‘Misconceptions of Madness’ and ‘Racialised Mythologies’: Black Mothers’ Lived Experiences of Postpartum Psychosis and Racism

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Abstract

Context: Current literature indicates multi-systemic racism and a lack of consideration of community culture or values, inhibiting the recovery of Black postpartum women. Little research has been conducted on the experiences of postpartum psychosis for Black mothers, despite the increased risks and poor maternal mental health outcomes.

Aim: This study aims to explore the experiences of recovery from postpartum psychosis for Black mothers, who may or may not have accessed support. The objective is to gain understanding of how racialisation has impacted women's experiences and relationship with healthcare.

Method: This is a qualitative design. Semi-structured interviews were conducted with 17 women that identified as Black, with self-reported experience of postpartum psychosis, and were over 18 years. Participants were recruited via UK third-sector charities and social media. An interpretative phenomenological analysis was carried out.

Findings: The findings portray acceptance of postpartum psychosis in the context of racial marginalisation as extremely challenging for Black mothers, leading to detrimental experiences of healthcare. Facilitation of community groups which encompass shared identity norms and lived experience, and the support of significant others with shared values, helpfully mediate recovery experience.

Discussion: Racialised mythologies endorsed within healthcare provision perpetuate the internalisation of rejection and shame. Community misconceptions of madness ostracise women further in their recovery. Implicit white cultural bias and multi-systemic racism arguably serve the interest of the dominant and oppressive white medical system, where differential racialisation of Black mothers maintains inequity.

Implications: Current healthcare systems require redressing, and racism challenged at systemic and individual levels within service culture, with the hope to improve accessibility and care experiences for Black mothers with postpartum psychosis. Black motherhood, in the context of ‘psychosis’, requires increased colloquy and development of intersectional ideas.

Declaration

I can confirm that this thesis is an original piece of work carried out by the author. It was completed and submitted as a requirement for the author's Clinical Psychology Doctorate at the University of Essex. This thesis has not been submitted for any other academic award.

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Contents

1. Introduction

1.1 Maternal Mental Health and Postpartum Psychosis

Maternal mental health problems can affect one in five women, inclusive of antenatal and/or postnatal depression, anxiety, obsessive compulsive disorder, posttraumatic stress disorder, or postpartum psychosis (Maternal Mental Health Alliance (MMHA), 2023). Overall, mental health difficulties represent the most common cause of death within the perinatal period for mothers, with the leading cause being suicide (Jones et al., 2014; Knight et al., 2016: Wilkinson et al., 2017). In the UK, the Five Year Forward View for Mental Health report indicated the need for further investment in evidence-based specialist mental health care, including greater access to perinatal support that incorporates psychological support (The Mental Health Taskforce, 2016). The NHS Long Term Plan builds on these goals and there are now specialist perinatal mental health services in all 44 NHS localities in England (NHS England, 2018).

Whilst perinatal depression approximately affects between one and seven-ten of mothers in the UK/US and is the most vigorously researched perinatal mental health illness, less is known about postpartum psychosis despite the greater severity of symptoms (Royal College of Psychiatrists, 2023). Postpartum psychosis can be defined as experience of ‘delusions’, ‘hallucinations’, ‘disorganised behaviour’, and ‘depression’, usually with rapid onset and deterioration, typically within two-four weeks postpartum (Di Florio et al., 2013; Forde et al., 2020; Heron et al., 2008; Sit et al., 2006; NHS England, 2020). Postpartum psychosis has been found to affect 0.89 to 2.6 per 1000 women, and those with a diagnosis of bipolar disorder, previous experience of psychosis (or other psychotic illness), or a close relative with history of postpartum psychosis, being more at risk (Howard, 2014; Jones et al., 2014; Royal

College of Psychiatrists, 2023; Vanderkruik et al., 2017). The adverse risks and long-term consequences can be devastating, with high rates resulting in suicide and infanticide (Comtois, Schiff, & Grossman, 2008; Knops, 1993; Spinelli, 2004). Adverse outcomes associated with postpartum psychosis can include low birth weight, poor mother-infant interaction, impacted family and partner relationships, and child cognitive, emotional and behavioural development problems (Alhusen et al., 2013; Howard et al., 2014; Kingston et al., 2012; Myers & Jones, 2018; Prady et al., 2016; Stein et al., 2014).

