Women's Experiences of Postpartum Psychosis During the Onset and Early Days

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Abstract: Although research has identified some clear risk indicators for the onset of postpartum psychosis (PP), little is known about the experiences of women for whom onset appears to come "out of the blue." Semi-structured interviews focused on seven women's "out of the blue" experiences of PP during the onset and transcripts were analyzed using Interpretative Phenomenological Analysis. Four superordinate themes: "What's happening?", "Lack of recognition of the seriousness," "Breast is best?" and "Trauma" were identified depicting various anxieties, difficulties, distress and reflections on possible precipitating and perpetuating factors. An interpretive account provides insight into how PP might be experienced, barriers to identifying the presence of PP and possible contributing factors.

Keywords: postpartum psychosis, perinatal, qualitative research

Postpartum Psychosis (PP) is a serious mental illness that affects one to two women per 1,000, following childbirth (Berrisford, Lambert & Heron, 2015). Characterized by delusions, hallucinations, bizarre behavior, and mood lability (Heron, McGuiness, Blackmore, Craddock & Jones, 2008), PP is associated with negative consequences, such as impaired mother and infant bonding (Hipwell, Goossens, Melhuish & Kumar, 2000), infant abuse and neglect (Chandra, Bhargavaraman, Raghunandan & Shaligram, 2006), and risk of recurrent psychiatric illness (Robertson, Jones, Haque, Holder & Craddock, 2005). It has also been associated with suicide (Appleby, Mortensen & Faragher, 1998) and infanticide (Spinelli, 2004).

Biological explanations describe falls in estrogen and progesterone levels as a trigger for PP (Cookson, 1982); however, evidence is inconsistent (Jones & Smith, 2009), suggesting that hormonal factors may account for a vulnerability. Stress vulnerability may be an alternative explanation to the hormone theory of PP.

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The Stress Vulnerability Perspective applies the principles of a stress vulnerability model (Flemming & Martin, 2012) to the context of pregnancy and childbirth (Glover, Jomeen, Urquhart & Martin, 2014) suggesting that the onset of PP depends on both predisposing factors and a woman's capacity to manage stress.

There is compelling evidence to suggest that women with a previous diagnosis of schizophrenia (Sit, Rothschild & Wisner, 2006), women diagnosed with bipolar disorder (BD), and women with a family history of PP in a first-degree relative (Jones & Craddock, 2001) are at higher risk of developing PP. For women diagnosed with BD, who also have a first-degree relative with a history of PP, the risk of onset is 74%.

The known link between BD and PP means that there is a strong research focus on BD-related PP, (Heron, et al., 2008; Bergink et al., 2012). While such research is invaluable, there is limited knowledge about the onset of PP in women with none of these known factors.

Evidence suggests that being a first-time mother (Kendell, Chalmers & Platz, 1987; McNeil, 1988; Howard, 1993; Kendell, 1984), difficult birth experiences (Robertson & Lyons, 2003; Howard, 1993; Kendell, 1984; Kendell et al., 1987), psychological distress (Glover et al., 2014), traumatic life experiences (Thippeswamy, Dahale, Desai & Chandra, 2015; Kendell et al., 1987; Bilszta, Meyer & Buist, 2010), personality (Thippeswamy et al., 2015), antenatal stress (Glover et al., 2014; Robertson & Lyons, 2003), cultural issues (Thippeswamy et al., 2015; Howard, 1993), relationships (Kendell, 1987; Howard, 1993), and sociological factors (McNeil, 1988) may be associated with the onset of PP.

Rationale for the Study

Examination of women's experiences of PP in women with no known risk indictors may be immensely valuable in terms of better understanding this illness. Increased knowledge and understanding about the onset of PP will help to ensure that services can manage care effectively. The study will add to existing evidence about PP, improving our understanding of the onset, and potentially increasing the likelihood of healthcare professionals recognizing the signs.

Qualitative research is viewed as "rich" and "real" (Robson, 1993) and has a quality of "undeniability" (Smith, 1975) providing credibility for findings. Previous qualitative work has focused on living with PP (Robertson et al., 2003), perceptions of the cause (Glover et al., 2014), and explanatory models (Thippeswamy et al., 2015). The present study focuses on experiences during the onset and early days. Since the aim of the research is to examine women's experiences, according to their own perspectives, Interpretative Phenomenological Analysis (IPA) was chosen for its emphasis on seeking to provide a detailed examination of human lived experiences (Smith, Flowers & Larkin, 2009).

