This model has been used to understand fertility decision-making alongside physical and mental health difficulties, such as cancer and depression (Carlsson & Kim, 2024; Huang et al., 2019).

As part of a developing literature exploring experiences of recovery following PP, fertility decision-making has emerged as an important aspect of longer-term recovery within this group (Forde et al., 2019; Forde et al., 2020; Holdford et al., 2018; Jefferies et al., 2021; McGrath et al., 2013; Robertson & Lyons, 2003; Vanderkruik et al., 2024). Themes around fear of recurrence and loss of subsequent children have been highlighted. For example, McGarth et al. (2013) noted that for many women "fear of recurrence strengthened their decision to have no further children" (p.5) and Forde et al. (2020) highlighted couples' "sense of loss in relation to their decision-making about future pregnancies" (p.608) following an experience of PP. This suggests fertility decision-making after PP may be a complex and emotive process. However, due to the broader scope of these studies, there is a lack of depth in understanding the meaning and experience of fertility decision-making after PP. Moreover, these studies draw from varied samples of women with experiences of PP, including those with pre-existing bipolar disorder, therefore the specific experience of fertility decision-making after first-onset PP remains unknown.

Qualitative PP recovery literature has also highlighted women's wishes for advice and support from professionals and family members when considering future pregnancies after PP (Forde et al., 2019; McGarth et al., 2013). The need for proactive preconception advice was emphasised as a clinical implication by two recent studies (Forde et al., 2019; Forde et al., 2020), in response to some women's experiences of being "let down by professionals and given the 'wrong advice'" (p.11, Forde et al., 2019). However, again, due to the wider focused aims of this research, there remains a lack of richness in understanding the experience and meaning of support during fertility decision-making after PP. Additionally, broad sampling inclusion criteria leads to uncertainty about whether women with first-onset PP have unique experiences or specific needs during this process. This could be hypothesised given that fertility decisions after first-onset PP will be women's first experience of making such decisions within the context of a history of severe mental health difficulties.

Current clinical guidance in the UK suggests preconception counselling should be offered to support fertility decision-making in mothers who have a history of severe mental health difficulties (National Institute for Health and Care Excellence (NICE), 2020). However, there is no specific guidance for women with a history of PP, particularly where this has been first-onset. Moreover, most of the current recommendations focus on relaying information regarding risk rates, including recurrence (NICE, 2020), and do not address the wider psychosocial impact of making such decisions (Forde et al., 2020).

More detailed guidance has recently been developed for healthcare professionals delivering preconception care to women with current severe mental illness (Howard et al., 2020). However, many women with first-onset PP make a full recovery and do not experience subsequent nonpostpartum psychiatric episodes (Gilden et al., 2020; Rommel et al., 2021), therefore this guidance does not pertain to their experiences. The public health importance of tailored preconception care for women with a history of mental health difficulties has been highlighted (Catalao et al., 2020) and given the current significant investment in perinatal mental healthcare within the UK (NHS England, 2019) it is a crucial time to understand how to best meet the needs of women within this population. Therefore, developing a more nuanced understanding of women's fertility decision-making experience and support needs after first-onset PP would appear an important next step, with clear clinical implications.

The present study conducted the first in-depth, qualitative exploration of women's experiences of fertility decision-making after an experience of first-onset PP.

The study aimed to answer three research questions:

1. What are women's experiences of fertility decision-making after an experience of first-onset PP?
2. What meanings do fertility decisions hold for women after an experience of first-onset PP?
3. What are women's experiences of support when making fertility decisions after an experience of first-onset PP?

Method

The study followed the JARS-Qual ('Journal Article Reporting Standards for Qualitative Research in Psychology') guidelines (Levitt et al., 2018).

Design

The study employed a qualitative design, using semi-structured interviews to generate data about the phenomenology (i.e., the meaning and experience) of fertility decision-making for women following an experience of first-onset PP. Findings were derived via an Interpretative Phenomenological Analysis (IPA) of the data (Smith et al., 2022).

Participants

Using purposive sampling, the study recruited nine participants, in line with IPA sample size recommendations (Pietkiewicz & Smith, 2012; Smith et al., 2022), between August 2023 and February 2024. Participants' eligibility to take part in the study was assessed against inclusion and exclusion criteria (Table 1), to ensure an appropriate level of homogeneity, as required for IPA (Smith et al., 2022). The study was advertised to participants via social media, including PP, perinatal mental health, and psychosis related groups (Appendix G), and through a PP charity newsletter (Appendix H).

Participants' demographic information is summarised in Table 2.

Materials

A demographic questionnaire (Appendix I) and the interview schedule (Appendix J) were developed by the researcher and their supervisors. They were reviewed by an expert-by-experience to check the understandability and appropriateness for potential participants.

The demographic questionnaire was used to aid contextualisation of the qualitative data. Questions were based largely on previous qualitative research on PP (e.g., Wicks et al., 2019), including broad demographic (e.g., age, ethnicity) as well as PP-specific questions (e.g., time since onset of PP), but additionally included questions specific to fertility decision-making (e.g., whether they had a further pregnancy after first-onset PP).

Questions in the interview schedule were developed by reviewing qualitative PP recovery literature (Forde et al., 2020; McGrath et al., 2013) and wider fertility decision-making literature (Dolman et al., 2016; Marklew, 2014), alongside IPA interview guidance (Smith et al., 2022). The schedule was formed of open questions, starting with orienting questions about family and the first-onset PP experience, moving onto the experience and meaning of fertility decisions after first-onset PP (e.g., how did you feel about potential future pregnancies after your (first) experience of PP?). The schedule was used as a guide, incorporating 'funnelling' (Guba & Lincoln, 1981), flexibly using prompts to elicit in-depth information about experiences (e.g., what did those decisions mean to you at the time?).

Table 1

Inclusion and Exclusion Criteria and Rationale

Inclusion Criteria	Exclusion Criteria	Rationale
Women who self-report having recovered from an episode of first-onset PP within the last 10 years.	Women who have experienced distressing or unusual beliefs or experiences, or been diagnosed with bipolar disorder, psychosis or schizophrenia **before** their **first** experience of PP (e.g., not first-onset PP).	The focus of the study was women's experiences of *first-onset* PP specifically. Self-report was used due to the varied history regarding clinical diagnosis (Spinelli, 2021). The 10-year period is consistent with previous qualitative research (e.g., Glover et al., 2014; Jefferies et al., 2021).
	Women currently experiencing an episode of PP or distressing or unusual beliefs or experiences.	Due to the higher risk of potential distress caused by participating and/or difficulties obtaining informed consent.
Have made decisions about whether to have a further pregnancy/ies after first-onset PP: including deciding to try for or have had further pregnancy/ies, deciding not to have further pregnancy/ies, subsequent termination(s) or pregnancy/birth loss.	Have not yet made decisions about whether to have a further pregnancy/ies after first-onset PP.	The interview required participants to be able to retrospectively reflect on their experience of making fertility decisions after first-onset PP.
Over 18 years of age.	Under 18 years of age.	To support informed consent procedures.

English-speaking.	Do not have a good level of fluency in English.	A good level of fluency in English was required for the interview.
Currently living in the UK.	Not currently living in the UK.	To support homogeneity in terms of socio-political-cultural context, as required for IPA (Smith et al., 2022).
Have access to internet connection and Microsoft Teams software.	No access to internet connection or Microsoft Teams software.	This was required to complete the online interview.

Table 2

Participant Demographic Information

Demographic	Number of participants *(n = 9)*
Age at interview (years)	Mean = 38 (Range = 31 – 45)
Ethnicity	White British *(n = 7)* White Irish *(n = 1)* White Other *(n = 1)*
Area of living	South England *(n = 5)* North England *(n = 2)* North Wales *(n = 1)* Central Scotland *(n = 1)*
Relationship status at interview	Married *(n = 4)* Cohabiting *(n = 3)* Relationship but not cohabiting *(n = 1)* Single *(n = 1)*
Highest level of completed education	Postgraduate degree *(n = 4)* Undergraduate degree *(n =2)* A-levels/ further education *(n= 3)*
Employment status at interview	Employed *(n = 6)* Unemployed *(n = 3)*
Sexual orientation	Heterosexual *(n = 9)*

Time since onset of PP (years: months)	Range = 2:6 – 10:2
Number of children at time of interview	1 *(n = 5)* 2 *(n = 3)* 1 + currently pregnant *(n = 1)*
Further pregnancy after first-onset PP	No *(n = 7)* Yes *(n =2)*
Experience of recurrent PP	No *(n = 9)*
Intention to have more children at time of interview	No *(n = 5)* Yes *(n = 2)* Maybe *(n = 2)*

The expert-by-experience also reviewed other study materials, including the research advert, participant information sheet (Appendix K), consent form (Appendix L), and sources of support and information document (Appendix M). The expert-by-experience subsequently expressed interest in participating in the study. As their reviews only led to minimal changes to materials, it was agreed they could participate. They are included in the final sample.

Procedure

Eighteen potential participants expressed interest by emailing the researcher, as instructed on the research advert. The researcher replied providing the participant information sheet. Eight women did not meet the eligibility criteria and one woman withdrew due to recently giving birth. A subsequent phone call was arranged with the nine remaining participants to share a summary of the study, confirm eligibility with the inclusion/exclusion criteria, and offer an opportunity to ask questions. Their videocall interviews via Microsoft Teams were then arranged. The researcher emailed the consent form for participants to review and the demographics questionnaire that participants were asked to complete before the interview. Participants were required to complete the interview in a private and quiet space. At the beginning of the interview, participants were given a further opportunity to ask questions, then the consent form and any outstanding demographics forms were completed.

Interviews were audio-recorded, lasting between 42 and 59 minutes with an average of 50 minutes. After completing the interview, participants received the sources of support and information document and a £10 e-gift voucher as a token of thanks. They were reminded of their right to withdraw their data up to two weeks following the date of their interview.

Data Analysis

Interview data were analysed using the Smith et al. (2022) IPA guidelines. IPA was chosen as it provides a methodology for in-depth, idiographic exploration of how individuals make sense of lived experiences of certain phenomena (Pietkiewicz & Smith, 2012). Given the personal nature of fertility decision-making and PP experiences (Dommermuth et al., 2011; Wicks et al., 2019), this approach was deemed well-suited to capture the uniqueness of experience without attempting to generate theory (Smith et al., 2022). This approach has been applied successfully to broader experiences of PP (Glover et al., 2014; Stockley, 2018).

Analysis commenced with verbatim transcription of the audio recording of the first interview. The researcher then immersed themselves within the data by reading and re-reading the transcript, whilst simultaneously making exploratory notes highlighting points of interest and initial thoughts regarding the participants' experience. These exploratory notes were then constructed into experiential statements, which involved summarising discrete sections of notes to develop a more concise and interpretive summary of the original transcript (see Appendix N for an example). Experiential statements were then written onto separate pieces of paper, visualised, and subsequently clustered by identifying connections between them (see Appendix O for an example). These clusters were then consolidated and assigned a name, representing the Personal Experiential Themes (PETs) for that participant. This method was repeated for each interview, employing ‘bracketing’ (Tufford & Newman, 2010) so far as possible, to support an idiographic approach to analysis.

The final stage of analysis involved visualising all participant’s PETs together, to identify broad patterns of similarity and difference. This involved an iterative process of cross-case analysis, exploring the full ‘hermeneutic circle’ (Smith et al., 2022), including returning to transcripts to ensure emerging group interpretations were grounded within the original data. Through narrowing and consolidating interpretations, the final Group Experiential Themes (GETs) and sub-themes were developed (see Appendix O).

Reflexivity

A reflexive approach was adopted throughout the research process (Malterud, 2001), with both the researcher’s epistemological position (see Appendix C) and the IPA approach acknowledging the active role of the researcher in shaping the research, particularly during analysis. In IPA, the researcher is engaged in a 'double hermeneutic' meaning they are attempting to make sense of the participant's attempt to make sense of their own experiences (Smith et al., 2022). Therefore, the researcher engaged in various reflexive techniques to develop and maintain awareness of how their lens was involved in co-constructing the findings (Willig, 2022). This included regular supervision, a reflexive interview with one of their supervisors, and the use of a reflective journal, to consider how their position, experiences, and values were interacting with the sense-making process.

The researcher identifies as a white British, female, trainee clinical psychologist, with a long-standing research and clinical interest in perinatal mental health. The researcher identifies as an insider with participants by identifying as a woman, but an outsider with regards to having no personal experiences of motherhood or severe mental health difficulties, such as PP. The researcher also acknowledges and actively seeks to engage with feminist and psychosocial approaches to understanding perinatal mental health experiences (Brown, 2021). All of these elements shaped how the researcher constructed the research process. For example, identifying as an outsider regarding key characteristics of the participant sample, led the researcher to seek expert-by-experience consultation during the early stages of research development and design. The researcher’s feminist and psychosocial lens also influenced design, with importance and value given to utilising a methodology that could offer women a platform to share in-depth, personal meanings and experiences about a wider element of PP recovery, that sits “beyond acute symptom remission” (p. 608, Forde et al., 2020; see Appendix B for further discussion).

During analysis, specific attention was paid to elements of the data that were more likely to be privileged or obscured based on the researcher’s position and assumptions. For example, pulls to feminist interpretations of data were noted and discussed with supervisors and then reviewed in the context of the research questions to ensure that answering these remained the focal point of the final analysis. Supervisors, who differed from the researcher in elements of position such as gender, experiences of parenthood, and ethnicity, also reviewed a sub-sample of transcripts and were involved in the final stage of GETs and sub-theme development to further support the depth and rigour of analysis.

Ethical Considerations

Ethical approval was granted by the Faculty of Health Sciences Research Ethics Committee at the University of Hull (Appendix Q). The study conforms with the British Psychological Society Code of Human Research Ethics (Oates et al., 2021). All participants gave informed consent before completing the interview. All data were stored in accordance with relevant ethical and legal guidelines. Participants' confidentiality was maintained by using pseudonyms, anonymising all identifiable interview data, and collectively presenting demographic information. Participants were given the choice to select their pseudonym, if participants declined it was agreed the researcher would select the pseudonym. The researcher did not have any pre-existing relationships with participants before the study.

Findings

Six GETs comprising 12 subthemes were generated by the researcher (Table 3). They are subsequently explored with supporting participant quotes. Transcript line numbers are presented in brackets.

Table 3

Overview of Themes

GET	Subtheme
1. Decision-making as *"a bit of a process"*	1.1 Emotional weight of decisions
	1.2 Needing time to recover
2. Fear of recurrence	2.1 Playing with chance
	2.2 Trauma of PP
	2.3 Guilt about PP
3. Desire to have more children	3.1 Practical and contextual factors
4. Grief	4.1 Grieving further children
	4.2 Desire for a *"normal experience"*
5. Support needs	5.1 Specialist support
	5.2 Informal support
6. Accepting the decision	6.1 Focusing on the positives
	6.2 Embracing uncertainty

Note. GET = Group Experiential Theme.

1. Decision-making as *"a bit of a process"* *(Jane, 940)*

This theme signifies how, for all participants, fertility decision-making after first-onset PP was not a straightforward or linear experience. It was described as a complex, difficult, and emotive process, and the experience of first-onset PP significantly shaped how subsequent fertility decisions were experienced across all interviews.