According to the National Institute for Health and Care Excellence (NICE, 2018), referral to a secondary mental health service for assessment is always required for women presenting with symptoms or experience of postpartum psychosis. Subsequent inpatient care, ideally within a Mother and Baby Unit, and pharmacological intervention is nearly always recommended as standard care offered within the NHS for psychosis in the postpartum period, which has been established as best practice following the preceding attachment research (Bowlby, 1969; Cazas & Glangeaud-Freudenthal, 2004; Gillham & Wittkowski, 2015; Green et al., 2016; Jones & Smith, 2009; NICE, 2018). A systematic review evaluating the efficacy of Mother and Baby Units indicates greater benefits for co-admission of mother and baby where there is space for attachment formation, comparative to general hospitalisation resulting in separation (Connellan et al., 2017). Despite this, Mother and Baby Units are most situated in the UK, France and Australia, and there is a lack of comparative research in other Western and non-Western countries (Connellan et al., 2017). The historical dearth in qualitative research within medical literature appears to be shifting, but randomised controlled trials (RCTs) are required to secure funding and examine cost-effectiveness on a global scale. The lack of consensus in how established Mother and Baby Units are facilitated could likely impact the experience and initial stages of recovery for mothers with postpartum psychosis across varied cultures (Elkin et al., 2009).

Bergink et al. (2015) conveys how with appropriate intervention, including Mother and Baby Units, the most severe symptoms of postpartum psychosis can be resolved within 2-12 weeks. Whilst this can diminish immediate risk dramatically, there can still be devastating long-term impact on wellbeing, increased risk of further perinatal mental health problems, and resulting long-lasting feelings of shame, guilt, loss and fear (Burgerhout et al., 2017; Forde et al., 2019; Heron et al., 2012; Nager et al., 2013; Plunkett et al., 2016; Robertson et al., 2005; Wittkowski et al., 2014). Further psychological intervention and psychosocial support is recommended, yet lesser is known about women's personal experiences of recovery and what types of intervention may be most effective and are specifically applicable to postpartum psychosis (Doucet et al., 2011).

Studies indicate the process of recovery from postpartum psychosis for women has a temporal element, with initial seeking of safety and containment, followed by making sense of and responding to their experience, and finally, finding strategies that are helpful and planning for the future (Dolman et al., 2013; Forde et al., 2019; Heron et al., 2012; McGrath et al., 2013). This is considered parallel to women developing an understanding of their experience, which is plausible given the nature of separation from 'reality' and confusion many experience (Engqvist et al., 2011; Heron et al., 2012; Mcgrath et al., 2013; Robertson & Lyons, 2003). Frank (1993) proposed narratives of illness require self-change yet must be inclusive of realignment with a recognisable self, rather than adhering to a new identity. This fits with the notion of adjusting to and accepting the self and identity within the experience of postpartum psychosis, where beliefs about reality and motherhood are arguably an ever-evolving process and tailored to recovery stage. Much literature indicates that women utilising their experience for positive realignment within the self, such as learning more about their strengths and what they can accomplish, or by becoming agents of positive change for others and encompassing a sense of purpose, can be broadly helpful (Heron et al., 2012;

McGrath et al. 2013). Substantiating research indicates ‘posttraumatic growth’, whereby experiencing severe adversity in the context of psychosis, can lead to improved outcomes and wellbeing comparative to even before the illness (Beck, 2020; Tedeschi & Calhoun, 2004).