Methodology

Ethical Considerations

Ethical approval was received from Staffordshire University (UK) Ethics Committee. Capacity to consent was assessed by the researcher and written consent was provided by the participants. Due to the potential for distress to occur when discussing emotive topics, sources of support were signposted within the participant information sheet. Women who were currently experiencing a psychiatric crisis were excluded due to the potential for participation to increase distress.

Public Involvement

Involving the public in research helps to improve quality and credibility (INVOLVE, 2012). The researcher consulted a woman and her husband with lived experience of PP for advice regarding the proposed study. Their feedback was used to develop the protocol for recruitment and in the development of the materials used for consent.

Recruitment

The sample was identified on social media with the support of *Action on Postpartum Psychosis* (www.app-network.org). Participants were 18 years old or older, with capacity to consent. Since no distinct diagnosis of PP appears in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V; American Psychiatric Association 2013), or the International Classification of Diseases (ICD-10; World Health Organization, 1990), women who both identified as having experienced PP and were able to recall their experiences met the criteria for inclusion in the study. There was no time constraint with regards to time elapsed since the episode, because the nature of IPA is concerned with how people make sense of their life experiences and imposing a timeframe would prevent potentially important and meaningful experiences from being captured. Due to the focus of the research, women who had previously experienced a psychotic episode unrelated to the postpartum period, or women with a diagnosis of BD or a familial history of PP, schizophrenia or psychosis in a first-degree relative were excluded. Women were unable to participate if they were not fluent in English or if they were currently experiencing a psychiatric crisis, as defined by high levels of input from psychiatric services or an admission to psychiatric care. The criteria ensured that the sample was homogeneous and appropriate to address the aim of the study.

Participants

Participants in the purposive sample, who were allocated numbers to preserve anonymity, were recruited between December, 2017, and January, 2018, from the Midlands, North West of England, and North Wales. Initial expressions of interest were made directly to the researcher following an advertisement on the APP Facebook page. Six of the participants' experiences were between two and nine years ago with one participant's experience being 22 years ago. Until recently, PP was not prevalent in the public domain, so understandings of PP may have changed somewhat during this timeframe. That said, the participant whose experience was 22 years ago gave an account of PP that is reflected in nine of the 12 subordinate themes. This suggests that while it is important to acknowledge the possible impact of an awareness shift and potential limitations relating to reminiscence, the effect of these factors on the validity of the study may be only minimal.

Procedure

An advertisement was posted on the APP Facebook page by the director of the charity. Twenty-five women expressed interest and were sent a copy of the participant information sheet. Interested parties were provided with the opportunity to ask questions by either telephone or email. Seven women were forthcoming in confirming their desire to participate, at which point, mutually-convenient times for interviews were arranged to take place in the individual's home. During the interview visit, capacity to consent was assessed and verbal and written consent was obtained by the researcher.

Interviews were recorded on an audio device, and interview questions and prompts focused on encouraging participants to talk about their experiences. When the interview was finished, participants were debriefed, reminded of the timeframe for withdrawing their data, and alerted to the section in the participant information sheet regarding sources of support.

Data Analysis

All interviews, ranging from 20 to 49 minutes, were transcribed verbatim by the researcher and analyzed according to IPA principles (Smith et al., 2009). Transcripts were read and reread while listening to the audio recording so that the researcher could become immersed in the data. Transcripts were then explored, and extracts of interest were identified by close analysis. Exploratory comments covering descriptive, linguistic, and conceptual content were developed and provided the basis for analyzing the transcripts to identify emergent themes. The emergent

themes were developed into meaningful, interpretive statements, which were clustered by searching for connections. The analytical process of *subsumption* (Smith et al., 2009) enabled the development of superordinate themes, providing a framework in which to organize subordinate themes.

Validity and Reliability

The study demonstrates its quality by adhering to Yardley's (2000) principles for good quality qualitative research. Regular supervision focused on reducing the likelihood of any researcher bias, and a clear paper trail charting the progress of the study forced the researcher to question the evidence of their claim (Smith et al., 2009).

Epistemological Position and Reflexivity

IPA is concerned with the interpretation of an experience through engagement with reflections about the significance and meaning of that experience. The focus on experience is consistent with the researcher's critical realist epistemology, in that "Postpartum Psychosis" is seen as a construct; in contrast to an *illness* or *disorder* perspective, PP is understood in terms of an expression of understandable distress in response to the experience of adversity, such as life events, personal experiences, and the impact of society.