"it did massively alter the way I thought about future pregnancies" (Becky, 102-103)

Becky's use of the phrase *"massively alter"* describes the magnitude of impact PP had on her later fertility decisions, ultimately leading her to decide not to have any further children. Whilst

Isla came to the same decision, she described a tension of not wanting PP to define her fertility decisions and laughed in disbelief at the pull to justify to others why she is not having another child.

> *"it's a decision, regardless of whether you've become ill or not, it's the person who's giving birth's decision (laughs)…and their decision only" (Isla, 813-818)*

The experience of decision-making itself was often described in a dynamic and elusive way. Many participants described having multiple conversations, primarily with partners, family, friends, and healthcare professionals, and had difficulty identifying specific time points of when decisions were made. Emily described the experience of coming to her decision of wanting a further pregnancy after first-onset PP as *"very gradual"*, using the imagery of *"little drips"* to symbolise subtle movement towards the decision over time.

> *"a very gradual decision-making process…not, nothing, nothing quick. Erm…like drip, drip feed, little drips of positive, erm positive feedback and information, added to it like oh, maybe that's something I could do" (Emily, 493-501)*

1.1 Emotional weight of decisions

This subtheme speaks to the level of emotionality that was associated with fertility decision-making after first-onset PP, with multiple participants becoming emotional whilst talking about their experiences. Melanie began using the words "*it"* and *"thing"* when describing her experience and when asked what she meant by this she explained:

> *"all that sadness and grief and horribleness, it is-, it is like an-, it's a thing, it's like an "it", it's the emotions attached to it" (Melanie, 945-948)*

Melanie appears to use these words as a way of externalising and distancing from the emotions related to her decision not to have any further children. She notes *"sadness", "grief"*, and *"horribleness"* which seem to denote how emotionally unpleasant the experience of fertility decision-making after first-onset PP was for her.

The emotional quality of fertility decisions seemed to have a lasting impact for some participants. Penny described how she had repressed emotions related to her decision not to have any further children (*"you shut the door, don't you")*. Despite making the decision many years ago, she explained how the interview gave her time and space (*"really sit with it"*) to reconnect with these emotions, with the words *"sting"* and *"stung"* signifying the pain related to these emotions.

> *"I think you just kind of go right, decision and you shut the door, don't you, and then as you open the door and you go that does still sting a little bit, or it never stung before, whereas now when I really sit with it, you kind of notice it a little bit more" (Penny, 1411-1417)*

1.2 Needing time to recover

A few participants normalised the need for time after having a child before considering subsequent fertility decisions. However, this subtheme relates to a distinct need for time to recover, process, and make sense of the experience of first-onset PP before making fertility decisions, which was discussed by all participants. Many participants described not even beginning to think about whether they would like further children until at least two years after the onset of their PP.

> *"I think talking about what happened definitely helped me make a decision…because I thought, well, I can talk about it now, whereas before I couldn't talk about it. Cos I would get too upset. So, I knew it wasn't the right time for me to even try and have another child because, I thought I haven't really lived or talked about that experience that I went through first of all, so how can I have another child and potentially go through another experience and like, not sort of, like overcome my last experience, to be honest" (Jane, 896-904)*

Jane describes a need to process (*"overcome"*) her experience of first-onset PP and the emotions related to it (*"upset"*) by talking about her experience with others. Processing her experience of PP seemed to be a necessary step to be able to make the decision to have another child and begin trying to conceive, particularly when considering that further pregnancy may lead to the recurrence of PP (*"potentially go through another experience"*).

Conversely, Penny described regret at her and her husband's rushed (*"premature"*) decision for him to have a vasectomy around a month after she gave birth. Penny uses the metaphor of firefighting to describe how their decision to have a vasectomy was viewed as a solution to the ongoing trauma of her PP experience. On reflection, Penny suggests they should have taken the time to recover and emotionally process PP to allow them to have fertility decision-making conversations more dispassionately (*"in the cold light of day"*).

> *"it felt like we'd been a bit premature in that decision making and, we should have both sat down, and actually really had that conversation, in the cold light of day and not, whilst we were in a midst of, "Oh, my God, this is just awful". And the quickest thing I can do right now is firefight and put the fire out, which is we're going to do this" (Penny, 548-555)*

The theme 'Decision-making as a *"bit of a process"*' describes the complex quality of fertility decision-making after first-onset PP. This was demonstrated by the intense emotions that can be related to the experience ('Emotional weight of decisions') and the importance of time to recover and process PP before making fertility decisions ('Needing time to recover').

2. Fear of recurrence

This theme describes the fear of recurrence of PP in subsequent pregnancies, which was described in all interviews. Fear of potential recurrence had a significant impact on decisions and for some appeared to be the definitive reason for not having another child.

> *"ultimately, for me, it was about the fear and getting ill again, and not...that the, the risk outweighs having another child which, which is huge. Because when I look at other people, having babies after having postpartum psychosis, I think it's h- ho-, it's really interesting, because how do you get over that risk...benefit [...]then I feel guilty again, because I'm like, I obviously, like I've put my, like the scared, feeling scared and the fear over actually having another child, which is huge" (Melanie, 996-1008)*

Melanie's description of how her fear of recurrence has impacted her fertility decision-making conjures the image of scales, describing that the fear of experiencing PP again *"outweighs"* the *"benefit"* of having another child. Melanie notes the enormity of this statement with the repetition of the word *"huge"*, which appears related to her feelings of guilt when comparing herself to peers who do not appear to fear recurrence as strongly.

Isla emphasises how her fear of recurrence is specifically related to the potential risks another episode of PP could pose to herself and her family. Whilst she recognises the unlikelihood of this happening (*"probably wouldn't come to that"*), the scale of her fear is palpable (*"scares the living daylights out of me"*).

> *"the notion of putting me, family, [son] in danger scares the living daylights out of me. And I know that it, it probably wouldn't come to that, but it's just, to me not even worth thinking about erm, it's just scary, it's* ***scary****, really scary" (Isla, 744-750)*

2.1 Playing with chance

Most participants described having a 50% chance of recurrence of PP in subsequent pregnancies. For many, this appeared to be a figure that was shared with them by healthcare professionals. Gabrielle describes her distress (*"shock", "upsetting"*) at the realisation of the drastic change in risk of PP, before and after the experience of first-onset PP.

> *"the first initial shock was like, "Oh my God, it's that bad of odds", like 50%, like, if you think about the percent of women who have, you know, it's like one or two in a 1000… And then you're suddenly being told that now that percentage is like 50%. So that was really upsetting" (Gabrielle, 329-343)*

After receiving this risk statistic, multiple participants seemed to view the decision to have a further pregnancy after first-onset PP as playing with the chance of recurrence.

> *"if when you're pregnant and you know, there's a- somebody stood at [the] end of pregnancy flipping a coin, whether you're gonna be poorly or you're going to be fine. I can't imagine that would make for an enjoyable pregnancy either" (Becky, 695-701)*

Becky's use of the image of *"somebody stood at [the] end of pregnancy flipping a coin"* emphasises the lack of control and level of uncertainty involved in the decision to have another pregnancy with this risk statistic. Her use of sarcasm in considering how *"enjoyable"* pregnancy would be in this context highlights how difficult she imagines a further pregnancy after first-onset PP to feel.

2.2 Trauma of PP

This subtheme represents how the fear of recurrence was often discussed in the context of how traumatic the experience of first-onset PP was, with many participants focusing specifically on the impact PP had on their partners and family members. Olivia describes how her husband continues to attend sessions with a support worker many years after the onset of her PP because of the significant impact it has had on him (*"he's not over it"*). She then replicates a conversation she had with her husband about fertility decisions, which highlights the connections between the trauma of first-onset PP, the consequent intensity of fear of recurrence, and subsequent wish not to have another pregnancy

> *"he still has sessions now four years on, because he's not over it. So erm...I think it really impacted him. And he was like, "No, I can't go through that. I can't see you going through that again, I don't want to risk it."" (Olivia, 532-539)*

Gabrielle described a conversation with her mother after deciding that she would like more children. The use of existential language (*"I won't survive"*) indicates the intensity of trauma Gabrielle's mother experienced during Gabrielle's first-onset PP and the accompanying fear associated with the potential of recurrence following Gabrielle's decision.

> *"when I told her, her first answer was, "I'm not going to survive this". She said, "if it happens again, I won't survive"" (Gabrielle, 464-467)*

2.3 Guilt about PP

This subtheme represents how, for many participants, guilt appeared to shape and interact with the fear of recurrence and associated experience of fertility decision-making. Most participants described feeling guilty about their experience of first-onset PP, specifically the impact they believe it had on others. This sense of guilt seemed most present early on in participants' experience of recovery. However, for some, this feeling of guilt seemed to continue into their experience of subsequent fertility decisions.

Despite recognising that experiencing first-onset PP was not her *"fault"*, Isla describes that deciding to have another child in the context of the risk of recurrence would feel *"selfish"*. This seems underlined by both existing guilt about the impact first-onset PP had on her family and imagined guilt about the impact of potential recurrence on her family.

> *"I wouldn't put them through it, and I know becoming ill was not my fault but to make a decision, knowing what the outcome could be, feels like quite a selfish decision" (Isla, 285-291)*

Olivia describes feelings of guilt about having first-onset PP and how it is impacting subsequent fertility decision-making with her husband. These two layers of guilt appear to connect to Olivia's sense of identity as both a *"woman"* and a *"mother"*. Experiencing first-onset PP appears to have made her feel like a lesser version of these identities (*"inadequate"*, *"failed"*) due to it disrupting her first postpartum experience and acting as a barrier to her and her husband having further children, due to the fear of recurrence. The hesitant and stuttering nature of her speech seems to indicate the difficulty of connecting with these thoughts and feelings.

> *"it's natural for a woman to have babies, but obviously like I wasn't able to do it. Like prop-, well obviously I had a baby, but obviously I wasn't able to do it, w- and be well. And erm, and obviously [husband] worrying about that happening again makes me feel like I'm not as good as other people. Erm and that's a- being inadequate, like I'm not as, as a- as a mother and as a woman. Erm, because erm...yeah, just because obviously, I feel like I've failed a bit" (Olivia, 653-665)*

The theme 'Fear of recurrence' describes how distress about the risk of recurrent PP in further pregnancies after first-onset PP impacts the experience of fertility decision-making. This distress is understood in the context of a 50% risk of recurrence statistic ('Playing with chance'), how traumatic the experience of first-onset PP was for participants and their family members

('Trauma of PP'), and participants' feelings of guilt about their experience of first-onset PP ('Guilt about PP').

3. Desire to have more children

This theme represents how most participants appeared to engage in a process of considering how strong their desire was to have more children, within the context of the risk of potential recurrence. Most participants spoke about their own experiences of family, particularly with siblings, which seemed to inform longstanding ideas about how many children they wanted before their experience of first-onset PP.

> *"ultimately, erm, we always said we wanted two or three kids before we started having children, before we had [daughter]. And I've grown up […] on my mum's side and dad's side of the family is huge, cousins, lots of family get-togethers, huge thing and [it] makes me kind of sad when I think about, [daughter] just being a single child" (Gabrielle, 204-213)*

Gabrielle connects her established desire to have more children with her own experiences of coming from a *"huge"* family. The emotional importance of continuing this is clear, as she expresses sadness at the thought of her daughter being an only child.

Some participants discussed alternative pathways to having further children, such as surrogacy, fostering, and adoption, as a way of balancing their desire to have more children whilst reducing the risk of recurrence. Whilst Isla has currently made the decision not to have further children, she describes how *"fostering or adopting"* would be preferred options for her and her partner if they would like more children in the future.

> *"I don't have the desire to have more and if I do in a few years, we would, we would, much quickly go down the route of fostering or adopting" (Isla, 254-258)*

3.1 Practical and contextual factors

The desire to have more children was also discussed in the context of various practical and contextual factors, outside of first-onset PP. Multiple participants discussed factors such as age, fertility, financial factors, current relationship status, and their own/family health needs. Both

Susanne and Emily discuss how various factors outside of PP can pose barriers to the desire to have a further pregnancy.

> *"then we kind of just talked about, sort of, practicalities and he [husband], he's very sort of practical and logical and quite like "we need to make sure that we've got finances and I'm going to be able to get time off work."" (Susanne, 563-568)*
>
> *"I feel a bit like the, the sort of chance for it [further pregnancy] to happen is kind of, you know, fading away anyway. Erm, yeah, in terms of age, and it took me two years to get pregnant in the first place" (Emily, 756-781)*

The theme 'Desire to have more children' describes participants' experiences of weighing up the strength of their desire to have further children alongside PP and non-PP related factors ('Practical and contextual factors').

4. Grief

This theme signifies how, for many participants, the process of grieving losses related to first-onset PP, such as caring for their newborn, appeared to interact with the experience and meaning of their subsequent fertility decisions. Most participants described how experiencing first-onset PP led to numerous unmet expectations of the postnatal and newborn period, which for many was their first postpartum experience.

> *"I had quite a lot of hand-me-downs, baby grows and I washed them all and I hung them out on the drier, this was a few days before she [daughter] was born, in anticipation of everything, and that image is really strong because, that was like how it was supposed to be, not that- and I hate that word in terms of that "this is how things should have been" but I think it was more, it was just really sad, that of- getting everything ready, I had all this stuff dried and washed and the nursery set and it just completely blew apart" (Melanie, 911-923)*

Melanie describes a memory of preparing in the days before her daughter's arrival. Although she appears somewhat resistant (*"I hate that word"*), this image seems to represent her specific hopes and expectations for her first postnatal experience (*"how it was supposed to be"*). Her later use of the phrase *"completely blew apart"* creates explosive imagery of how first-onset PP destroyed this positive image.

Susanne describes how her grief about experiences she *"missed out on"* because of first-onset PP, led her to feel *"jealousy"* when comparing her postpartum experience to others who did not experience PP (*"normal"*).

> *"there was like jealousy, kind of towards other people who had, in my eyes, the normal kind of experience and, erm and things I felt that I'd missed out on when I had him [son]" (Susanne, 821-825)*

4.1 Grieving further children

Some participants who had made the decision not to have further children described a process of grieving the ideas of family they had before first-onset PP. This included grieving for the children they no longer felt able to have due to the fear of recurrence. Becky describes the longstanding (*"still...gets to me now"*) sense of *"grief"* she continues to experience for the child she felt unable to have after her experience of first-onset PP.

> *"But I would've loved like, another…child at least. Erm so to have, it just felt like, yeah, it just felt like grief, like I were missing out on something. Yeah, but quite upsetting. It still...gets to me now" (Becky, 161-165)*

Penny describes finding an old baby name list after she and her husband had decided to have no further children. Whilst she describes the name list in the context of her pregnancy with her daughter, she seems to connect with the idea that the presence (*"still there"*) of the boys names on the list represented a further child they no longer felt able to have (*"we could've had a boy"*). She then cries in recognition of the loss of this further child.

> *"we'd have the list where we kept baby names and like the boys names were still there. Erm because even though I kind of had got a fairly good idea, just intuitively that it was going to be a girl, we never actually found out. So there was always this we could've had a boy (cries)" (Penny, 1348-1355)*

4.2 Desire for a "normal experience"

For the participants who had made the decision that they would like or have gone on to have a further pregnancy after first-onset PP, most described a desire for a postpartum experience in the absence of PP. The desire for a *"normal experience" (Emily, Susanne)* appeared connected to the grief they felt following first-onset PP and seemed to relate to an ongoing process of recovery from their PP experience. Emily describes how her desire to have another child sits alongside a desire to experience the enjoyment related to the postpartum period that she feels she missed out on because of first-onset PP.