There is consensus that women view postpartum psychosis as a distinctly separate form of mental illness comparative to other postpartum mental health, which can manifest in feelings of numerous losses and endure long after the puerperal episode (Di Florio et al., 2013; Forde et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003). Time and relationships in the early months during hospitalisation, a sense of self and identity, and breakdown of relationships where there has been strain and tension, can be understood within the context of multiple losses (Engqvist & Nilsson, 2013; Forde et al., 2019; Wyatt et al., 2015). The strength of emotions such as guilt and shame many emphasise as multi-layered, in the context of becoming a mother, the stigma around severe mental illness within motherhood, and the trauma of hospitalisation on significant relationships and families (Dolman et al., 2013; Edwards & Timmons, 2005; Robertson & Lyons, 2003). Some mothers indicate that even after their acute experience of psychotic symptoms, any expression of emotion can feel pathologised by others, leading to a further sense of isolation (Robertson & Lyons, 2003). Traditional societal roles depicted for women around being ‘good mothers’ and nurturing homemakers, can understandably lead to a further sense of failure to fulfil these roles and emphasise feelings of guilt, loss and shame. This can feel specifically relevant where women are unable to meet such expectations, due to the severe and isolating nature of postpartum psychosis and subsequent hospitalisation (Lewis & Nicholson, 1998; Robertson & Lyons, 2003). Despite these earlier implications indicating societal standards around motherhood can greatly medicate intense and debilitating emotions such as shame, current intervention for postpartum psychosis remains relatively generic and vague, with little consideration of systemic factors within the predominantly offered medical treatment.

Robertson and Lyons' (2003) finding that women conceptualised the cause of their psychosis as 'biological' has been criticised; participants were previously involved in a genetics study and potentially indirectly biased due to their treatment being predominantly medical (McGrath et al., 2013). Thus, this criticism depicted by McGrath et al (2013), prompts speculation that little contextual and social factors have been historically considered within psychiatric intervention for postpartum psychosis. These findings support the need for existing standardised psychiatric care to incorporate formulation of individual presentations, which include social context.

A broad array of evidence supports the crucial benefits of social support from significant others, including partners and families within the recovery process for women (Engqvist & Nilsson, 2013; Forde et al., 2019; Forde et al., 2020; McGrath et al., 2013; Plunkett et al., 2016; Wyatt et al., 2015). Women also report strengthened relationships following experience of postpartum psychosis, aligning with the relevance of posttraumatic growth for this population (Wyatt et al., 2015). However, where women volunteer to participate and speak in front of partners within research interviews, benefits are presumed in the context of comfortable and trusting relationships. Critical family narratives, a lack of support and highly stressful pregnancies seem to be replicated within the extreme anxiety, negative self-appraisals and persecutory delusions women can report, indicating social factors can be also a hindrance in these cases (Glover et al., 2014). Women with considerably stronger social networks, including more proactive partners, or pre-existing links with mental health services, appear to experience better and faster access to support (Roxburgh et al., 2022). Despite this, women still report varied experience of care before reaching crisis point, indicating other social factors specific to postpartum psychosis are involved. It is likely there are a multitude of women that are not accessing help until they reach crisis point, with evidence suggesting healthcare professionals' knowledge of postpartum psychosis symptoms and necessary information provision to be poor (Dolman et al., 2013; Doucet et al., 2011; Heron et al., 2012).

The implication is that family can be a ‘double edged sword’, where secure relationships are required for managing the potentially debilitating and isolating emotions of guilt and shame (Forde et al., 2020; Glover et al., 2014; McGrath et al., 2013). However, even in secure relationships where partners are keen to share support, the interpretation of the experience can vary. The intensity of language women use to describe their experience of postpartum psychosis can differ tremendously comparative to partners, who can prescribe much more mild and vague accounts (Enqvist & Nilsson, 2013a). In contexts where partners may not fully, or want to, realise the risk of infanticide or suicide, this reiterates the need for consistent information provision and an inclusive approach with families and partners. Additionally, for heterosexual dyads, help seeking in men is typically low and should be considered within care provision (Doucet et al., 2005). This does not necessarily account for homosexual dyads, and assumes a gender normative approach that may not reflect many couples within the community. Regardless of gender, postnatal narratives within social networks are understandably important for elements of stability and consistency in the context of postpartum psychosis, where elements of confusion and paranoia are also present (Beck, 2020). However, the temporal element of relationships and of postpartum psychosis indicates women’s social systems are likely to be changeable and impacted by multiple factors, thus this must be considered within the broader system of care.