IPA is underpinned by the epistemological principle that the experience of a phenomenon is mediated by the individual's thoughts, beliefs, and judgements about that experience (Willig, 2008). Therefore, the objective of this IPA study is not to find an absolute, singular truth about the onset of PP, but to provide a rich and comprehensive interpretive account of women's experiences during the onset.

In IPA, the researcher is engaged in a double-hermeneutic (Smith et al., 2009). The researcher attempts to make sense of the participant making sense of their experiences. As such, the researcher's account is second-order, and since the quality that the researcher and participant share is that of being human, it is important that the researcher acknowledges and is transparent about his or her biases, personal feelings and preconceptions. The extent to which this can be achieved depends on reflexivity and the willingness of the researcher to engage in strategies to reduce researcher bias.

Before commencing the study, the researcher sought clinical supervision to explore her personal circumstances in relation to the research, such as the implications of being a female researcher, her experiences of becoming a mother, and identifying any assumptions. This process of reflexive bracketing (Ahern, 1999) meant that the researcher was able to identify preconceptions about birth trauma, assumptions that

may have arisen from her own personal experiences and her professional interests. As a subscriber to trauma-informed approaches (Sweeney, Clement, Filson, Kennedy, 2016) for mental health difficulties, and having personally experienced the impact of birth trauma on psychological well-being, the researcher reflected on her personal experiences and professional position, and was able to identify where this preconception about a possible link between trauma and PP arose from. During the *identification of emergent* themes phase of the analysis, the researcher was able to adopt a reflexive stance, incorporating the insight she had gained during clinical supervision to develop meaningful interpretive statements, while holding knowledge of her own biases in mind.

Padgett (1998) suggested that peer debriefing or support can help to reduce the threat of researcher bias. During the data collection stage of the study, the researcher experienced emotional responses in relation to some of the content of the interviews which resonated with personal experiences. To access and make sense of these feelings, the researcher sought additional clinical supervision, to reduce the impact of these feelings upon the analysis.

Results

There were four superordinate themes and 12 subordinate themes (Table 1) which were present in a minimum of three cases and on average in five cases, with three of the subordinate themes being present in all cases.

Table 1

Superordinate themes and subordinate themes

Superordinate Themes	Subordinate Themes	Theme present in cases
1. What's happening?	a. *"I just didn't sleep"* (participant 7)	2, 3, 4, 5, 6, 7
	b. Anxieties relating to the baby	All
	c. *"There's something not right"* (participant 5)	1, 3, 5, 6, 7
	d. Not feeling or acting like self	1, 2, 3, 4, 5, 6
	e. Losing touch with reality	All
2. Lack of recognition of the seriousness	a. Keeping up appearances	1, 4, 5, 6
	b. Misinterpretation of the problem	All

3. Breast is best?	a.	Difficulties related to feeding	1, 3, 4, 7
	b.	Anxieties related to breastfeeding	1, 2, 4, 7
4. Trauma	a.	Birth trauma	3, 4, 5, 7
	b.	Compromises to the baby's well-being	3, 5, 6
	c.	Childhood trauma/ distress and traumatic events	1, 2, 4, 6, 7

What's Happening?

Sleep deprivation. Six participants referred to a significant lack of sleep during the onset of PP. The pertinence of this issue was evident, not just by the number of cases, but by the way it was portrayed as a dominant aspect of the experience, with women returning to the point numerous times.

"I just didn't sleep." (Participant 7)

"For five days, I didn't really sleep." (Participant 2)

Reflections about severe sleep deprivation depicted experiences far more serious than the level of sleep deprivation expected for a new mother and included accounts of difficulties initiating sleep, suggested reasons for not sleeping, and the anxieties contributing to the lack of sleep.

"I started to not be able to sleep because I was worrying about not being able to feed him." (Participant 2)

"The midwives took her at one point to settle her and let us have some sleep, but I just couldn't sleep." (Participant 3)

Sleep deprivation was also cited as a possible causal factor, reflecting an effort to make sense of why they experienced PP.

"I think a lack of sleep had a lot to do with it. To start with, I wasn't sleeping and then I don't think I could sleep…." (Participant 5)

Anxieties relating to the baby. All participants described anxieties relating to the baby, with anxious thoughts concentrating on the baby's well-being, the need to protect the baby from harm, a lack of confidence in their ability to look after the baby, and the fear that the baby may be taken away. Some anxieties were driven by beliefs that something terrible might happen to the baby, resulting in women becoming highly protective. Although it is a mother's instinct to protect her baby, there was a sense of heightened anxiety about this.