> *"I always felt like I kind of wanted to do it, again, to have a more normal experience...to have, you know, to to have a child and not have that happen, and just enjoy the early stages of having a newborn" (Emily, 126-132)*

Gabrielle describes how part of her desire to have another pregnancy relates to how the losses associated with first-onset PP led to a sense of loss in her identity as a mother. She is hopeful that if she has the chance to have another child, without experiencing PP, this will provide her with the opportunity to reaffirm (*"prove"*) her identity as a *"good mum"*.

> *"so there's a part of me that's like...I know that I am a good mum and that I would be a good mum to a newborn as well. And it's like, I didn't get to prove that to myself" (Gabrielle, 813-817)*

The theme 'Grief' represents how losses associated with first-onset PP shaped the meaning and experience of subsequent fertility decision-making. The decision to have no further children was associated with a process of 'Grieving further children' and the decision to have further children was associated with a desire to rectify losses ('Desire for a *"normal experience"*').

5. Support needs

This theme describes the presence of support needs as part of fertility decision-making after first-onset PP. All participants described a need for and the value of having a support network through the fertility decision-making experience. Susanne describes how talking to and receiving *"encouragement"* from her support system (*"friends"*, *"health professionals"*) helped her make the decision to have a further pregnancy.

> *"just talking about it with other friends, erm, health professionals that I kind of knew, erm, kind of socially that kind of thing. Erm, lots of encouragement from people who had kind of seen my, seen my journey" (Susanne, 259-264)*

Across all interviews, participants described information needs as part of their decision-making experience, in particular, risk statistics and options for support before, during, and after a further pregnancy. Emily describes how fundamental receiving information was in coming to her decision of wanting a further pregnancy (*"just information really"*). She also highlights how being made aware that specialist support is available (*"well supported"*) for further pregnancies after first-onset PP supported her decision.

> *"I mean just information really…like being, being aware, like being aware of, that it-it can be a, erm, well supported, erm, experience" (Emily, 465-469)*

A few participants faced barriers in accessing information to support their fertility decision-making, which appeared to relate to a lack of clinician awareness of PP. Jane describes a distressing and stigmatising (*"I'm not in a mental health crisis"*) experience of trying to access preconception information and support through her GP.

> *"basically, she told me that she don't know what I'm on about. And erm for me, if I want any help, for me to go to the front desk, and say that I'm in a mental health crisis, which obviously I wasn't. So, I went to erm, went to the front desk, explained to her and I was like, "I'm not in a mental health crisis. I just wanna know, like my options and information about my second pregnancy"" (Jane, 203-213)*

5.1 Specialist support

Multiple participants described the importance and value of specialist support as part of fertility decision-making after first-onset PP. For participants who would like or have gone on to have a further pregnancy, preconception support and information from professionals with specialist knowledge appeared to build hope for further pregnancy. For example, they described how specialist preconception planning and preventative intervention options helped to work with the risk and fear of recurrence by creating a sense of safety.

> *"we had been told pretty early that our risk of a re-occurrence of postpartum psychosis was 50/50, if I went on to have a further pregnancy, but the support would be different [...] So I would be getting like pre-pregnancy support, and then support throughout pregnancy and not just kind of after…so that kind of made it seem a bit safer to start considering it" (Susanne 195-206)*
>
> *"I spoke to a perinatal psychiatrist who went all through my options. She was amazing. Obviously, she knew like what she was doing and what she talking about and stuff. And then yeah, and then we agreed a plan" (Jane, 295-300)*

A few participants highlighted negative experiences with non-specialist healthcare professionals as part of their fertility decision-making. Some participants specifically highlighted the inappropriate timing and approach of standard fertility conversations offered by maternity services in the context of first-onset PP. Melanie describes the distress she experienced following a passing conversation about fertility decisions during an obstetrics and gynaecology review, early on in her recovery from first-onset PP.

> *"right at the end she was like…erm...something about contraception, "make sure you're using contraception, if you don't want any more children", and then she said "we can have a chat at some point about, you know, in the future, if you want more children". And that was it, it was just really weird. And I was still ill [...] and looking back, that was just like, not the time to have that conversation. I was still psychotic, I was still being treated, I was you know, I was* ***really, really*** *poorly. And I just saw it as a message or a sign because I was still having delusions, like, "Why is she talking about other children?" Like, "I've got this one that I don't really want, and then all this stuff's happened, and it's all gone wrong. And why is she talking to me about another child?"" (Melanie, 1093-1114)*

5.2 Informal support

Most participants described their partners and family as key sources of support during fertility decision-making. Of those participants who would like or have gone on to have a further pregnancy, most described valuing the knowledge their family had developed as a result of their first-onset PP experience. Often noting that they and their family members had never heard of PP before their experience. As Gabrielle describes the lived-experience knowledge (*"learning experience"*) of family appears to support the decision to have a further pregnancy by creating an additional layer of safety if recurrence occurred (*"we would know how to react"*).

> *"I also really believe in the, experience that we've had, me individually, us as a couple, and then me as a, us as a family has been a really learning experience [sic]. Not just learning about mental health in general, or postpartum psychosis in general, but learning about how the NHS system works. And like, you know, who to call, what to say, what to do, what does it mean […] if something was to happen again, we would know how to react and what to do so much better, so much quicker." (Gabrielle, 585-600)*

Whilst many participants described the positive impact of peer support on their overall recovery, there was a varied picture regarding its role in fertility decision-making. Emily describes how seeing a peer she met through a PP charity have a positive experience of further pregnancy, provided hope (*"this is possible"*) for her own fertility decisions.

> *"I knew before she'd [peer] had her second child that, that there were options and that, erm, but it all became more sort of, erm, you know, when it act-, when it actually happened for her, it's was like, oh, okay, […] this is possible" (Emily, 476-482)*

Conversely, Olivia described receiving largely *"negative"* comments about further pregnancy after first-onset PP (*"don't do it"*) in online peer groups, which influenced her decision to have no further children.

> *"I remember it being quite negative that erm...a lot of people said that they'd struggled the second time…or erm some people had put don't-don't, I remember like quite strongly saying*

> *don't do it. You have to come off your, change your medication [...] I don't remember getting any positive one- responses" (Olivia, 781-790)*

The theme 'Support needs' represents the importance of support during fertility decision-making after first-onset PP, particularly from specialist services ('Specialist support'), as well as more informal sources, such as family ('Informal support').

6. Accepting the decision

Across all interviews, participants described a process of acceptance regarding their fertility decisions, regardless of what the decisions and associated outcomes were. Melanie describes being *"at peace"* with her decision not to have further children. Her change in phrasing from *"I think"* to *"I am"* seems to represent a need for certainty around acceptance of the decision, despite acknowledging that the decision continues to hold significant emotional weight and quality (*"still quite emotional and raw"*).

> *"I think like we're at peace with, I am at peace in that decision, even though you can sense it, tell today that it is still quite emotional and raw."* *(Melanie, 1253-1256)*

Penny uses two idioms (*"things happen for a reason", "roll with that"*) to describe her and her husband's acceptance of their decision to have no further children. These phrases suggest a need to move on and not dwell on their decision, perhaps indicating an avoidance of connecting with the meaning of the decision on a deeper emotional level.

> *"they say things happen for a reason so we kind of roll with that" (Penny, 801-802)*

6.1 Focusing on the positives

Multiple participants, particularly those who have decided not to have a further pregnancy, described gratitude for their child(ren) as part of accepting their decision. Both Olivia and Isla used positive adjectives, such as *"blessed"*, to describe their appreciation of their children. While also acknowledging the role of PP and the risk of recurrence within their fertility decision-making (*"changed our future", "why rock the boat?"*).

> *"becoming ill has changed our future. But I don't feel negative about it, because I've got [daughter], which is amazing. And she's amazing. So I-I'm blessed to have one child, because some people don't have any children." (Olivia, 1055-1060)*
>
> *"I'm so happy and blessed with [son]…why rock the boat?" (Isla, 331-334)*

Becky also acknowledges her gratitude for her children (*"so grateful for what I've got"*). However, she also jokes about how having another child "*wouldn't have harmed anybody"*. Later in her interview, she connects with regretful feelings about not having further children which seem to underly her prior joke.

> *"I'm so grateful for what I've got, but I do kind of still think, just another little kind of baby, wouldn't have harmed anybody (laughs)" (Becky, 422-425)*
>
> *"now we're talking about it, I massively regret not having more children" (Becky, 1033-1034)*

6.2 Embracing uncertainty

All of the participants who would like or have gone on to have a further pregnancy after first-onset PP, described embracing the uncertainty of recurrence as part of the process of accepting their decision. Jane, who was pregnant at the time of her interview, described reaching the limit of control she has over reducing the risk of recurrence (*"nothing else I can do"*) and a need to accept the continued potential risk of recurrence (*"if it do happen, it do happen"*). The acknowledgement of the support network around her appears to increase the sense of safety related to this uncertainty (*"everybody is on board"*).

> *"there's no...else, nothing else I can do. We don't know what's gonna 'appen, if it do happen, it do happen [sic]. Erm but […] everybody is on board" (Jane, 1012-1016)*

Gabrielle describes how the meaning of her decision to have another pregnancy represents *"submitting"* herself to a *"loss of control"*. Her use of the word *"submitting"* symbolises the power held by PP and its risk of recurrence. Accepting the presence and influence of this power appears an important step in Gabrielle's decision-making experience.

> *"I think that when you make that decision to have another child, and therefore the risk associated with it, I think you're kind of just...submitting yourself to loss of control" (Gabrielle, 488-492)*

Emily describes how the meaning of her decision, that she would like a further pregnancy, represents that she is no longer fearful of PP or potential recurrence. Emily seems empowered (*"it feels good"*) by noticing the absence of fear, possibly indicating this decision signifies a way of reclaiming the trauma associated with her experience of first-onset PP.

> *"It feels good to not have the fear…you know […] to not be scared of the, of the process"(Emily, 785-788)*

The theme 'Accepting the decision' represents participants' need to accept the fertility decisions they have made following first-onset PP. For those who have chosen not to have a further pregnancy, 'Focusing on the positives' appeared especially important to the process of acceptance. Alternatively, those who would like or have had a further pregnancy described 'Embracing uncertainty' regarding the risk of recurrence, as part of accepting their decision.

Discussion

This study aimed to explore women's experiences of fertility decision-making, including the meaning of decisions and experiences of support, after an experience of first-onset PP. Despite participants representing varied fertility decisions and outcomes, the overarching findings indicate that the experience of first-onset PP considerably shapes the experience of subsequent fertility decision-making. All participants described strong and complex emotions as part of the fertility decision-making experience, which seemed to connect to various aspects of their first-onset PP experience and ongoing recovery. Specialist input appears valued in supporting women through the fertility decision-making experience regardless of their final decisions.

Fertility decision-making after first-onset PP was described as a complex process. This aligns with previous findings about fertility decision-making after PP (Forde et al., 2019) and resonates with findings regarding the overall experience of PP recovery as a “lengthy and non-linear process” (p.608, Forde et al., 2020). As suggested by PP recovery literature, this is perhaps indicative of the traumatic nature of PP (Forde et al., 2019; Forde et al., 2020; Heron et al., 2012; McGrath et al. 2013), meaning time is required to understand and integrate the meaning of the PP experience, including for future fertility decisions. It could be hypothesised that this may be particularly marked for women who have experienced first-onset PP, due to having no prior experiences of mental health difficulties. However, further research is needed to explore similarities and differences in the recovery experience of those with first-onset and non-first-onset PP.

The non-linear progression of fertility decision-making after first-onset PP is just one issue that calls into question the applicability of the TPB framework (Ajzen, 1991) of fertility decision-making for this population. For many participants the ‘intention’ to have another child was impacted by first-onset PP and the recovery process, meaning there was not a straightforward path from the intention to have another child after first-onset PP to then having another child. The TPB framework also lacks capacity for the level of emotionality involved in fertility decision-making after first-onset PP. The framework describes the role of ‘positive and negative attitudes’ in impacting the intention to have a child. However, this does not account for the depth of emotions, such as fear, guilt, grief, and regret, that were described by participants, including after the decision had been made.

Findings regarding the role of fear of recurrence within women’s experiences of fertility decision-making after first-onset PP aligns with PP recovery literature (Forde et al., 2019; Forde et al., 2020; Jefferies et al., 2021; McGarth et al. 2013). Additionally, the present study expands understanding of the potential meaning of this fear, with many participants describing how the traumatic impact of their first-onset PP experience on partners and family and related feelings of guilt informed their worries about recurrence. The traumatic nature of PP and feelings of guilt about the experience are common themes within PP qualitative literature (Forde et al., 2020; Wicks et al.., 2019). However, the present study’s findings illuminate how persisting these emotions can be and the long-term impact they can have.

Fear of recurrence was discussed by most participants in the context of a 50% risk statistic. This suggests women with experiences of first-onset PP are receiving information about their risk of recurrence based on research that is non-specific to first-onset PP (e.g., Blackmore et al., 2013). Whilst risk estimate research into first-onset PP is still in the early stages (Gilden et al., 2020), the subtheme of ‘Playing with chance’ highlights how the potentially overestimated 50% risk statistic can lead to a high level of uncertainty and lack of control when women with first-onset PP are considering subsequent pregnancies. Urgent research is needed to firmly establish the specific risk estimate of recurrence for those with a history of first-onset PP.

The theme ‘Desire to have more children’ aligns and expands on previous research, with women with previous PP and bipolar disorder, which considers the process of weighing up the desire to have more children against the fear of recurrence (Dolman et al., 2016; McGrath et al., 2013). The consideration of alternative pathways to having further children as part of this process has been described in the experiences of women with bipolar disorder (Dolman et al., 2016) but has not been previously noted within PP qualitative literature. This theme and the subtheme ‘Practical and contextual factors’ represented the findings most closely aligned with the TPB framework (Ajzen, 1991). Participants discussion of their own experiences of family and wider factors, such as age and finances, map onto the 'background factors' that shape factors, such as 'positive and negative attitudes' and 'perceived norms', which are said to precede the intention to have a child. The coherence of these findings with the TPB framework perhaps represents aspects of the fertility decision-making experience after first-onset PP that are least related to first-onset PP. This may suggest the importance of striking the balance between acknowledging the unique factors related to fertility decision-making after first-onset PP, alongside more fundamental factors that exist in its absence.

Participants' description of grieving losses related to first-onset PP, such as unmet expectations of the newborn period, supports similar findings within PP qualitative literature (Forde et al., 2019; Forde et al., 2020; Robertson & Lyons, 2003). However, this study provides new insight into the depth and meaning of this grief within women's experiences of subsequent fertility decision-making. To the researcher's knowledge, this is the first study to illuminate a process of grieving for further children that some women can experience after making the decision not to have a further pregnancy after first-onset PP. This experience of grief resonates with research regarding nonfinite loss and chronic sorrow (Harris & Gorman, 2011). Nonfinite loss typically follows an event, such as a diagnosis, which prevents one's expectations, hopes, or ideals from being met in some aspect of life (Bruce & Schultz, 2001). This can subsequently be associated with the response of chronic sorrow (Roos, 2002) - an ongoing sense of grief and sadness at the dissonance between perceived reality and what was dreamed of. Nonfinite loss and chronic sorrow have been associated with women’s experiences of infertility (Harris, 2017). Therefore, future research exploring nonfinite loss and chronic sorrow in women who feel unable to have further children after an experience of perinatal mental health difficulties, such as first-onset PP, may be valuable.