The power imbalance experienced within postpartum illness is considered paramount within postpartum psychosis, where there is a greater risk of losing a child or hospitalisation (Heron et al., 2012; McGrath et al., 2013). For many women, receiving the diagnosis of postpartum psychosis can enhance the process of understanding and acceptance, yet when this is not communicated in a compassionate context with positive agency around recovery, this can ultimately lead to disempowerment and hopelessness, due to the dire associated consequences for mother and baby (Robertson & Lyons, 2003). The pressure to be seen as coping, due to the removal of a child is raised often, as well as the minimisation of symptoms (Forde et al., 2020). The label of a psychotic illness in patriarchal society where women’s mental health is stigmatised, specifically in the context of motherhood, undoubtedly influences help-seeking behaviour (Bondi & Burman, 2001; Forde et al., 2019; Robertson & Lyons, 2003). Heron et al. (2012) highlights the need to screen for stigma within women’s social worlds, as fear of judgement leads to difficulties experienced within groups and further isolation. The systematic review conducted by Forde et al. (2020) indicates peer support to be essential, but social connectedness is mediated by lived experience, as fear of judgement can have an adverse effect and lead to a greater sense of isolation. Whilst these findings propose screening for stigma in women’s social worlds could help understand and challenge this narrative for some women, this approach arguably still regards the experience of postpartum psychosis as controllable and preventable within women, failing to account for social stigma as an inevitable systemic factor impacting mothers. An individualistic focus on the personal risks and symptomology within postpartum psychosis fails to account for external factors outside of the woman’s control, and the influence of wider social systems.

The political nature of the healthcare system and the external context of care has been found to mediate experience of recovery (Roxburgh et al., 2022). Inconsistent medical management, including presumptions the cause of postpartum psychosis is biological, can diminish a sense of control and agency for women. Poor maternity care, where mothers are not offered sufficient space to rest, can potentially worsen symptoms, for instance by contributing to sleep deprivation that often precipitates hallucinations (Engqvist & Nilsson, 2013). The need for consistent care is crucial, particularly in the context of postpartum psychosis where confusion and paranoia greatly impact women’s relation to ‘reality’

(Roxburgh et al., 2022). Information provision within maternal healthcare should be tailored to recovery stage, with consideration of the tensions between the risks associated with postpartum psychosis and motherhood facilitated at the start of pregnancy before any indication of symptoms (Heron et al., 2012). Discourses are powerful in influencing the conceptualisation and response to postpartum psychosis, and this needs to be addressed across women's social worlds and in antenatal contexts (Beck, 2002). Contradictory narratives around what is in women's control and is preventable needs to be highlighted by healthcare providers, with consideration of partners' and families' level of conceptualisation and need.

A systematic review and meta-synthesis of women's and families' experiences of recovery from postpartum psychosis highlighted that a more individualised and integrative approach to psychological interventions, that are ideally longer-term and consider the needs of the family and significant others, are required to improve clinical outcomes (Forde et al., 2020). This suggests a need to build on the evidence conveying short-term cognitive and behavioural interventions to be helpful (NICE, 2014). Whilst these recommendations are generically useful, they are not necessarily transferable across social and cultural context, due to a focus on White middle class women with higher education levels and access to resources in the literature. Maintaining an individualistic focus within interventions fails to acknowledge the political hierarchies surrounding healthcare systems, and the complex multifaceted social controversies associated with diagnosis and motherhood. Perhaps highlighting difficulties faced by more socially privileged women only further insinuates how disadvantaged groups of lower socioeconomic status can experience greater difficulties accessing support. However, there is extremely limited research exploring the experiences of women with postpartum psychosis from differing cultural, social and racial backgrounds, and how healthcare may need to be adapted to meet diverse needs. Evaluating short-term behavioural outcomes with those holding the privilege of access to healthcare and participating in research, potentially only further marginalises the experiences of politically, socially or racially minoritised communities that are at greater risk of developing postpartum psychosis and worse associated outcomes.