> "So, it was my protective anxiety but just really extreme… I couldn't change her nappies…. I was like, I can't do it; can you do it? So it was definitely anxiety getting worse and worse." (Participant 3)

For Participant 2, this was evidenced by safety behaviors, a known behavioral response to the experience of anxiety (Salkovskis, 1991).

> "I'd be downstairs cleaning, writing myself instruction manuals on how to look after him…. I would sit and write instructions. So, I did that for myself. I labelled everything, like the erm, sterilizer, I went around and labelled everything overnight." (Participant 2)

Other anxieties presented as fears that they had, or would, harm, or kill the baby, and in Participant 3's case, this fear became part of a distorted reality.

> "That was the point when I had started to say something bad is happening or happened, or, erm, I think I have done something to my baby… I was like, I get it now. I have basically done something to Baby, she's died, so I have killed her." (Participant 3)

The subordinate theme, "Anxieties relating to the baby" defines the prevalence of anxiety in the onset of PP, with a specific emphasis on the nature of the anxiety, and its relation to the baby.

"There's something not right." (Participant 5). Participants described the felt sense that something was not right. These feelings, described by five of the participants, were reported as both personal feelings and as feelings expressed by others.

> "So, the next day, my husband was thinking there's something not right." (Participant 5)

The inability to be specific about what was not right emphasized a sense of confusion and characterized this theme.

> "I knew something was wrong, but I couldn't pinpoint." (Participant 1)

The subordinate theme, "There's something not right" depicts the participants' implicit sense of the illness in the absence of explicit understanding. Participant 2 stresses her and her family's lack of awareness about PP, and this may explain, in part, why it was so difficult to detect the specific nature of it.

> "Nobody would have thought in a million years because, we hadn't heard of postpartum psychosis." (Participant 2)

Further weight is added to this perspective when consideration is given to how much misinterpretation was made about what was happening by professionals (theme 2b).

> "They still didn't know what it was, and I don't know how many days I was there before someone said it's postpartum psychosis." (Participant 5)

Not feeling or acting like self. Most of the participants described not feeling or acting like their usual self and a clear sense of "out of

character" behavior and unusual changes, which compromised their sense of identity, were portrayed. This was detected by the women themselves and those around them, who were confused and concerned by changes in behavior.

> "Day three post-birth was when my behavior started changing." (Participant 4)

Frustration in communicating these changes in character to healthcare professionals was palpable, and a sense that the discreetness of the change, in that it is less distinct than specific symptoms of psychosis, added to the difficulty in identifying the presence of PP.

> "She is not acting like she normally would be, that's not how she is. I was going in and I was really chatty with them and I seemed as if I was coping with everything, I seemed okay. But my husband was like, that's not who she is, she's not that type of person." (Participant 5)

Losing touch with reality. All the participants experienced some degree of "losing touch with reality." Auditory and visual disturbances, unusual and distressing beliefs and suspicious or paranoid thinking characterizes this subordinate theme. Participants described experiencing racing thoughts and a lack of clarity in respect to reality. For some women, who did not ordinarily identify with spirituality, there was a spiritual background to this aspect of the experience.

> "I remember thinking that when I had him, angels had been in the room and I'm not a spiritual person, so I think that is all related to the postpartum psychosis because not long afterwards, I started to tell people that I could speak to dead people." (Participant 2)

For others, similarly to the subordinate theme which distinctively defines anxiety in relation to the baby, narratives about losing touch with reality often had the baby caught up in them.

> "Oh, I realize what I have done now, but that must have been in my head and I turned around and one of the midwives was taking Baby away to be resuscitated but that didn't happen in real life." (Participant 3)

There was variation in the awareness of losing touch with reality. Participant 3 could not distinguish reality from her distorted version of reality, while other women described a conscious awareness of a distorted reality, with feelings such as not being there, or that it was happening to someone else.

> "I suppose because it feels like it happened to another person, it's hard for me to say how I felt. I felt like, throughout most of it… like I was watching someone else do it." (Participant 4)

Participant 6 captures the unusual nature of this aspect of the experience, by communicating that she had not spoken about some of the experiences to anyone before, due to them being "weird."

"It's really odd. I have never told anyone any of this. It's really weird stuff." (Participant 6)

The subordinate theme, "Losing touch with reality"' defines the distinct distortions of reality that all the participants experienced.

Lack of Recognition of the Seriousness

Keeping up appearances. Four participants described how they were able to present themselves, to the outside world, as though nothing was wrong.