The present study's findings also reveal how some women's decision to have or want to pursue a further pregnancy after PP appears to represent a way of processing or resolving the grief and losses associated with first-onset PP. This resonates with a qualitative study that found some women felt they "needed a more positive birth experience" (p. 11, Forde et al., 2019) after PP. The depth of current findings suggests this desire may be closely related to the stigma associated with PP, with multiple participants describing a need for a *“normal experience”* and that a further pregnancy in the absence of PP would reaffirm their identity as a mother. The experience of stigma associated with PP is found throughout qualitative literature (Forde et al., 2020; Wicks et al., 2019), however further research into the potential longer-term implications of stigma following PP would appear worthwhile.

Participants' discussion of support needs, including information needs and support from both informal and formal sources, maps onto findings within wider PP recovery literature (Forde et al., 2019; Heron et al., 2012; McGrath et al., 2013). Current findings also strengthen the clinical implications of two previous studies that suggested the importance of offering specialist and proactive preconception support to women who have experienced PP (Forde et al., 2019; Forde et al., 2020). In particular, the current study suggests that receiving well-timed information, reassurance, and choice around preventative measures with specialist services can help build a sense of hope and safety for women to consider further pregnancy after first-onset PP. Similar to qualitative research on fertility decision-making in women with bipolar disorder (Dolman et al., 2016), findings indicate the importance of increasing non-specialist clinicians' awareness of PP to reduce the stigma and barriers associated with women accessing preconception support. The varied findings regarding the role and value of peer support as part of fertility decision-making after first-onset PP warrants further exploration to understand how this type of support can be most effective.

The final theme, ‘Accepting the decision’, echoes findings from a qualitative study that identified the need to accept losses as part of recovery from PP (McGrath et al., 2013). Together, this suggests that both the experience of overall PP recovery and fertility decision-making after first-onset PP may resonate with the Kübler-Ross (1969) model of grief, with acceptance being the final stage. More contemporary research (Prigerson & Maciejewski, 2008) has found that over time as grief decreases, acceptance increases. Therefore, the fertility decision-making process may symbolise a gradual acceptance of first-onset PP and its impact on subsequent fertility decisions, with some women accepting that the fear of recurrence is too significant to risk further pregnancy and other women accepting the uncertainty about the risk of recurrence in future pregnancy.

Strengths and Limitations

The present study should be considered in the context of certain strengths and limitations. The variety of fertility decisions and associated outcomes was a strength of the study considering the small sample size. However, there were more participants in the sample who had not had a further pregnancy after first-onset PP and did not intend to have further children at the time of the interview. Therefore, whilst the aim of the study is not to generalise findings, the experiences of women who have had a further pregnancy after first-onset PP may be underrepresented. Future research exploring the experience of the perinatal period of a further pregnancy after first-onset PP would be an important next step in the field.

In line with IPA guidelines (Smith et al., 2022), the sample represented a high level of homogeneity. However, the sample lacked diversity in certain demographic areas. For example, all participants identified as white and heterosexual. Again, whilst the study did not aim to generalise its findings, there remains a gap in understanding how racialised and minoritised identities might intersect with the experience of fertility decision-making after first-onset PP. Systemic racism is known to cause significant harm within perinatal health care in the UK (Birthrights, 2022; Pilav et al., 2022). For example, compared to white women, Asian women are twice as likely to die, and black women are four times as likely to die within the perinatal period (MBRRACE-UK, 2023). The lack of ethnically diverse samples in perinatal research (e.g., Edge, 2008, Murphy et al., 2022), as mirrored by the current study, must be addressed in future research. To ensure the inclusion of ethnically minoritised women's experiences and to inform proactive actions to address the impact of systemic racism within the perinatal period.

Clinical Implications

The findings of this study would indicate the importance and value of specialist, psychologically-informed preconception support for women making fertility decisions after an experience of first-onset PP. The level of emotionality associated with the experience and meaning of fertility decisions after first-onset PP indicates support should be sensitively timed, delivered in a psychologically safe environment, and in a compassionate manner. Findings would suggest impromptu fertility conversations within routine postnatal appointments may be distressing for women who have experienced first-onset PP.

Moreover, the discussion of the traumatic impact of first-onset PP on partners and family and the associated guilt women can experience as part of fertility decision-making would suggest that involving partners and family within preconception support could be valuable. Adopting a ‘Think Family’ approach (Darwin et al., 2021) to preconception support could also aid the early identification of needs and implementation of preventative interventions across the family system, in line with NHS Long Term Plan aims (NHS England, 2019).

This study would also suggest the need for clearer pathways for women who have experienced first-onset PP to access specialist preconception support. Most participants described needing at least two years to recover from first-onset PP before they began considering subsequent fertility decisions. Therefore, women with a history of first-onset PP are unlikely to be under the care of community perinatal mental health services at the time that they may benefit from preconception support, as most services work to a one-year postpartum remit (Royal College of Psychiatrists, 2023). Increasing knowledge and awareness of PP and preconception support at primary care level is one approach that might reduce barriers that some participants described in trying to access preconception support.

Finally, the study’s findings indicate the need and value of developing specific clinical guidelines for preconception support after first-onset PP. This will be aided by further research exploring the specific experience and needs of preconception support after first-onset PP, alongside further research to establish a more accurate risk of recurrence estimate after first-onset PP.

Conclusion

This is the first study that has explored, in-depth, the experience of fertility decision-making after first-onset PP. Participants described a complex, emotional, and deeply personal process of fertility decision-making that was considerably shaped by their experience of first-onset PP. Decisions could represent a range of interconnecting emotions and meanings, such as fear, guilt, grief, regret, hope, and empowerment. Support from both formal and informal sources, in particular specialist services, partners, and family, symbolised an important part of the decision-making experience. Overall, these findings indicate the need for and importance of specialist, psychologically-informed preconception support for women making fertility decisions after an experience of first-onset PP.

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Part Three: Appendices

Appendix A: Submission Guidelines for the Psychology of Women Quarterly

Manuscript Preparation, Length, and Style

All manuscripts should be prepared according to the Publication Manual of the American Psychological Association (7th edition).The entire manuscript - including abstract, quotations, notes, and references- must be typed double-spaced, with margins of at least 1 inch on all sides and use of Times New Roman 12 point font. Manuscript pages must be numbered consecutively. The use of sexist or ethnically biased language is unacceptable. As a general guideline full-length manuscripts reporting results of a single quantitative study should not exceed 35 pages total (including title page, abstract, text, references, tables, and figures). Reports of qualitative studies generally should not exceed 45 pages. For manuscripts that exceed these page limits, authors should provide a rationale to justify the extended length in their cover letter (e.g., multiple studies are reported).

Title and Acknowledgements (page 1). To facilitate masked review, all indication of authorship must be limited to this page (other pages must show the short title plus page number at the top right). Include on the title page (a) full article title, (b) names and affiliations of all authors, (c) acknowledgments, and (d) mailing and email addresses and telephone and fax numbers of the individual serving as the point of contact.

Abstract and Keywords (page 2). Abstract should not exceed 200 words. After the abstract, list appropriate keywords for the manuscript, preferably using terms from the Thesaurus of Psychological Terms.

Text (page 3). Use a five-character paragraph indent. Do not use desktop publishing features, such as right margin justification or underline. Only bold and italics may be used. Use a 12-point typeface.

References. References cited in text must appear in the reference list, and entries in the reference list must be cited in the text. References should conform to the 7th edition of the *Publication Manual of the American Psychological Association*.

Notes. Footnotes are not permitted in the text. If necessary, endnotes may be used. Number consecutively throughout text and list on a separate page preceding the following section.

Tables. Tables must appear as a unit following the reference section. Each table should be typed double-spaced on a separate sheet, be numbered consecutively, and include a caption. All tables must be cited in the text.

Figures. Figures and artwork should be submitted in the following digital file formats and with minimum resolution of 300 DPI (600 DPI for line art): TIFF, EPS, PDF, JPEG, or

Microsoft Word. Prepare figures according to the guidelines provided in the 6th edition of the APA manual.

Transparency and Openness

All manuscripts submitted to PWQ should follow APA Style Journal Article Reporting Standards (JARS) for quantitative, qualitative, and/or mixed methods research and Level 1 (Disclosure) for each of the eight aspects of research planning and reporting of the Transparency and Openness Promotion (TOP) Guidelines (OSF | TOPGuidelines.pdf; Nosek et al., 2015). A summary of the guidelines can be found here: TOP Guidelines Summary - Google Sheets. Authors should describe the efforts they made to comply with the TOP guidelines in the Method section. An example follows:

- We report how we determined all data exclusions, sample size, manipulations, and measures in the study, consistent with reporting standards for quantitative research (Appelbaum et al., 2018). All data, analysis code, and research materials are [available at link to repository OR available by emailing the corresponding author OR are not available]. Data were analyzed using IBM SPSS v27 and Hayes (2018) PROCESS macro v3.0. This study's design and its analysis were not pre-registered.

We realize there are both opportunities and challenges associated with the open science movement, whose scope, methods, and definitions continue to evolve. These challenges and opportunities may be especially pertinent and consequential for feminist scholars and scholarship. For a review of these issues, we refer authors to our PWQ special issue, Feminist Psychology and Open Science, guest edited by Jaclyn A. Siegel, Asia A. Eaton, Rachel M. Calogero, and Tomi-Ann Roberts: Psychology of Women Quarterly - Volume 45, Number 4, Dec 01, 2021 (sagepub.com).

Appendix B: Reflective Statement

This statement represents the opportunity to reflect on the research journey of the past few years that has culminated into the pages of this thesis. I will explore my experience of various stages of this journey, noting the learnings along the way, and conclude with some final reflections.

Developing the Study

Choosing the Research Area

Developing this research felt like a very natural coming together of two positions of interest. The spark of potential was first generated at the research fair, after noticing the possible cross-over between my longstanding interest in perinatal mental health, including postpartum psychosis (PP), and my supervisors' interest in psychosocial approaches to psychosis. After doing some scoping searches, I was gripped. Firstly, the stark scarcity of research into PP was shocking and yet sadly unsurprising, with the lack of understanding and research into women's health, including perinatal mental health, being one of the main reasons I was passionate about the area in the first place. Secondly, as I became more familiar with the literature base it became apparent how dominated it has been by the biomedical model. I remember reading a recent position paper by Brown (2021), which described specifically how the biomedical model, grounded in patriarchal ideas, has led to reductive narratives about psychosis in the female body. The paper ends: *"There is a need for greater scholarship on psychosis and the female body, both by psychosocial psychosis researchers and by feminist scholars, in an attempt to widen the conversation." (p.281, Brown, 2021).* Reading this felt like a direct call to action. I felt I could offer a blend of both positions, as being a feminist represents a core layer of identity.

The Brown (2021) paper and other writings by her (e.g., Brown, 2019) have been anchors that I have returned to many times throughout this research process, reigniting my passion and focus on why this research is needed. I have continued to hold a tension throughout the research about engaging with and offering a more psychosocially-based approach to PP. I found this particularly difficult in moments when I have read or interacted with experts-by-experiences who seem to hold the biomedical narratives of PP very strongly. The biomedical narrative of PP as an uncontrollable, biologically based event that we do not fully understand and so could not have been prevented, seems to offer comfort and perhaps a diffusion of guilt for some women who have experienced PP, particularly where this has been first-onset. Whilst I empathise and understand why this position might offer some reassurance, it feels ‘stuck’, powerless, and ultimately pathologises the female body. Instead, I believe the psychosocial approach can offer a more empowering narrative, looking much further outward to understand this experience of distress within the wider socio-political-cultural context. I think what I have learned from navigating this tension throughout the research journey is that research requires bravery. For me, this was the bravery to challenge existing ideas and narratives, as well as the bravery to hope that my research might find support for alternative ideas and narratives. As such, I think it has been integral that I chose a research area I was passionate about. I think my passion and belief in the importance of this research allowed me to find bravery even in the trickiest of moments. This is something I will take forward with me into future research endeavours.

Building the Rationale and Choosing the Design

Pinning down the specific focus of the empirical study was difficult. On reflection, whilst my passion for the general need for psychosocial engagement with PP was helpful, it also made it harder to narrow down to a specific rationale for the study. Seeking expert-by-experience perspectives was invaluable to this process. I did this informally by reading PP online forums and narratives, and more formally by seeking consultation with the charity Action on Postpartum Psychosis (APP). Through these methods, I was able to identify a meaningful gap in the research surrounding the experience of fertility decision-making after first-onset PP. Making decisions about subsequent pregnancies after PP was a frequent topic within the PP online forums. Jenny’s poem *“Time for Another”* (APP, 2015), which I have included as a preface to the empirical study, was also another source that powerfully stood out to me. Furthermore, I was struck when talking with APP about what this experience would specifically be like for women who, before PP, had no prior history of mental health difficulties and would subsequently be making decisions in the context of a significant risk of recurrence. Grounding my research within expert-by-experience perspectives was a strength of this research study and something that will be central to any research I conduct in the future. It supported me practically by guiding the development of the rationale of the study but also ensured the study represented a meaningful topic to this population, meaning I could use this research opportunity as ethically as possible.

Once I had identified the topic of fertility decision-making after first-onset PP, I began considering the various options and elements of research design and methodology. An exploratory qualitative approach was identified as most appropriate when considering the lack of research in the area and the highlighted importance of re-centring women's voices within the PP literature (Brown, 2021). Qualitative research also represented a new challenge for me, having only used quantitative methods in previous research experiences. This was a challenge that I wanted to embrace, with the doctorate training representing the opportunity for me to develop my skills in many areas. After considering various types of qualitative approaches, Interpretative Phenomenological Analysis (IPA) appeared the best fit. It offered a way of exploring, in-depth, the personal meaning and experience of fertility decision-making after first-onset PP, whilst also offering an in-built understanding of how my lens would interact with the research through the concept of the 'double hermeneutic' (Smith et al., 2022). This appeared especially important given the passionate position I had identified with so early in the research process. The foundations and concepts of IPA also felt comfortingly similar to the formulation and reflective skills I was building within the clinical areas of training, which I think helped me step into the uncertainty I had about conducting qualitative research.

The terms fertility decision-making and reproductive decision-making are used interchangeably within the literature. However, I chose the former for the empirical study for two main reasons. Firstly, reproduction is defined as the act or process of reproducing, whereas fertility is defined as the ability to reproduce, with the inference that this ability may be shaped by multiple factors, such as age and experiences (Vander Borght & Wyns, 2018). Therefore, I felt the term fertility was more aligned with the aims of the research, in exploring the potential individual complexities involved in the experience of decision-making about subsequent pregnancies after first-onset PP. Secondly, I felt the connotation of the term fertility was more inclusive, as I wanted recruitment to be open to women who had previously had or intended to use assisted fertility treatments and interventions.