1.2 The Role of Race and Maternal Mental Health

Regardless of the increase in available care in the UK, minoritised ethnic groups are greatly underrepresented within perinatal mental health services, yet theoretically are at higher risk of developing perinatal mental health illnesses (Anderson et al., 2017; Anderson et al., 2019; Edge, 2011; Prady et al., 2013; Prady et al., 2016; Womersley et al., 2021). Ethnic minority groups experience an on-going higher burden of mental health issues comparative to the majority white population, yet mental health issues are less likely to be detected or treated within ethnic minority groups, including during the perinatal period (Prady et al., 2016).

Health disparities among mothers and families from a minority ethnic background represent a salient national concern. It is important to acknowledge that ‘ethnic minority groups’ refers to a diverse number of groups, including individuals with varying levels of support and emotional needs, arguably mediated by cultural or racial background. The on-going impact of interpersonal and institutional discrimination in relation to how race is experienced across different racial groups should not be ignored. The literature that indicates how racism influences women’s experiences of perinatal mental health suggests even the narrative of ‘ethnic minority group’ promotes an ‘othering’, and unhelpfully labels all non-white groups under one broad category of ‘ethnic minority’ (Prather et al., 2018; Wallace et al., 2017). This is despite consensus that women’s experiences are significantly different, depending on several factors that may be facilitated by the meaning of ‘culture’, such as:

religious or spiritual beliefs; nationality; location; context; values; social norms; race or racism (Wallace et al., 2017). This provides a rationale for investigating the experiences of women from distinctive cultural groups separately and giving meaning to individuals that have experienced disadvantage specifically related to their own cultural or racial background (Anderson et al., 2017; Anderson et al., 2019; Edge, 2011; Prady et al., 2013; Prady et al., 2016; Womersley et al., 2021).

On a global scale, Black infants have specifically worse birth outcomes than other ethnic groups, including the significant disparity in the infant mortality rate (Centres for Disease and Control and Prevention (CDC), 2020; Peoples & Danawi, 2015; Robbins et al., 2018). The historical oppression of Black communities in Western society and unequal access to opportunity, healthcare and education strongly indicates social context to be a prominent factor in health inequalities (Ajzen, 1991; American Academy of Paediatrics, 2014; Broussard et al., 2012). Culturally incompetent healthcare has been reported to be a severe structural barrier to people from Black communities accessing support (Bolton et al., 2003). The relationship between race, socioeconomic status and healthcare indicates many factors may play a role in these issues, such as social isolation, transportation difficulties, structural racism, lack of social support and inequities within healthcare access and provision (Bolton et al., 2003; Prather et al., 2018; The Joanna Briggs Institute, 2016; Wallace et al., 2017).

Qualitative studies that explore Black women's experiences of perinatal mental health and perinatal services have begun to provide a voice for many of these mothers. Studies globally have found language and cultural barriers within accessing support, including cultural expectations and stigma associated with mental health (Quinn et al., 2009; Watson & Soltani, 2019). Some women have described how negative experiences of using other health services, for instance for physical health problems, to ultimately hinder their decision to access perinatal mental health support (Edge, 2011). Others have described experiencing prejudice and racial discrimination within perinatal care, in conjunction with a reported lack of trust towards professionals (Wallace et al., 2017).

The literature indicates a need to provide more culturally appropriate education and understanding of perinatal mental health across communities. Particularly in non-Western cultures, the value of family and community support is found to be much higher than in Western cultures, and the need to involve partners and families has been named by both partners in the dyad (Declercq et al., 2021; Edge, 2011; Watson & Soltani, 2019). Emerging evidence that provides insight into partners' experiences of having a partner with perinatal mental health issues, suggests many partners may lack specific understanding, support for themselves and the knowledge of how to support their partner (Coleman, 2009). Many mothers that identify from Black ethnic backgrounds, highlight a community narrative that dictates women as 'strong' and 'getting on with it' and mental health issues are just not talked about (Edge, 2011). This indicates another potential complex barrier in relation to help-seeking for Black women that experience poor perinatal mental health.