"I looked the picture of health. You would not have thought I was ill. You'd go, she looks immaculate…I used to put makeup on as like my mask. I used to make myself immaculate." (Participant 1)

Women concealed their experiences or ignored them, hoping they might stop, or be undetectable.

"So, I decided, very stupidly in hindsight, that I could hold it together long enough to convince the team that I was okay to go home. So, I said, I have had a good night's sleep and Baby was fine and I understood that it was being a new Mum." (Participant 4)

A distinct link between fear of the baby being taken away and creating the impression that everything was all right was evident, and the contrast between the internal world and the external presentation of the self was powerful.

"I think even if people have a checklist of things to ask, like things to do with psychosis and a statement at the top and ask them to sign it saying, by giving us this information and letting us know, we will not take your children away or we are not here to remove children, because that's a huge fear." (Participant 6)

"Keeping up appearances" depicts the process of concealing the internal world and emphasizes the fear experienced. This process, which happened during the onset of illness, possibly contributed to the delay in detecting PP.

Misinterpretation of the problem. All women described examples of when the onset of PP was attributed to something else, such as exhaustion, being a new mother, the baby blues, or a physical complication.

"He would go, you're a new Mum, it's normal." (Participant 7)

In some cases, misinterpretation of the problem was made by professionals, but often people who were close to the woman attributed their sense of something not being right to other phenomena too.

"My Mum, again was like, well she hasn't slept, it's sleep deprivation." (Participant 2)

> "I had lots of investigations. I had neurological people come down to check things but there was nothing that could say yes, that's what's going on." (Participant 3)

The subordinate theme, "Misinterpretation of the problem'" describes the degree to which the onset of PP was overlooked by the woman herself, her family and friends, and health professionals.

Breast is Best?

Difficulties related to feeding. Some participants described difficulties with feeding. Women struggled with breastfeeding for numerous reasons, including circumstantial barriers, such as the baby being in the hospital or physical difficulties in doing so. What was significant was the impact these difficulties had on the women.

> "It was a horrible feeling. I felt like her milk was dirty and I used to forget. My memory went, I would forget everything. Even counting the scoops of the milk, I used to forget, I used to have to throw it away. I don't know how many bottles I threw away 'cause I was so paranoid of making the baby sick. I was paranoid about everything." (Participant 1)

Difficulties with the process and preparation of formula feeding were reported and appeared to be linked to the underlying desire to breastfeed.

> "Before I had Baby, I always wanted to breastfeed, so I didn't buy him formula, I hadn't brought bottles. So when I had got a little boy at home that I couldn't feed, I didn't have anything to bottle feed him with." (Participant 4)

This theme depicts women's struggles in relation to difficulties with feeding, to the extent that it was significant to women, in their attempts to understand the onset of PP.

Anxieties related to breastfeeding. Women described anxieties relating to their struggles to breastfeed. Perceptions of bullying by healthcare professionals and feelings of failure amongst those who were unable to breastfeed, or struggled with breastfeeding, provoked particularly high levels of emotion.

> "I was actually given a leaflet on the emotional damage that you can inflict on your child by not breastfeeding and it actually said that you can emotionally retard them. I just kept thinking, what am I going to do?" (Participant 2)

The origin of these anxieties appeared to be rooted in fears or beliefs that the baby was not having its needs met. These fears and beliefs were either intrinsically part of the woman's existing belief system or had been instilled by the dominant message, "breast is best," which was sometimes experienced as bullying by the participants.

> "So, I really struggled. I could feed him, but he wasn't getting enough… eventually the midwife came back and erm, her words were, he's clearly starving.... And that phrase just stuck with me." (Participant 4)

Distress associated with the perception of being a bad, or not good enough mother, due to difficulties with breastfeeding, perpetuated anxieties about being unable to do so.

> "I kept going on to them (crisis team) about how I wasn't good enough for Baby and Baby needed a Mum and I couldn't feed him. Just obsessive, just round and round and round." (Participant 4)

"Anxieties related to breastfeeding" describes more than the stress associated with difficulties in breastfeeding; it defines the profound nature of this anxiety, which occurred for some of the women during their experiences.

Trauma

Birth trauma. Participants described a range of traumatic birth experiences with a focus on loss of control during the birth. For this sample, loss of control involved medical interventions such as induction, assistance with stage two labor, or emergency caesarean sections.

Participant 3, who had an emergency caesarean section under general anesthetic alongside other complications during labor, concluded that the resulting loss of control associated with this trauma contributed to the onset of PP.