Recruitment

The recruitment phase of the empirical study represents the period of this research journey in which I faced most challenges and dilemmas. This started with the elements of preparation for recruitment, such as seeking expert-by-experience consultation on the study's resources. In the early development of the study, APP had offered to provide expert-by-experience consultation on the study's resources, to ensure they were understandable and appropriate for potential participants. This felt like an invaluable offer but bringing this to reality was not straightforward. I sent multiple contacts over many months to no fruition. I often spoke about the ethical dilemma I experienced during this process with my supervisors, feeling like I was pestering a small charity that had made this generous offer at the cost of their time and resources but at the same time knowing how valuable their input would be. With patience and some carefully constructed emails, this hurdle was eventually navigated. Whilst this input was undeniably worth waiting for it did delay the commencement of my recruitment. Therefore, in future, I would approach processes like this much earlier on, in the hope this would allow enough time to prevent a knock-on effect to subsequent stages.

Another dilemma I faced before commencing recruitment was regarding payment for participants. Following a discussion with my supervisors during the ethics phase of the research, we agreed it would be important to offer participants a monetary token of thanks for their time. I received ethical approval for this but met a stumbling block when submitting my research budget. It was illuminated that there was no provision for participant reimbursement unless there was a specific reason this was needed to facilitate recruitment. In light of this, I went back to my supervisors and discussed my options and position. Through this discussion, I became more aware of how morally and ethically important it was to me that participants' time was acknowledged or repaid in some way. I, therefore, decided that I would self-fund the e-gift vouchers I had proposed, and, on reflection, I am glad I did so. Personally, facing this dilemma symbolises the need for continued conversation about the inherent power held by researchers and research institutions, and the undervalued nature of research participation. Without participants, there is no research. I hope this is a conversation I can continue to have in future research spaces I find myself in.

The active recruitment phase of the research is probably best summed up by a quote from my reflective research journal: *"recruitment is the biggest rollercoaster and most sensitive seesaw!"* Over six months, I faced many moments where I thought I would never reach the minimum sample size. Whilst I received quite a lot of interest, I soon learnt there could be a big gap between the initial expression of interest from a participant and completing an interview. This appeared especially relevant to working with a population who were mothers, often to young children, which meant a flexible and sensitive approach to their caring responsibilities was needed. This is something I would highlight to other researchers seeking to work with mothers of young children, as a lack of consideration or accommodation around these needs could pose further barriers to having their voices and stories captured within research. My sample size slowly but steadily built and with additional support from APP, I was suddenly faced with the potential of having 'too many' participants. At the start of recruitment, it was unimaginable that I might reach an unmanageable sample size, but I am incredibly grateful to have been able to capture and share the stories of the nine women involved in the study.

Interviews

Before beginning interviews with participants, one of my supervisors offered to complete a reflexive interview with me. Whilst I had some anxiety about what this might be like, it turned out to be an invaluable step in becoming more aware of my lens, assumptions, and potential biases before I began hearing participants' stories. For example, the interview helped me connect with the roots of my interest in feminism, such as the stories of strong women within my family, as well as when and where this crossed over into my interest in perinatal mental health and PP specifically. Through this process, I found myself rediscovering the short story, The Yellow Wallpaper by Charlotte Perkins Gilman (1892). The Yellow Wallpaper was my favourite text during my A-level English Literature course. As I went back and re-read the story, I realised how present the themes of misogyny and patriarchal oppression as enacted by the biomedical model were within the main character's experience of what would now be termed PP. I was taken aback at how present the call for psychosocial engagement was from this women's story of PP over 130 years ago. I have included a quote from the story as a preface to the systematic literature review, that I feel powerfully reflects these themes. Reflective techniques, such as this reflexive interview, supported me to reach a deeper level of understanding as to how and why I came to this research area. I believe these techniques were integral to the quality of this research and will be for any research I conduct in the future.

The prospect of interviewing the first participant was met with equal feelings of excitement and apprehension. I was eager to finally speak to participants and move away from the somewhat abstract and theoretical nature of the research up until that point. However, I was very uncertain about whether I had the skills and knowledge to conduct the interviews 'well enough', being particularly conscious of not falling too heavily into the clinical interviewing style that I had been developing over training. My anxieties about this were not realised in the first interview and I was struck by how forthcoming the participant was to share her story, emotions, and experiences. Whilst I did have to adapt and build my research interviewing skills to meet the needs of different participants, I was overwhelmingly in awe at how open and willing participants were to tell their stories. I wondered whether this represented the lack of spaces for these women to talk about this specific aspect of their first-onset PP experience. Using my reflective diary after every interview helped me to become aware of parts of participants' stories that I was more or less drawn to. For example, I noticed that I was less drawn to the practical and contextual factors that participants spoke about as part of their fertility decision-making. Noticing this helped me to remain curious about these aspects in subsequent interviews so that I did not become too blinkered into thinking that PP was the main and only focus of participants' experiences of fertility decision-making. I am hopeful that if I was to conduct a similar study in future following this process would help illuminate potential traps like this.

Data Analysis and Write-Up

The data analysis and write-up phases of this research journey were marked by a battle with perfectionism. After transcribing the first interview, I was extremely hesitant to begin data analysis. Despite reading extensively about IPA and reading examples of IPA papers, I felt completely out of my comfort zone. My fear of getting IPA ‘wrong’ led to avoidance, which had repercussions for the subsequent write-up stage. Whilst logically I knew there was no one ‘right’ way to do qualitative analysis, due to its transparent level of subjectivity, getting to a place where I could trust in my intuition and ability was difficult. One moment that stands out in building this inner trust was a comment from a tutor in a research teaching session. They reassured us that the many years of further education in psychology and research methods we had completed to this point meant that, despite qualitative research feeling like a different beast, we were not coming to analysis from square one. This gave me the push I needed to make that first step and be more comfortable in the process of learning along the way. This is a highly valuable lesson I learnt during this research journey, and I am hopeful that in further research experiences, I will be less hesitant to take the leap of faith into analysis.

During the analysis phase of my research, I was on clinical placement within a community perinatal mental health team. This was the first time I had gained clinical experience of perinatal mental health, and it undeniably shaped my research journey that was happening alongside. For example, during the placement, I became more aware of current key texts, enquiries and policies within the perinatal mental health field, such as the Birthrights report (2022): *Systemic Racism, not*

Broken Bodies. Reading this report cast light on the extent of harm that continues to be created as a result of systemic racism within services during the perinatal period. This supported me to reflect on how the role of systemic racism within the PP experience was a ‘blind spot’ both within my research and the wider PP literature base. I reflected on my position as a white individual and the whiteness associated with the dominant biomedical model as ways of making sense of this. Whilst these reflections helped me to understand some of the limitations of my research and shape implications for future research, these actions were retrospective. In any future research I conduct, I hope to take more proactive actions, such as identifying ways to support the recruitment of ethnically minoritised participants to support their stories to be heard.

Once I came to writing up, I was daunted by the long list I had created to represent the many steps and sections that this process required. Reminiscent of my experience with analysis, I was hesitant to make the first step. However, for this phase, time pressure towards the deadline was mounting which helped me to take action. During write up I attended a few writing retreats, within which I had opportunities to try out the Pomodoro technique and generative writing. I found the combination of these techniques especially helpful in battling the perfectionism I can experience when I write. It helped reduce my tendency to pore over finding the ‘right’ words and get stuck in editing mode before I have even got a full sentence onto the page. Whilst writing up this thesis has been the most mentally exhausting academic endeavour I have ever faced, applying these techniques helped make the process slightly easier and will be methods I look to in any future research writing.

Choosing a journal was an integral step before writing up. However, it did not unfold in a straightforward manner. I first looked to other qualitative PP studies to see if there were common journals used that may suit my study. However, after doing some research I was disheartened by the limited word count of many of the frequently used journals. I was mindful of advice received from tutors and supervisors about not creating additional pressure to write up by choosing a journal with a low word count. I eventually settled on a journal specific to perinatal psychology, with an 8,000-

word count. However, during the write-up process, I went back to this journal's guidelines and realised they had recently been updated and the word count had been significantly reduced to 5,000. I knew this would be unmanageable, particularly as I had already had difficulty selecting and reducing participant quotes, so I went back to the drawing board. Finding the Psychology of Women's Quarterly journal was a relief. The journal fits well with the feminist stance of the research and practically accommodated the needs of the write-up.

Systematic Literature Review (SLR)

The review initially appeared to offer a simpler process of development in comparison to the empirical study. It felt like a more suitable opportunity to channel my broader interest in exploring the psychosocial approach to PP. I read various quantitative reviews that had tried to understand the role of different psychosocial factors in the onset of PP. Upon reading their conclusions I noticed that despite acknowledging the lack of replication and well-powered studies in the area, they suggested biological factors, such as hormones, should be further explored. This lit another fire within me, and I felt driven to fill the gap by using the qualitative PP literature base to explore the role of psychosocial factors in women's experiences of PP.

Whilst it felt hard at times to give the review the attention it needed, I continued to make steady progress alongside my empirical study, including developing the search strategy, registering to PROSPERO, and running the searches. It was during this latter phase that I experienced a heartdrop moment. Through the searching process, I found an unpublished thesis of another trainee clinical psychologist who had conducted their SLR on the role of psychosocial factors in the onset of PP using qualitative and quantitative literature. I found this one of the hardest moments of the whole research journey, as I was filled with worries about whether I was unintentionally replicating work that had already been completed. However, on reflection, I think facing this hurdle significantly improved the end product of my review. For example, finding this SLR made me go back to my rationale and helped strengthen my understanding of the specific purpose and scope of my review, which I believe enriched all further stages of the review process. In future, I hope I can use this experience to understand the importance of taking enough time and space at the beginning of the research process to get more ‘in tune’ with the rationale.

During the analysis and write-up phases of the review, I faced similar challenges that I noted with the empirical study. For example, worries about whether I knew how to do thematic synthesis ‘right’ led to familiar procrastination in getting started with analysis. Furthermore, due to the more direct applicability of the psychosocial and feminist approaches to the review, I had to be especially engaged in reflexivity during analysis and write-up to consider how my lens and position were interacting with the data. Again, using reflexive techniques, such as my reflective journal and supervision discussions, helped maintain this awareness.

Overall, the review experience helped me to understand the value of this type of research. It offered a method to bring together women’s voices by connecting findings across a growing research base to illuminate themes on a larger scale. I hope it is one step towards offering alternative narratives and understandings of the PP experience.

Final Reflections

This experience is not an easy one to sum up. However, if I were to develop themes for this research journey they would probably be: Passion, Reflection, and Trust. As I write this concluding paragraph, Trust is the one that stands out most strongly to me. Although it is somewhat of a cliché, this research journey and my broader training experience have taught me countless times to trust in the process. To trust that even in the moments when I cannot see the woods from the trees, I will find my path. I am incredibly proud of what I have achieved with this research and writing this final sentence symbolises the very trust that has allowed me to complete this thesis.

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Appendix C: Epistemological Statement

This statement will explore the concepts of ontology and epistemology and the corresponding positions the researcher identified with. It will also consider how these positions and their accompanying assumptions have shaped this portfolio thesis.

Ontology is concerned with the nature of reality and what is believed can be known about reality (Ormston et al., 2013). Realism and relativism are typically described as two opposing ends of the spectrum of perspectives regarding ontology (Willig, 2022). Realism posits that a singular, external reality exists, while relativism theorises there are multiple, subjective realities (Al-Ababneh, 2020). One's position on this ontological spectrum directly implicates one's epistemological position. Epistemology is concerned with the nature of knowledge and how it is possible to know and learn about the world and 'reality' (Willig, 2022). Again, epistemology can broadly be characterised by a spectrum formed by contrasting positions: positivism and constructionism (Ormston et al., 2013). Positivism considers that through meticulous, scientific observation, knowledge about the objective 'truth' of reality can be discovered. Conversely, constructionism argues all knowledge is socially constructed, meaning there are multiple and infinitely changeable 'truths' to be explored about 'reality'. There is no one 'correct' position on these spectra of ontology and epistemology. However, it is vital researchers understand and maintain awareness of their positions (Willig, 2022), as they inextricably shape research from conceptualisation through to dissemination.

The present researcher's ontological stance is relativism. As such, they believe there is not one objective version or 'truth' to know about 'reality' (Ormston et al., 2013). Connecting with this ontological perspective meant the researcher was drawn to explore qualitative enquiry, as aligned with corresponding constructivist-leaning epistemologies (Willig, 2022). Once the researcher identified women's experiences of fertility decision-making after first-onset postpartum psychosis (PP) as the topic of exploration of the empirical study, they engaged in both personal and epistemological reflexivity (Willig, 2022) to consider the appropriateness of different qualitative approaches. Thematic Analysis (TA; Braun & Clarke, 2006), Grounded Theory (GT; Corbin & Strauss, 2014), and Interpretative Phenomenological Analysis (IPA; Smith et al., 2022) were explored. IPA was ultimately selected as the most appropriate methodology and the reasoning for this will be subsequently explained.

IPA seeks to explore the lived experience of certain phenomena, by generating rich data about the quality and texture of experience, whilst also considering its meaning within a specific sociocultural context (Willig, 2022). IPA is underpinned by three theoretical foundations: phenomenology, hermeneutics, and idiography (Smith et al., 2022). Phenomenology is an approach to the study of human experience, meaning IPA is focused on offering rich explorations of what it is like to have certain experiences, including thoughts, feelings, and perceptions (Willig, 2022). Hermeneutics is the theory of interpretation, which IPA employs to consider the active role of the researcher in interpreting data, including drawing meaning from the data within the wider sociocultural context that it exists within (Smith et al., 2022). Finally, idiography is an approach which focuses on the particular, meaning IPA is concerned with the details and uniqueness of participants' experiences (Smith et al., 2022).

As the researcher developed the rationale and research questions for the empirical study, they connected with the value and importance of conducting an in-depth exploration that was sensitive to individual variation, due to the personal nature of both PP and fertility decision-making (Dommermuth et al., 2011; Wicks et al., 2019). To which the IPA principles of phenomenology and idiography would facilitate. Furthermore, through personal reflexivity, the researcher acknowledged the value of the interpretivist epistemological stance of IPA, as underlined by the principles of hermeneutics (Willig, 2022). Interpretivism recognises how the researcher and their lens, interact with the research itself and the meanings that are created (Alharahsheh & Pius, 2020). This interconnected relationship between researcher and research is understood through the 'double hermeneutic' within IPA, which describes how the researcher is attempting to make sense of the participant's attempt to make sense of their experience (Smith et al., 2022). During this circular sense-making process, it is acknowledged that the researchers ‘fore-conception’ (e.g., biases, prior knowledge, assumptions) will influence interpretations and findings (Smith et al., 2022). Therefore, on acknowledging elements of the researcher’s lens, such as their feminist stance, they recognised the importance of adopting an epistemological position and methodology that offered a transparent awareness of the inherently political nature of this perspective (Siegel et al., 2021).

In comparison, both TA and GT broadly seek to generate more generalisable patterns and theories from data, meaning they are less curious and accommodating to depth and points of difference between participants (Braun & Clarke, 2021). Furthermore, GT’s positivist epistemology means it does not attend to the active role of the researcher in the construction of findings (Willig, 2021). Therefore, IPA was favoured above TA and GT for the empirical study.

The researcher’s ontological stance of relativism and epistemological position of interpretivism also shaped the systematic literature review. Again, the relativist stance drew the researcher to the qualitative literature base. Their interpretivist position subsequently informed the interpretative approach of Thematic Synthesis (Thomas & Harden, 2008), which was utilised to develop new insights about the role of psychosocial factors within women’s experiences of PP (Flemming & Noyes, 2021).