1.3 Race, Cultural Difference and Postpartum Psychosis

The sparse literature exploring cultural, religious and racial factors within postpartum psychosis echoes the gap in current care provision for impacted marginalised mothers and families. It is likely that the inclusion of partners or significant others, including family members, and even communities, in postpartum psychosis care for Black women, could help reduce the burden of severe mental illness, improve the quality of mother-infant relationship, and reduce feelings of loss, guilt and shame, which can lead to further feelings of isolation and hopelessness (Baiden & Evans, 2021; Declercq et al., 2021; Di Florio et al., 2013; Edge, 2011; Engqvist & Nilsson, 2013; Forde et al., 2019; Forde et al., 2020; Heron et al., 2012;

McGrath et al., 2013; Plunkett et al., 2016; Robertson & Lyons, 2003; Watson & Soltani, 2019; Wyatt et al., 2015). Addressing these issues within current provision of healthcare could improve clinical outcomes and the mother-infant relationship, and reduce the tragic possibility of suicide or infanticide.

An understanding of Black mothers' experience of recovery from postpartum psychosis could indicate how and why race and culture may have impacted their experience of recovery, and how this needs to be addressed within healthcare systems. Challenging racial and cultural barriers and even discrimination within healthcare provision, could potentially improve accessibility and reduce the devastating long-term impact of postpartum psychosis. A focus on Black women's experiences specifically could provide insight into how and why a specific racialised group that often experiences the poorest mental health outcomes is not currently being managed effectively.

1.4 Critical Race Theory and Postpartum Psychosis

The Critical Race Theory (CRT) is both a collective action and academic movement committed to changing the relationship between race, racism and power (Delgado & Stefancic, 2023). CRT incorporates many of the issues within civil rights movements (CRMs), within the context of economics, law, historical thought, self-interest, and emotions. The movement is composed of variably developed bodies of Asian, Latino, LGBTQ+, Black ethnicities and Muslim religions, all with sets of literature and priorities. CRT originated in the 1970s, and proposes several principles (Delgado & Stefancic, 2023). Firstly, 'racism' is depicted as 'ordinary' in that it is difficult to eradicate because it is normalised and part of implicit racism maintained within societal structures; for instance, within employment biases, housing, or immigration laws. Secondly, 'interest convergence', meaning racism is in the best interests of dominant white group and consequentially the majority of society do not have the motivation or power to challenge this. For instance, the CRM has been criticised by CRT for being implemented within the interests of elite white people rather than for the desire to benefit Black people. Thirdly, the notion that ‘race’ is a ‘social construction’, culturally invented by dominant society to manipulate people when convenient, with there being no evidence that race corresponds to the biological realities of traits such as personality, intelligence, or moral behaviour. The complex use of the term ‘race’ started with colonialism and towards the 19th Century it became the interweaving of biology, culture and language, whereby claims that colonised groups were racially inferior sustained political hierarchies in society (Go, 2004). ‘Racism’ has been depicted as a product of colonialism, ‘essential to the social construction of an otherwise illegitimate and privileged access to property and power’ (Stoler, 1992, p. 322). Fourthly, the proposal of ‘racialisation’ of different minorities at different times historically, and in everyday situations, in response to shifting needs and social contexts, contributing to stereotypes for the benefit of the dominant white society. Rattansi (2005) indicates ‘racialisation’ provides conceptual and political advantage comparative to ‘racism’, whereby ‘racialisation’ can encompass statements which explicitly vilify the inferiority of racialised groups, and implicitly and dynamically encapsulates institutional assumptions upon the intersections of race with class, gender, sexuality and nation (Rattansi, 2005). The fifth CRT principle is the ‘intersectionality’ framework, which infers that multiple identities in relation to race, class, gender, socioeconomic status and sexuality are used to understand the many ways individuals are oppressed. ‘Intersectionality’ was proposed by Kimberle Crenshaw (1989), who argued that the intersectional experience is greater than the sum of ‘racism’ and ‘sexism’, and that any account which predicates on the discrete experiences of ‘race’ and ‘gender’, fails to understand the specific way in which Black women are marginalised. Finally, the legal ‘storytelling’ movement depicts that individuals from racialised communities are in a better position to communicate their unique accounts and experiences comparative to the white master narratives in law.