> "I think some of it is to do with anxiety and losing control of what happened in the birth." (Participant 3)

In addition to the perception of losing control, other experiences such as preeclampsia and infections contributed to the experience of trauma.

> "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. Transpired that I had got surgical emphysema."
> (Participant 7)

Birth trauma describes how women make sense of the onset of PP in the context of the trauma which preceded it.

Compromises to the baby's well-being. Compromises to the baby's well-being were discussed and interviews depicted the vulnerability of a baby's life. Accounts reflected experiences when a baby required time in the Special Care Baby Unit (SCBU), and two women endured the terrifying experience of when their newborn babies stopped breathing.

> "I suddenly realized there was something not right and she had actually stopped breathing…I was left thinking, I've killed my baby." (Participant 5)
>
> "My husband came running up the stairs and he'd got Baby in his arms and Baby was completely blue, limp, erm…he was really floppy." (Participant 6)

Both women described fears relating to these experiences, such as it potentially happening again or their perception of being responsible in some way.

"Compromises to the baby's well-being" describes women's interpretations of the significance of these experiences in their onset of PP.

Childhood trauma/distress and traumatic events. Women described previous traumatic events and distress, which occurred in their childhood and in the years preceding their pregnancies. Reference was made to childhood abuse, problems within the childhood family setting, and difficult relationships with their mothers.

> "I was a victim of abuse as a child, erm, and I relived that." (Participant 2)
>
> Interestingly, participant 6 emphasized the relevance of her fractured relationship with her mother in her understanding of her own vulnerability to PP.
>
> "Because of my issues with my Mum… I think it's a huge impact on people. Those that have got their parents there or a parent that's strong and is supportive…makes a huge difference…my mother-in-law is amazing, but she's my mother-in-law. So, I do think it's a lot to do with your relationship with your family."

Miscarriages and significant traumatic life events were part of the story when providing background to the context of PP.

> "…cause I had a miscarriage before I had my little girl." (Participant 1)

The subordinate theme, "Childhood trauma/distress and traumatic events" expresses the focus drawn, by the participant to the researcher, towards their understanding of the impact that various traumas had in their experience of the onset of PP.

Discussion

Although it is impossible to know from the findings whether sleep deprivation is a consequence or causal factor in the onset of PP, the important issue is that sleep deprivation characterizes this sample and supports previous research into PP. Sharma, Smith & Khan (2004) showed how sleep deprivation may be a precipitant of PP, in women who were predisposed to it, while Glover et al. (2014) found that women identified sleep deprivation as a contributing factor in their experiences

of PP. Heron et al. (2008) found that around a quarter of women had no need for sleep or that they could not sleep during the early stages of PP. The present study offers richer insights into the idiographic nature of the experience of sleep deprivation. Many people may identify with some degree of sleep disturbance, but a richer understanding of what that might be like for women during the onset of PP is helpful for healthcare professionals, women, and their families. Women in this study emphasized sleep deprivation as a phenomenon that characterized the onset of PP and it appears to be more prevalent than has been reported (Heron et al., 2008).

More subtle experiences, as depicted by, "There's something not right" and, "Not feeling or acting like self" are undeniably important in the stories women tell, but how this translates into a helpful phenomenon is not without problem. In a world where the medical model prevails, diagnosis often depends on clear and distinct symptomology. This is not congruent with the experiences women described and calls to question the way in which mental health and psychological distress is identified. It seems that attracting timely and appropriate help may well be hindered by such intangible experiences. This study stresses the importance of recognizing and paying attention to idiosyncrasies in the context of the perinatal period. This is especially important for women who appear to develop PP "out of the blue," since a lack of other clinical indications mean that it is already difficult to predict the occurrence of PP in such cases.

Anxiety is known to be associated with psychotic disorders (Achin, Sutliff & Roy, 2015) but interestingly, the experience of anxiety amongst the women in this study reflected anxieties relating to the well-being of the baby and with difficulties in breastfeeding. Although it is understandable that many women may experience anxieties relating to their baby, differentiating the content of anxious thinking or behavior might be helpful in the early detection of PP.

The relationship between difficulties with feeding and anxieties relating to breastfeeding was cyclical in nature. From the outset, the women in this sample either wanted to breastfeed or felt strongly that they should do so, due to perceived pressure from healthcare professionals. In the instance that they could not breastfeed, it seemed to lead to distinct confusion about how to prepare and use formula-feeding systems, paranoid beliefs about formula milk harming the baby, or distressing feelings of failure as a mother. These experiences perpetuated existing anxieties or introduced further anxieties about their baby's well-being. In an IPA study (Glover et al., 2014), women identified feelings of "falling short as a mother," and similar anxieties about feeling like a failure as a mother were associated with anxieties related to breastfeeding in this study.