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Willig, C. (2022). *Introducing Qualitative Research in Psychology* (4th ed.). Open University Press.

Appendix D: Data Extraction Tool

Author(s)	
Publication year	
Study title	
Location	
Research aim(s)	
Participant demographics **(n, age, gender, ethnicity etc.)**	
Ethics	
Design	
Sampling	
Measures	
Data collection	
Analysis	
Key findings	
Limitations	
Recommendations	

Appendix E: Quality Appraisal Checklist for Qualitative Studies (NICE, 2012)

Study identification: Include author, title, reference, year of publication		
Key research question/aim:		
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach?	Defensible Indefensible Not sure	Comments:

• Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?		
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/ Inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances? • Was context bias considered?	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method?	Reliable Unreliable Not sure	Comments:

• Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?		
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feedback on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example:	Convincing Not convincing Not sure	Comments:

• Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?		
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? • Is there adequate discussion of any limitations encountered?	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:

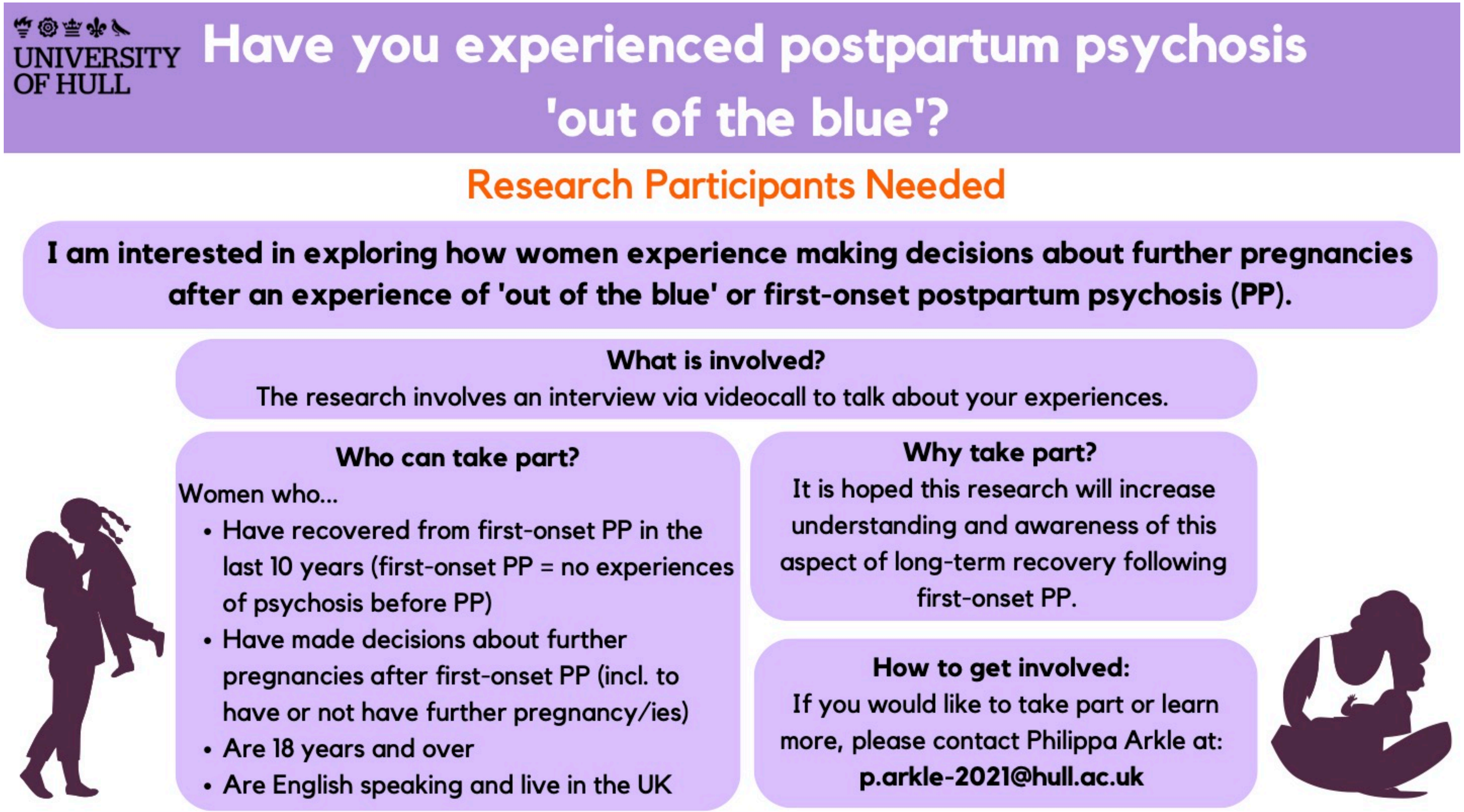
Overall assessment		
15. As far as can be ascertained from the paper, how well was the study conducted? Grade the study according to the list below: ++ All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter. + Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter. – Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.	++ + -	Comments:

Appendix F: Summary Table of Quality Appraisal Checklist Ratings (NICE, 2012)

Study	1. Is a qualitative approach appropriate?	2. Is the study clear in what it seeks to do?	3. How defensible/ rigorous is the research design/ methodology?	4. How well was the data collection carried out?	5. Is the role of the researcher clearly described?	6. Is the context clearly described?	7. Were the methods reliable?	8. Is the data analysis sufficiently rigorous?	9. Is the data 'rich'?	10. Is the analysis reliable?	11. Are the findings convincing?	12. Are the findings relevant to the aims of the study?	13. Conclusions	14. How clear and coherent is the reporting of ethics?	Overall assessment
Beck (2020)	Appropriate	Clear	Defensible	Inadequately reported	Clearly described	Clear	Not sure	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropriate	++
Engqvist et al. (2011)	Appropriate	Mixed	Defensible	Appropriately	Clearly described	Unclear	Reliable	Rigorous	Not sure/ not reported	Not sure/ not reported	Not convincing	Partially relevant	Inadequate	Not sure	-
Engqvist & Nilsson (2013)	Appropriate	Clear	Defensible	Inadequately reported	Not described	Clear	Not sure	Rigorous	Not sure/ not reported	Not sure/ not reported	Not sure	Relevant	Not sure	Appropriate	+
Glover et al. (2014)	Appropriate	Clear	Defensible	Inadequately reported	Not described	Not sure	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Jefferies et al. (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Not sure	Appropriate	++
Robertson & Lyons (2003)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Not sure	Rich	Not sure/ not reported	Convincing	Relevant	Adequate	Not sure/ not reported	+
Stockley (2018)	Appropriate	Clear	Defensible	Inadequately reported	Clearly described	Unclear	Not sure	Rigorous	Not sure/ not reported	Not sure	Not sure	Relevant	Adequate	Appropriate	+
Thippeswamy et al. (2015)	Appropriate	Clear	Defensible	Inadequately reported	Unclear	Unclear	Reliable	Not sure/ not reported	Not sure/ not reported	Reliable	Convincing	Relevant	Adequate	Appropriate	+
Vanderkruik et al. (2024)	Appropriate	Clear	Defensible	Not sure	Not described	Clear	Reliable	Rigorous	Not sure/ not reported	Reliable	Convincing	Relevant	Adequate	Appropriate	+

Note. Engqvist et al. (2011) was removed from the review following quality assessment.

Appendix G: Research Advertisement



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Have you experienced postpartum psychosis 'out of the blue'?

Research Participants Needed

I am interested in exploring how women experience making decisions about further pregnancies after an experience of 'out of the blue' or first-onset postpartum psychosis (PP).

What is involved?

The research involves an interview via videocall to talk about your experiences.

Who can take part?

Women who...

- Have recovered from first-onset PP in the last 10 years (first-onset PP = no experiences of psychosis before PP)
- Have made decisions about further pregnancies after first-onset PP (incl. to have or not have further pregnancy/ies)
- Are 18 years and over
- Are English speaking and live in the UK

Why take part?

It is hoped this research will increase understanding and awareness of this aspect of long-term recovery following first-onset PP.

How to get involved:

If you would like to take part or learn more, please contact Philippa Arkle at:

p.arkle-2021@hull.ac.uk

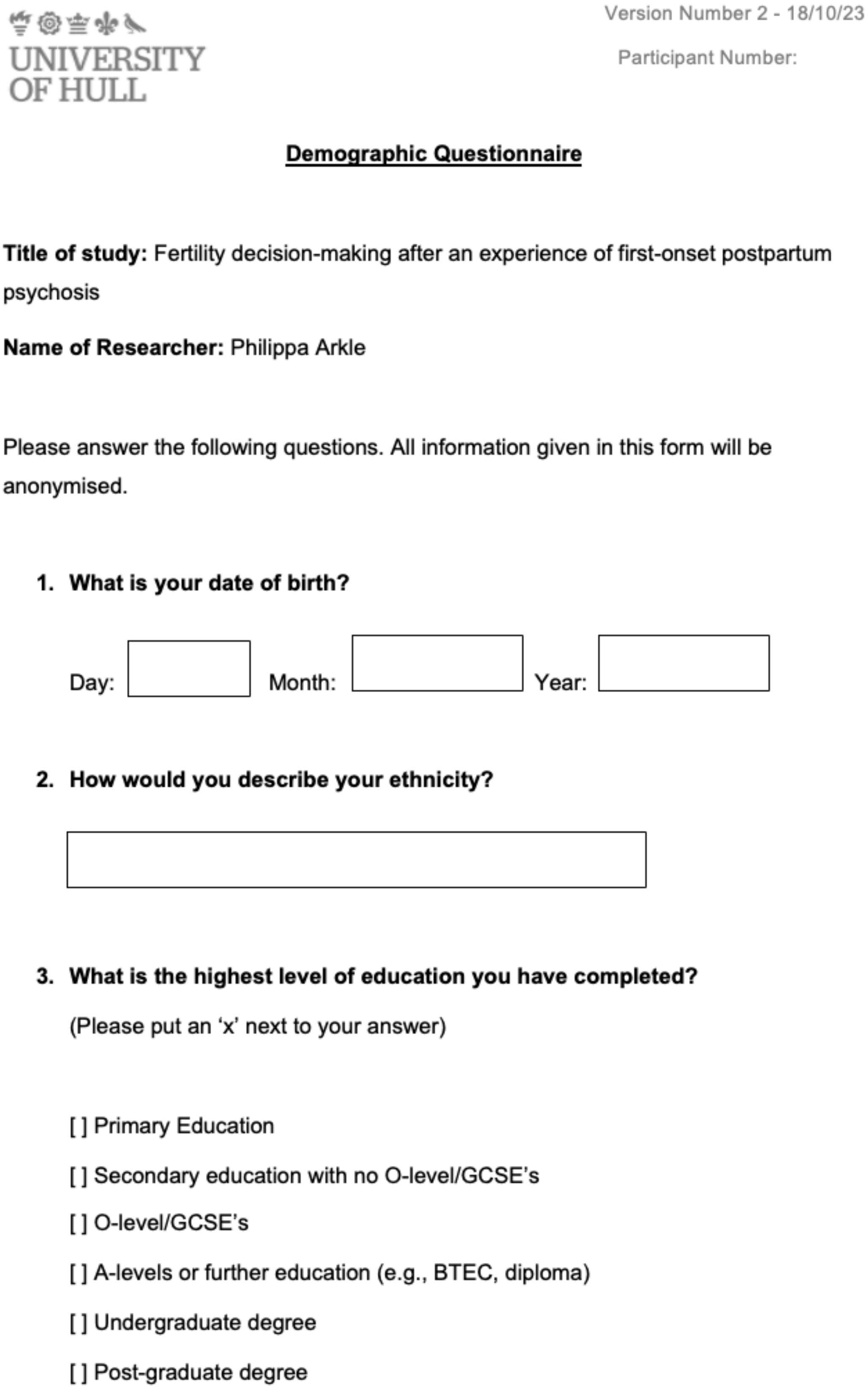
Appendix H: Research Advertisement in PP Charity Newsletter

Experience of decision making after postpartum psychosis

Philippa Arkle, at the University of Hull, is running a study exploring how women experience making decisions about further pregnancies after an experience of 'out of the blue' or first-onset PP. The research involves an interview via videocall. For more information, email: p.arkle-2021@hull.ac.uk.

Find out about all our studies currently recruiting here. If you are a researcher and would like us to support your research, please get in touch at an early stage in planning: research@app-network.org.

Appendix I: Participant Demographic Questionnaire



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Version Number 2 - 18/10/23

Participant Number:

Demographic Questionnaire

Title of study: Fertility decision-making after an experience of first-onset postpartum psychosis

Name of Researcher: Philippa Arkle

Please answer the following questions. All information given in this form will be anonymised.

1. **What is your date of birth?**

   Day: ☐ Month: ☐ Year: ☐

2. **How would you describe your ethnicity?**

   ☐

3. **What is the highest level of education you have completed?**

   (Please put an 'x' next to your answer)

   [ ] Primary Education

   [ ] Secondary education with no O-level/GCSE's

   [ ] O-level/GCSE's

   [ ] A-levels or further education (e.g., BTEC, diploma)

   [ ] Undergraduate degree

   [ ] Post-graduate degree

4. What is your current employment status?

(Please put an ‘x’ next to your answer)

[ ] Employed Job Title:

[ ] Retired

[ ] Unemployed

Other (please specify):

5. What is your current relationship status?

(Please put an ‘x’ next to your answer)

[ ] Single

[ ] Married

[ ] Divorced

[ ] Cohabiting

Other (please specify):

6. How would you describe your sexual orientation?

(Please put an ‘x’ next to your answer)

[ ] Asexual

[ ] Bisexual

[ ] Heterosexual

[ ] Lesbian

[ ] Queer

Other (please specify):

Participant Number:

7. **How many children do you have?**

8. **When were your children born (dd/mm/yyyy)?**

9. **When was your first experience of postpartum psychosis (PP)?**

Month: Year:

10. **Have you had any further experiences of PP?**

(Please put an ‘x’ next to your answer)

[ ] Yes

[ ] No

If yes, when were these experiences (mm/yyyy)?

11. **What mental health support have you accessed since your first experience of PP?** (Please put an 'x' for all that apply)

[ ] Counselling

[ ] Electroconvulsive therapy (ECT)

[ ] Family therapy

[ ] Inpatient mental health care

[ ] Peer support groups

[ ] Psychiatric medication (e.g., antidepressants, antipsychotics)

[ ] Psychological therapy

[ ] Preconception counselling

Other (please specify): ☐

12. **Have you experienced further pregnancy/ies since you experienced your first experience of PP?** (Please put an 'x' next to your answer)

[ ] Yes

[ ] No

13. **Do you intend on having any more children?**

(Please put an 'x' next to your answer)

[ ] Yes

[ ] No

Thank you for completing this questionnaire.

Please return the completed questionnaire to the researcher at

p.arkle-2021@hull.ac.uk.

Appendix J: Interview Schedule

Interview Schedule – v3 – 08/12/2023

Title of study: Fertility decision-making after an experience of first-onset postpartum psychosis
Name of Researcher: Philippa Arkle

Thank you for agreeing to take part in this study. As we have discussed, I'm interested in hearing about your experience of making decisions about whether to have further pregnancies after an experience of "out of the blue" or first-onset postpartum psychosis or PP.

So, I'm now going to ask you some questions about your experience of making such decisions, the meaning of these decisions and your experience of support when making these decisions. However, please also feel free to share anything else which feels important to you in relation to this topic.

Before we start do you have any questions?

1. I was wondering if you could start by telling me about your **immediate** family?
    - Who is in your **immediate** family? How many children do you have?
2. As you are aware the focus of the study is about the experience of making decisions about whether to have further pregnancies after an experience of first-onset PP. Whilst it is not the focus, I was wondering if you could **briefly** tell me about your experience of first-onset PP?
3. How did you feel about potential future pregnancies after your (first) experience of PP?
    - What was that like for you?
    - How did that make you feel?

  - What were you thinking about at the time?

4. How did you make decisions about whether to have further pregnancies after your (first) experience of PP?
   - What did you consider/think about?
   - How did it feel to make those decisions?
   - **What did those decisions mean to you at the time?**
   - **What was your experience of support when making those decisions?**
   - Who/what helped you to make those decisions?
   - Who/what got in the way when making those decisions?
   - What would have helped you to make those decisions?
   - **What do those decisions mean to you now?**
   - How do you feel when you think about those decisions now?
5. Is there anything else that you would like to share?

Appendix K: Participant Information Sheet

Version Number 2 - 31/08/23

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INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: Fertility decision-making after an experience of first-onset postpartum psychosis

I would like to invite you to participate in a research project. It forms part of my Clinical Psychology Doctorate research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Research suggests women who experience “out of the blue” or first-onset postpartum psychosis (PP) are at a higher risk of having another experience of PP in subsequent pregnancies. PP is described as “out of the blue” or first-onset when the person has no previous experiences of distressing and unusual beliefs and experiences, sometimes referred to as “delusions” and “hallucinations”, or mental health diagnoses, like bipolar disorder, psychosis, or schizophrenia.

Previous research has suggested that making fertility decisions, such as whether to have another pregnancy, is an important part of long-term recovery for women who have experienced first-onset PP. However, there is no current research exploring, in-depth, what the experience of making fertility decisions is like after an experience of first-onset PP.

The current study, therefore, aims to explore women’s experiences of this and their support needs during this process. We hope this will help increase understanding and awareness of this aspect of long-term recovery, which may help improve support offered by services.

Who can take part?

You can take part if you meet **all** the following criteria:

- You are a woman who identifies as having recovered from an episode of first-onset PP (e.g., a first experience of distressing and unusual beliefs and experiences, sometimes referred to as “delusions” and “hallucinations”, following childbirth) within the last 10 years.
- You have made decisions about whether to have a further pregnancy/ies after your experience of first-onset PP.
  - This includes women who have decided to try for or have had further pregnancy/ies, women who have decided not to have further pregnancy/ies and women who have had subsequent termination(s) or pregnancy/birth loss after an experience of first-onset PP.

- You are over 18 years of age.
- You are English-speaking and live in the UK.
- You have access to internet connection and Microsoft Teams software to complete an online interview.

Unfortunately, you will **not** be able to take part in the study if you meet **any** of the following criteria:

- If you have experienced distressing or unusual beliefs or experiences, sometimes referred to as “delusions” or “hallucinations”, or been diagnosed with bipolar disorder, psychosis, or schizophrenia **before** your **first** experience of PP (e.g., not first-onset PP).
  - Whilst we appreciate the wide range of experiences of PP, this study aims to specifically focus on the experience of decision-making about further pregnancies after first-onset PP.
- If you are currently experiencing an episode of PP or distressing or unusual beliefs or experiences, sometimes referred to as “delusions” or “hallucinations”.
  - This is because of the higher risk of potential distress caused by participating.
- If you do not have a good level of fluency in English, as this is required to complete the interview.
- If you do not currently live within the UK, as this study is focusing on the experience of women living in the UK.

What will happen if I take part?

If you choose to take part in the study, you will be asked to accept a phone call from the researcher at a mutually agreed time. This call will give you the chance to ask any questions you may have and to potentially arrange a time and date that suits you for the interview, should you remain interested in taking part.

The interview will take place via online videocall on Microsoft Teams. The interview will last around 1 - 1.5 hours and will be audio recorded. At the beginning of the call, you will be given time to ask any further questions and asked to complete a consent form before the interview and audio recording starts. You will need a quiet and private space to complete the interview. However, if you have any children under the age of 1 year, they may be in the room with you if necessary.

The main interview will involve answering some questions that will prompt different discussions, such as how you made decisions about whether to have further pregnancies after your experience of first-onset PP. There are no right or wrong answers, I am interested in hearing about your personal experiences.

As part of participation, you will be asked to provide a personal account of your experiences regarding PP and fertility decisions. You will also be asked to complete a short questionnaire to gather demographic information, such as your date of birth and ethnicity.

Do I have to take part?

Participation is voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you decide about taking part.

If you decide to take part, I will ask you to give your verbal consent over videocall which I will document on a consent form. I will email you a copy of this consent form to keep.

What are the possible risks of taking part?

Participating in the study will require 1 – 1.5 hours of your time, which may be inconvenient for you.

It is possible that you may find completing the interview upsetting or distressing as it will involve talking about your experience of PP and fertility decisions, which may bring to mind difficult memories or issues. If you feel that this may be a problem, you do not have to take part in the study. If you experience any distress during your participation in the study, you will be able to withdraw up to 2 weeks after completing the interview and the researcher will offer you support.

At the end of the interview, you will be given a “Sources of Support” document, providing information about services which can offer further help and support if needed. It is also suggested that you set some time aside after the interview, with someone you trust and/or to do a calming activity, to further support your wellbeing.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, you may find it valuable to talk and share your experiences. It is also hoped this study will increase understanding and awareness of the experience of fertility decision-making after first-onset PP, which may help to highlight how services can better support this aspect of long-term recovery.

Voucher

If you choose to participate and complete the interview you will be sent a £10 Lush e-gift voucher as a token of thanks. The voucher will be sent to you via email within 72 hours of completing your interview.

How will we use information about you?

I will need to use information provided by you for this research project.

This information will include your name, contact details and other demographic information you provide in the short questionnaire (e.g., your date of birth and ethnicity). Only the research team will have access to this information to do the research.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

The research team will keep all information about you safe and secure.

Once I have finished the study, I will keep some data so I can check the results. I will write the results in a way that no-one can work out that you took part in the study.

Your data will be processed in accordance with the UK-GDPR and the Data Protection Act 2018.

- All personal information collected from you will be kept strictly confidential, including contact details and demographic information. Contact details will be stored on an encrypted laptop and a paper copy will also be kept in the research supervisors locked cabinet at the University of Hull. Demographic information will be stored on a secure online storage repository. The researcher and their supervisors will be the only people who have access to this information. All personal information will be destroyed after the completion of the research.

- The interview will be audio recorded on an encrypted laptop and stored on a secure online storage repository. The recording will then be transcribed and anonymised, meaning all identifiable information, such as places and names, will be removed. The researcher and their supervisors will be the only people who have access to the audio recordings. All copies of the audio recordings will be destroyed as soon as they have been transcribed. Information shared during the recording will not be confidential as direct quotes may be used in the final report, research publications and presentations. However, no quotes will be used that could identify you, such as specific events, and anonymity will be further protected with a pseudonym (i.e., a false name). The anonymised transcripts of the recordings will be stored on a secure online storage repository at the University of Hull for a period of 10 years.

- If you disclose information during the study that suggests you or someone else is at risk of serious harm the researcher is obliged to inform the appropriate services to ensure that you and others are safe. Where possible, the researcher will discuss this with you. If a safeguarding concern is identified, safeguarding policies will be followed.

What are your choices about how your information is used?

You are free withdraw from the study up to 2 weeks after completion of the interview, without having to give a reason. After this point, withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected from you will be destroyed.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- By asking one of the research team
- By contacting the University of Hull Data Protection Officer by emailing dataprotection@hull.ac.uk or by calling 01482 466594 or by writing to the Data Protection Officer at University of Hull, Cottingham Road, Hull, HU6 7RX
- By reviewing the University of Hull Research Participant privacy notice: https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/docs/quality/research-participant-privacy-notice.pdf

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in the public interest’.

If you are not happy with the sponsor’s response or believe the sponsor processing your data in a way that is not right or lawful, you can complain to the Information Commissioner’s Office (ICO) (www.ico.org.uk or 0303 123 1113).

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull’s online repository (https://hydra.hull.ac.uk). A summary of the results will also be published on the Action on Postpartum Psychosis website (www.app-network.org). The research may also be published in academic journals and/or presented at conferences.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by the Faculty of Health Sciences Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Philippa Arkle (Researcher)
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: 07593789744
Email: p.arkle-2021@hull.ac.uk

What if I have further questions, or if something goes wrong?

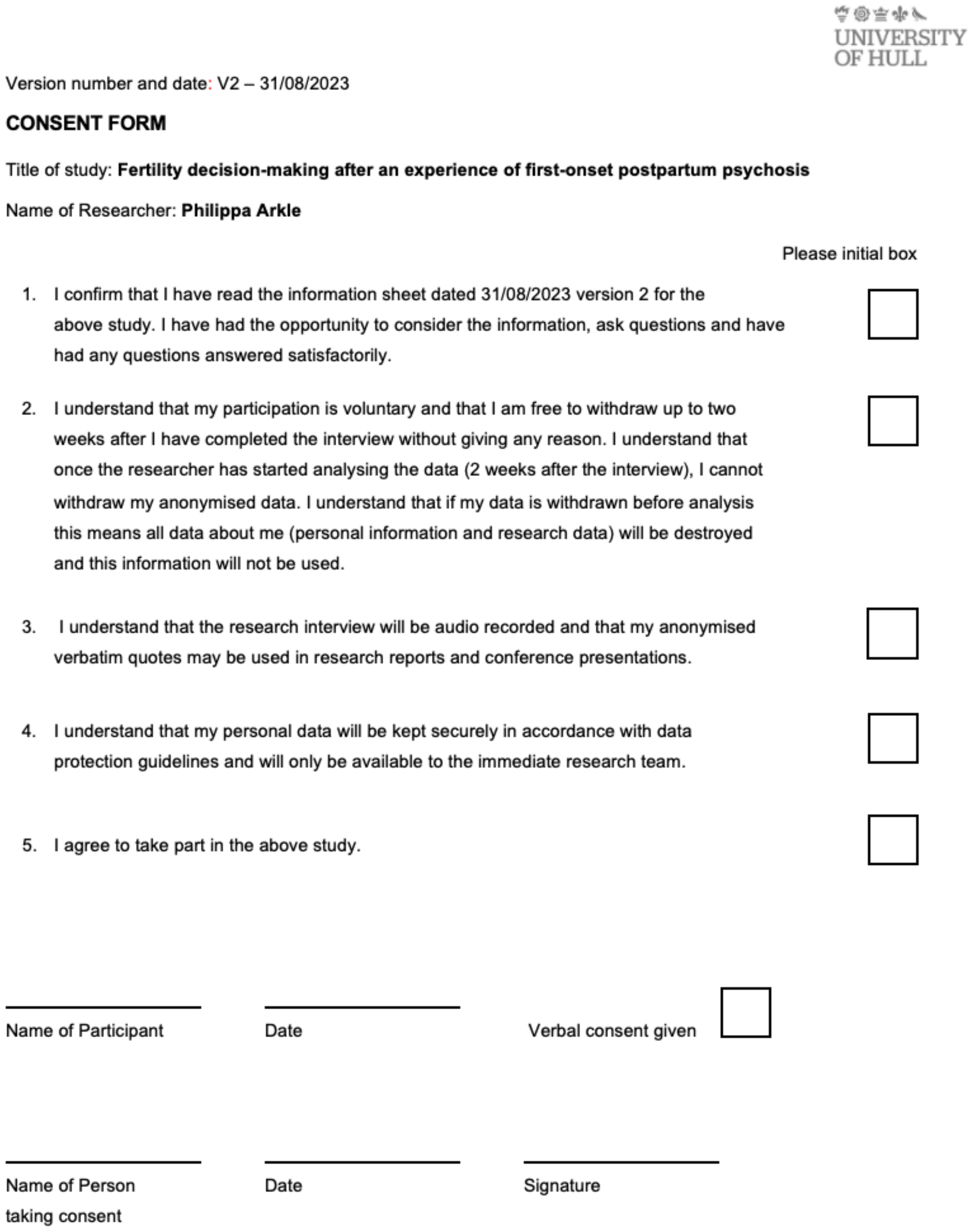
If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Anjula Gupta (Research Supervisor)
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email: a.gupta@hull.ac.uk

Alternatively, please contact university-secretary@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix L: Participant Consent Form



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Version number and date: V2 – 31/08/2023

CONSENT FORM

Title of study: **Fertility decision-making after an experience of first-onset postpartum psychosis**

Name of Researcher: **Philippa Arkle**

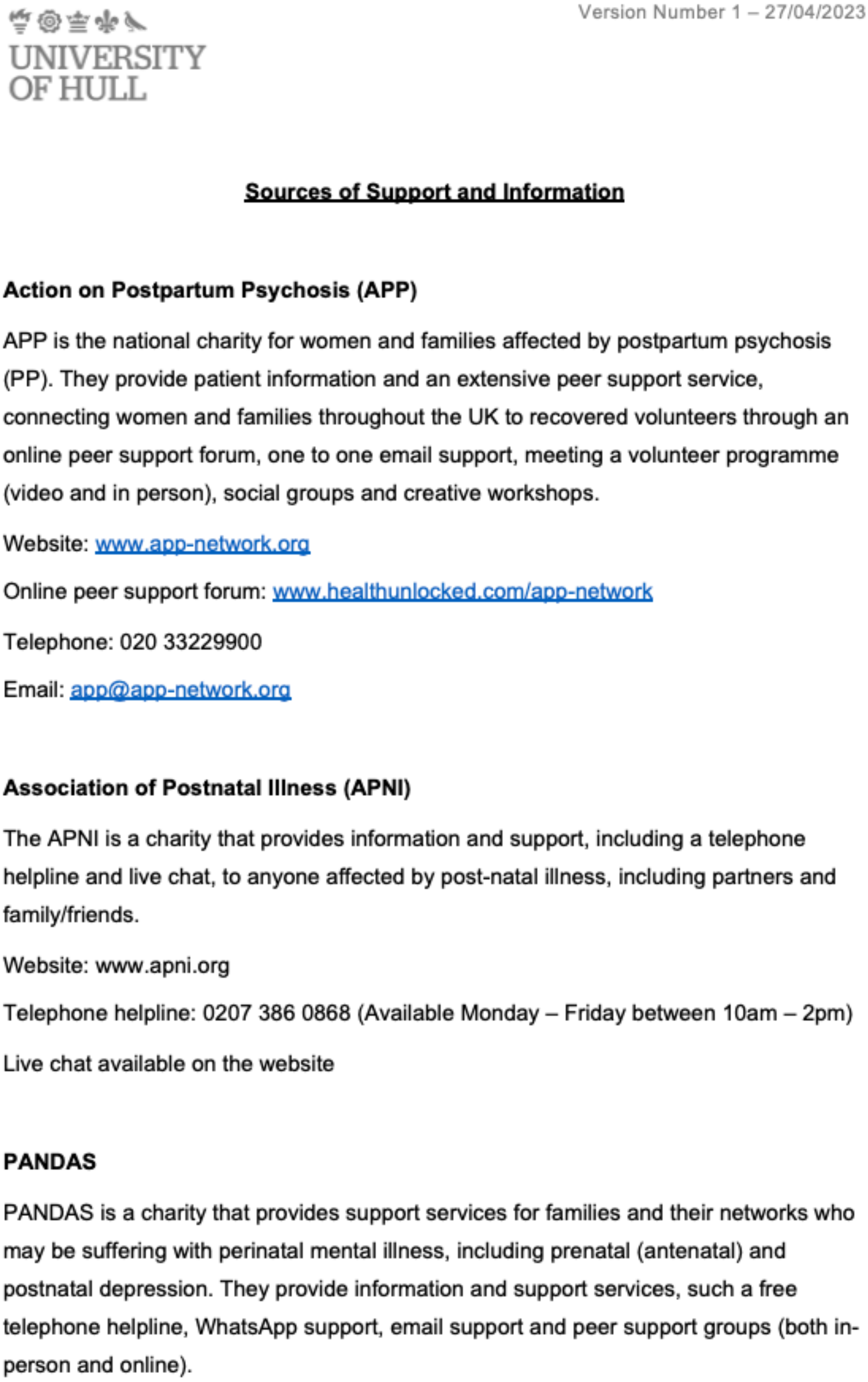
Please initial box

1. I confirm that I have read the information sheet dated 31/08/2023 version 2 for the above study. I have had the opportunity to consider the information, ask questions and have had any questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw up to two weeks after I have completed the interview without giving any reason. I understand that once the researcher has started analysing the data (2 weeks after the interview), I cannot withdraw my anonymised data. I understand that if my data is withdrawn before analysis this means all data about me (personal information and research data) will be destroyed and this information will not be used. ☐
3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐
4. I understand that my personal data will be kept securely in accordance with data protection guidelines and will only be available to the immediate research team. ☐
5. I agree to take part in the above study. ☐