Losing touch with reality is one of the most distinct features of other psychotic disorders. Interestingly, for some of the women, the baby was

very much part of the story in the theme, "Losing touch with reality." This theme was part of the experience for all of the mothers in the study, but the phenomenon was often hidden from healthcare professionals and those close to the woman. For women whose experience of PP appears to come "out of the blue," the association of the baby in this loss of touch with reality may provide a subtle indication of the presence of PP.

The superordinate theme, "Lack of recognition of the seriousness" perhaps sheds light on why losing touch with reality could be missed by others. Some women made efforts to act like everything was all right, or indeed on the surface, it appeared as if everything was alright. Glover et al. (2014) described women feeling judged by others, and this may go some way to explaining why women concealed their experiences and tried to create the image that all was well. In addition to "Keeping up appearances," the difficulties and experiences that the women faced, both internally and those that were evident on the surface, were often attributed to some other cause, such as sleep deprivation, being a new mother, the baby blues, or even a physical explanation.

Although a lack of recognition of the seriousness is understandable in the context of the subordinate themes, "Keeping up appearances" and "Misinterpretation of the problem," this research highlights a lack of awareness about PP, both in the wider population but also, even more concerning, within healthcare services. PP is serious and can have catastrophic consequences, so it is imperative that mental health and perinatal service providers are adequately informed and able to recognize it. It is possible that "Lack of recognition of the seriousness" is unique to the present "out of the blue" sample and future research could explore this prediction. If PP could be dealt with quickly and effectively, then economic and catastrophic costs, such as damage to families, impact on children, and death or serious injury could be avoided (Maternal Mental Health Alliance, 2014).

The theme, "Trauma" supports previous findings. Robertson et al. (2003) found more cases of PP amongst women who experienced trauma during the birth, and Howard (1993) identified a prevalence of PP in women who had caesarean sections, both of which are reflected in the interpretation of "Birth trauma." Thippeswamy et al. (2015) found the perinatal death of a child to be associated with PP. While there were no cases of perinatal death in this study, tentative similarities may be drawn between the loss of a baby and the experience of a traumatic event whereby a baby's life is compromised, as evidenced in the theme, "Compromises to the baby's well-being."

Kendell (1987) found that previous miscarriage was associated with increased admissions to psychiatric care after the birth of a child, and Bilszta et al. (2010) identified higher levels of childhood sexual abuse amongst people with PP than in healthy controls. Both experiences were described by participants in the present sample and were interpreted as

evidence for "Childhood trauma/distress and traumatic events." Participants in the present sample described difficult relationships with their own mother, and due to the significance women attached to this, understanding about the type of distress which may be pertinent in the onset of PP is increased. The relevance of life events is corroborated by Kumar et al. (1993), who report life events as a contributing factor in PP for women with no previous risk indicators. The present sample offered insights into the distinct types of trauma, distress, and life events that were deemed significant in their sense-making of the onset of PP. These adversities may be understood in terms of the Power Threat Meaning Framework (DCP, 2018). This framework draws on a variety of models and theoretical perspectives to offer a broad paradigm from which to understand emotional distress. The framework focuses on how power has operated in an individual's life, the threat this has posed to him or her, what sense the individual makes of the threat, and how the individual has responded to survive. As such, "Childhood trauma/distress and traumatic events" should be considered when attempting to make sense of distress in women who do not have any known risk indicators for developing PP.

For women who are not known to be at risk of developing PP, the findings provide a comprehensive account of what the onset might be like, and emphasizes the importance of paying attention to the subtle characteristics of the experience depicted by the themes. Furthermore, implementation of a Power Threat Meaning Framework (DCP, 2018) approach may provide a suitable practice for clinicians to better understand and detect PP-type experiences.

Clinical Implications

The results from the study emphasize the importance of active listening, raising awareness of PP in all perinatal settings, sensitivity and empathy regarding the emotional impact of difficulties with feeding, and the impact of trauma on a woman's well-being in the perinatal period.

By increasing our understanding of PP and disseminating findings in perinatal settings, it may help healthcare professionals to identify PP-type experiences, which is especially important for women without any known risk indicators. "Lack of recognition of the seriousness" may be a unique consequence of PP occurring "out of the blue," so if professionals can hold knowledge about PP in mind when they see women who are experiencing distress, they may be empowered to consider the possibility of PP.

Communications from women and their families about sleep deprivation, anxieties, the sense that something is not right, and perceptions of a change in character are too easily dismissed. These experiences are subtle, due to not being particularly distinct from the typical experiences many women who do not develop PP go through.

Paying attention to the nature of these experiences, remaining curious to the individual's context, and responding to the presence of distress associated with these feelings may allow healthcare professionals to effectively identify a potential episode of PP. There is an ethical responsibility for healthcare professionals to recognize signs of mental health deterioration wherever possible. In practice, this may be as simple as professionals querying whether the level of sleep deprivation a woman is experiencing is typical of that expected of a new mother or exploring what it is that makes someone feel that something is not right.

A more sensitive and empathetic approach to breast- and bottle feeding may reduce the levels of distress a woman experiences in relation to this issue. Mothers should never feel bullied, and a sensitive and empathetic approach would reduce the likelihood of this distressing experience. For the first-time mother, breastfeeding is an unknown area and has the potential to provoke feelings of vulnerability and psychological distress. Healthcare professionals should remain mindful of this, and always incorporate this awareness into their practice.

Finally, the importance of recognizing the impact of trauma on a woman's well-being is critical, and routine psychological assessment with women who have experienced birth-related or perinatal trauma, as well as known historical trauma, may alert health professionals to women who are vulnerable to a decline in their well-being. The presence of trauma should be considered when attempting to predict the onset of PP in women who do not have other risk indications of developing PP.

The psychological nature of the findings mean that clinical psychologists are well-placed to assist with the training and support of professionals involved in the care of women during the perinatal period. Clinical psychologists bring a unique and advanced skill set to the understanding and treatment of perinatal mental health problems (DCP, 2016), and can provide a psychosocial perspective through formulation. Formulation adopts a biopsychosocial model (Davey, 2008), which attributes psychological distress to biological, psychological, and social factors to provide a comprehensive and holistic account of PP.

Strengths and Validity

The study recruited a purposive sample of participants from various locations in the UK. The method followed the guidance set out by Smith et al. (2009), and a range of extracts show the depth and breadth of the analysis. Findings may contribute to specialist training for healthcare professionals to increase awareness of PP and strengthen the knowledge base regarding the experience of PP, specifically during the onset and early days.

Limitations and Recommendations

The research was retrospective in nature, and as such it relied upon individuals' memories of their experiences. Memories may not be reliable, as they are vulnerable to extraneous factors such as time, trauma, and attention. However, capturing prospective qualitative data for this group has ethical implications. IPA was an appropriate method and with its focus on people making sense of an experience, this limitation is somewhat mediated.

The study aimed to be accessible through its use of online recruitment and commitment by the researcher to travel throughout the UK; however, the sample was limited in its geographical spread. Participants in the homogeneous sample were Caucasian British women, so future work including cross-cultural exploration may highlight possible differences in a broader demographic, increasing the validity of the findings.

Although online recruitment provides a wide-reaching and efficient recruitment strategy, the study was limited to women who have accessed or engaged with APP via social media. Since the demographic reached by APP was not known, it is difficult to comment on the true nature of the accessibility of the study, and future work may consider additional recruitment initiatives.

Future work might benefit from exploring alternative perspectives, such as those of partners, family members, and health professionals involved in the care of women during the perinatal period. Owing to an absence of other clinical risk indicators in this sample, the findings pertaining to "Lack of recognition of the seriousness" may be unique, and future research may explore this prediction by comparing the experiences of women with known risk indicators and those whose experiences appear to come "out of the blue."

Conclusion

The findings in this study provide insight into how PP might be experienced, barriers to identifying the presence of PP, and possible contributing factors. Women experienced severe sleep deprivation and their experiences were characterized by anxiety relating to the baby, the sense that something was not right, or feeling and behaving unlike themselves. They experienced a loss of touch with reality, but a distinct lack of recognition of the seriousness of the problem meant that the onset of PP was not always easily detected. Possible contributing factors included difficulties associated with the feeding process, and identifiable traumatic experiences, either relating to the perinatal period or past trauma, which seemed to present as distress in the context of becoming a mother.

Results support previous findings regarding the role of sleep deprivation in the experience of PP (Glover et al., 2014; Heron et al., 2008; Sharma et al., 2004), but it is not clear whether this is a contributing factor or consequence of the experience.

Importantly, the findings highlight specific characteristics of the experience during the onset of PP in women who were not known to be at risk of developing PP. This knowledge can contribute to raising awareness and increasing the detection of PP in this group.

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