Name of Participant ______________ Date ______________ Verbal consent given ☐

Name of Person taking consent ______________ Date ______________ Signature ______________

Appendix M: Sources of Support and Information Document



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Version Number 1 – 27/04/2023

Sources of Support and Information

Action on Postpartum Psychosis (APP)

APP is the national charity for women and families affected by postpartum psychosis (PP). They provide patient information and an extensive peer support service, connecting women and families throughout the UK to recovered volunteers through an online peer support forum, one to one email support, meeting a volunteer programme (video and in person), social groups and creative workshops.

Website: www.app-network.org

Online peer support forum: www.healthunlocked.com/app-network

Telephone: 020 33229900

Email: app@app-network.org

Association of Postnatal Illness (APNI)

The APNI is a charity that provides information and support, including a telephone helpline and live chat, to anyone affected by post-natal illness, including partners and family/friends.

Website: www.apni.org

Telephone helpline: 0207 386 0868 (Available Monday – Friday between 10am – 2pm)

Live chat available on the website

PANDAS

PANDAS is a charity that provides support services for families and their networks who may be suffering with perinatal mental illness, including prenatal (antenatal) and postnatal depression. They provide information and support services, such a free telephone helpline, WhatsApp support, email support and peer support groups (both in-person and online).

Website: www.pandasfoundation.org.uk

Telephone helpline: 0808 1961776 (Available everyday between 11am-10pm)

WhatsApp support: Message 07903 508334 (Available everyday between 8am-10pm)

Email: info@pandasfoundation.org.uk

Sands

Sands is a charity that provides information on baby loss and bereavement support services. These include Sands free telephone helpline, live chat, mobile app, online community, family support packs, memory boxes and over 100 regional support groups run by trained befrienders.

Website: www.sands.org.uk

Helpline: 0808 164 3332 (Available Monday-Friday between 10am-3pm and 6pm-9pm Tuesday-Thursday evenings)

Live chat (GriefChat) available on the website Monday-Friday between 9am-9pm

Email: helpline@sands.org.uk

Family Lives

Family Lives offers a confidential and free helpline service for families in England and Wales. They can offer emotional support, information, advice, and guidance on any aspect of parenting and family life.

Website: www.familylives.org.uk

Telephone helpline: 0808 800 2222 (Available Monday to Friday between 9am-9pm and 10am-3pm on weekends)

Live online chat on website (Available Monday to Friday between 10:30am-9pm)

Email support: askus@familylives.org.uk

Refuge

Refuge is a domestic abuse charity that supports women and their children, by helping them to overcome the physical, emotional, financial, and logistical impacts of abuse and rebuild their lives. Refuge offers a range of services accessed via the National Domestic Abuse Helpline, which is free and confidential.

National Domestic Abuse Helpline: 0808 2000 247 (Available 24/7)

Live chat also available Monday-Friday between 3pm-10pm: www.nationaldahelpline.org.uk/en/Chat-to-us-online

Refuge website: www.refuge.org.uk

Samaritans

Samaritans is a charity that operates a free, 24/7 confidential helpline for anyone who's struggling to cope, who needs someone to listen without judgement or pressure.

Confidential helpline: 116 123 (Available 24/7)

Website: www.samaritans.org

Email: jo@samaritans.org (Samaritans volunteers answer each email that comes through to this address)

You can write a letter and send it via: Freepost SAMARITANS LETTERS (Samaritans aim to send a hand-written response within 7 days)

Self-help app available online: www.selfhelp.samaritans.org

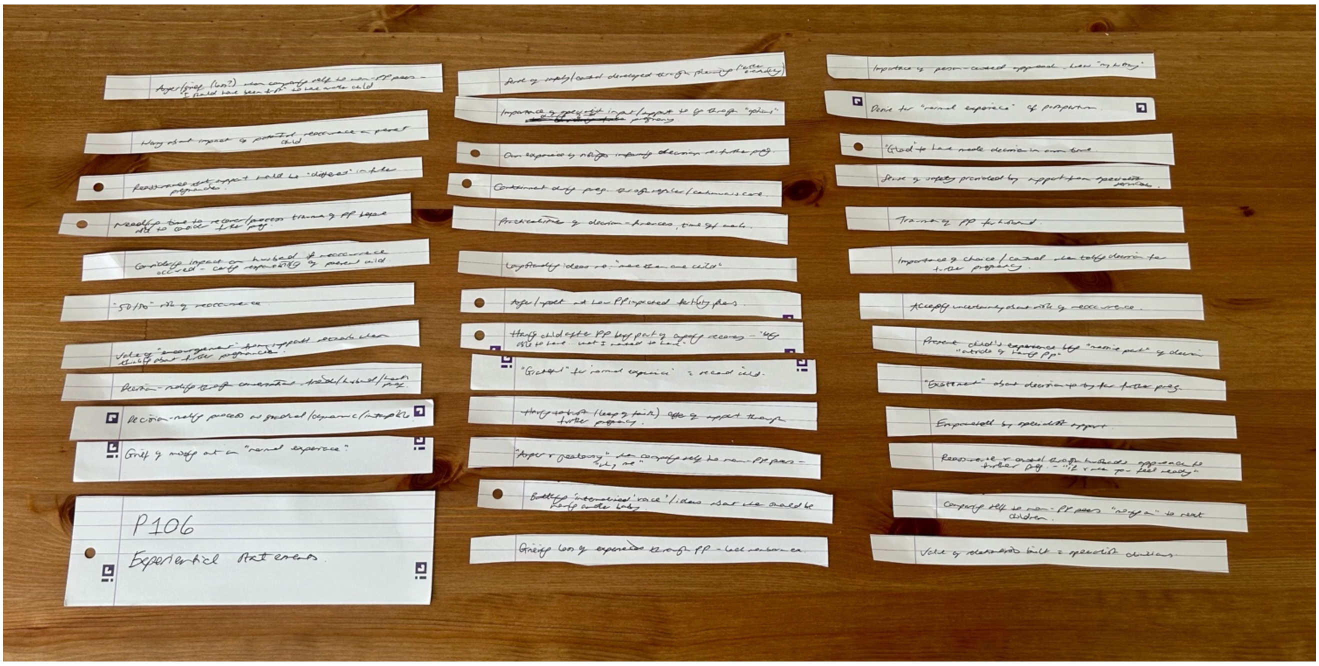
You can also seek help from your GP or someone you trust (such as a family member or friend).

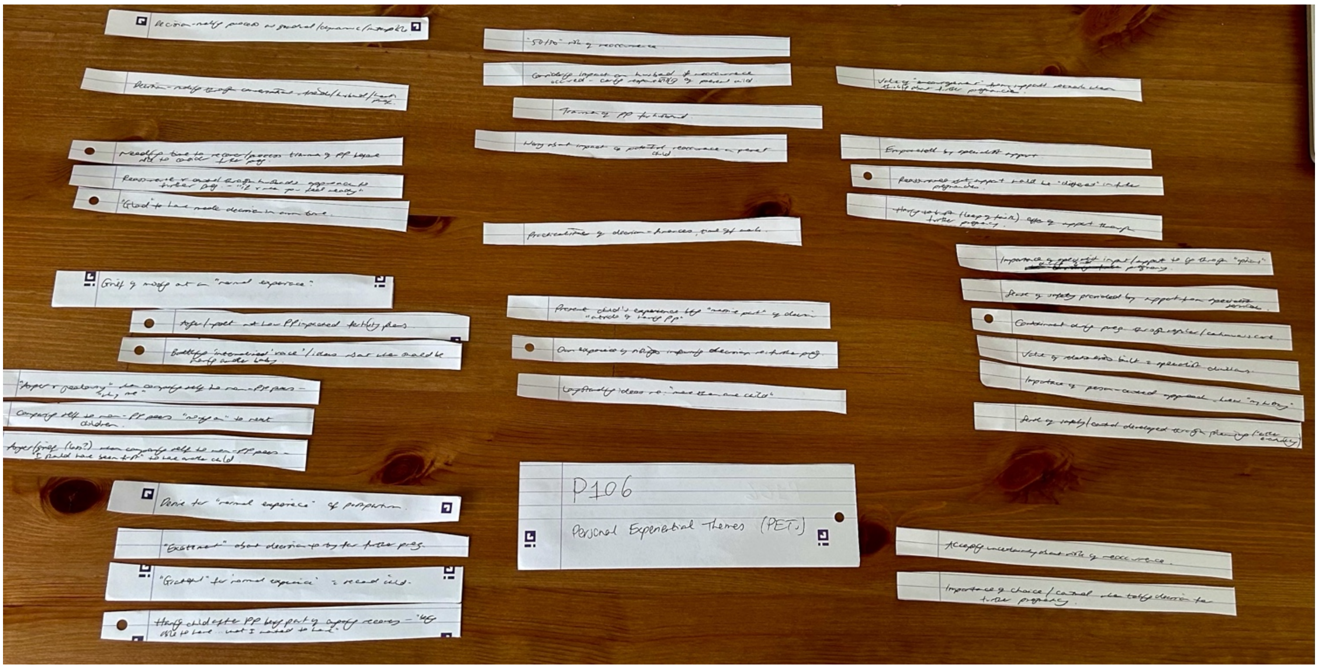
Appendix N: Example of Data Analysis – Exploratory Notes and Experiential Statements

Line No.	Transcript	Exploratory Notes	Experiential Statements
1043	R: You mentioned in there about your		
1044	partner and erm a clinician as well. But I		
1045	guess I was wondering generally about your		
1046	experience of support when you were sort		
1047	of making those decisions?		
1048	P: Yeah, so I think I had some weird	“weird conversations”	Unhelpful timing of fertility
1049	conversations in the beginning, when I was	about future pregnancies	conversations with
1050	still ill, because, again, it's quite difficult	early in recovery –	clinicians
1051	because...I didn't get the care that, that we	missed out on specialist	
1052	have now.	support	
1053	R: Mm-hm		
1054	P: So I, like now all these conversations,		
1055	although probably different in different		
1056	areas, I know they happen, you know,		
1057	there’s specialists in preconception, there	Acknowledging specialist	
1058	are specialists in nursery nursing in terms	support more available	
1059	of bonding with the child and yeah,	now	Needing specialist support
1060	psychological support. So, it is very		throughout PP and
1061	different now, but I just had no specialist	“no specialist input” as	recovery
1062	input. So that, that, for me is why I believe it	reason for “long recovery	
1063	took me a long time to get the treatment I	process”	
1064	needed and a long recovery process. So		
1065	until I met other women that had been	Meeting peers helping to	
1066	through stuff, I couldn't really process all of	process thoughts related	Value of peer support
1067	these other thoughts. And then that really	to PP	
1068	helped me in my recovery so. Erm...so in		
1069	terms of that, I think I definitely lacked that		
1070	specialist input.		
1071	R: Mmm		
1072	P: Erm so I didn't get that support that I	“didn’t get” support	
1073	probably needed in terms of everything, like	“probably needed”	Needing specialist support
1074	erm developing that bond with her, erm		throughout PP and
1075	working out what it all meant, you know, all		recovery
1076	the horrible stuff that I thought while I was		
1077	ill		
1078	R: Mmm		
1079	P: Like working through that probably would		
1080	have, could have been better. Erm...yeah, so		
1081	and then, and then in the beginning, when I		
1082	was still ill, I had weird...conversations with		
1083	like, non-specialists that were like, I mean, I	“weird conversations”	
1084	was	with “non-specialists”	
1085	still ill. So, I was still very psychotic at	whilst “very psychotic”	
1086	this time.		
1087	R: Mmm		
1088	P: I was going to like outpatients. It was like		
1089	a six-month obs and gynae review. And so, I		

was, I was still not with it, really not with it, I hadn't had the treatment that I needed at that point. I was on lots of medication, but and then right at the end she was like…erm...something about contraception, “make sure you're using contraception, if you don't want any more children”, and then she said “we can have a chat at some point about, you know, in the future, if you want more children”. And that was it, it was just really weird.	Obs and gynae review – “still not with it”, not on right treatment “make sure you’re using contraception if you don’t want any more”, “we can have a chat at some point about…if you want more” – “really weird”	
R: Mmm		
P: And I was still ill, and I was like…and looking back, that was just like, not the time to have that conversation		
R: Mmm	“not the time to have that conversation”	
P: I was still psychotic, I was still being treated, I was you know, I was **really, really** poorly. And I just saw it as a message or a sign because I'm still having delusions, like, “Why is she talking about other children?” Like, “I've got this one that I don't really want, and then all this stuff’s happened, and it's all gone wrong. And why is she talking to me about another child?”	Talking about potential future children whilst still unwell felt like “a message or a sign” – unhelpful, confusing?	Unhelpful timing of fertility conversations with clinicians
R: Mmm		
P: And I was just like-, like that's totally-, not her fault she wasn't a specialist, she was just doing a debrief of everything that had happened during the pregnancy. But that really, like stuff like that is really powerful. That I remember that weird feeling of like, “why is she talking about that?” So...so I think what my point is, like the is-, is that kind of non-specialist	“powerful” comments can be made by clinicians – importance of specialist approach	Needing specialist support throughout PP and recovery
R: Mmm		
P: You know, the impact that those like, very flippant conversations can have whilst you’re still poorly or recovering, can like really impact, those kind of feelings towards it. I can't actually remember your question, but it was in relation to…	“very flippant conversations” can impact feelings about decision-making?	

Appendix O: Example of Data Analysis – Developing Personal Experiential Themes





Appendix P: Data Analysis – Developing Group Experiential Themes