Whilst studies indicate cultural beliefs implicate women's conceptualisation of their experience of illness, CRT could be applied to understanding and challenging the inequalities marginalised women experience within healthcare. This is particularly relevant for the complex, dynamic and extended nature of the recovery from postpartum psychosis, where the impact of wider societal structures and cultural norms likely play a role in how diagnosis, women's social realities and motherhood are experienced (Beck, 2020; Bondi & Burman, 2001;Dolman et al., 2013; Edwards & Timmons, 2005; Engqvist & Nilsson, 2013; Forde et al., 2019; Forde et al., 2020;Heron et al., 2012; Lewis & Nicholson, 1998; McGrath et al., 2013; Plunkett et al., 2016; Robertson & Lyons, 2003; Roxburgh et al., 2022; Wyatt et al., 2015). It is plausible to consider how implicit racism manifests within healthcare providers and services, and how this could be maintained by unspoken rules about motherhood and the dominant medical system favouring white people. For instance, this is highlighted by Posmontier and Fisher (2013), where assumptions are made about women from non-Western cultures, and behaviours interpreted as 'interpersonal difficulties', whilst this practice is considered 'ordinary'. If implicit biases are maintained in healthcare provision, it is difficult to see how care can be applicable and relevant for Black mothers. The evidence base for the care offered to women is created by predominantly white male professionals, with the research focusing on the experiences of white women that could be perceived as typically socially and economically privileged. The pathway to help and care for Black women is adverse and difficult, with current interventions offering little applicability to varied cultural populations, particularly with the standardised individualistic focus in recovery.

It is evident that Black women with less power are offered less opportunity to provide accounts of what might be helpful despite enduring lived experience; aligning with CRT that proposes those directly marginalised can provide the most unique and relevant accounts to enable awareness and understanding. Community focused interventions are identified as helpful for Black women within maternal mental health (Declercq et al., 2021; Edge, 2011; Watson & Soltani, 2019); yet little of this is evidenced as being incorporated into psychological intervention for postpartum psychosis currently. This raises questions around why this is, and for whose benefit the facilitation of existing research is for.

According to CRT, the current research and available interventions are for the benefit of the dominant white medical system which focuses on diagnostic criteria and supports the unethical process of funding from pharmacological companies, particularly in the US (Delgado & Stefancic, 2023; Sismondo, 2021). Additionally, CRT would propose these processes and the nature of the hierarchal healthcare system perpetuate Black women's experience of inequality in the recovery from postpartum psychosis, maintaining dominant white power.

Co-production theory, initially developed by Vincent and Elinor Ostrom (1977), employs the perspective individuals with lived experience must participate in the story telling of their trauma, difficulties and views on change within service culture and design; this aligns with CRT narratives proposing racially oppressed individuals are in the most relevant position to tell their stories (Delgado & Stefancic, 2023). However, there is much speculation that current co-production is of inadequate quality and scarcely carried out, with some authors highlighting how co-production can essentially be a rhetorical device to hide power and social inequities (Flinders et al., 2016; Thomas-Hughes, 2018). Consequentially, the outcomes of various equality and diversity initiatives tend to be largely artificial at best. There is some evidence supporting the interpretation of postpartum psychosis symptomology within mothers' unique cultural contexts and identities (Posmontier & Fisher, 2012; Schoenberger et al., 2022), indicating a shift in applying rigid culturally biased medical thinking to postpartum psychosis. However, postpartum mothers' views are rarely considered within developing colloquy and formulation of mothers' difficulties, with case studies focusing on women's experiences of postpartum psychosis from healthcare providers' positions. Whilst co-production theory is one avenue to be considered to enhance current research, there are still many flaws in how this is actually incorporated within current service culture to benefit Black mothers. Thus, it is paramount that Black mothers with lived experience of postpartum psychosis are prioritised and privileged in providing their own accounts, including the experiences of 'psychosis' in the postpartum period, and of racial marginalisation.

It is important to note, that for the purpose of distinction and practical ease, the terms 'women' and 'mothers' are used throughout this document. However, these terms will also include 'birthing people' in a comprehensive sense, whilst recognising that 'birthing people' can encompass individuals which may or may not identify within a specific construct of gender.

2. Systematic Literature Review

2.1 Aims and Rationale of the Synthesis

The aim of the synthesis in this current study is to conduct a meta-ethnography of the literature exploring Black mothers' experiences of postpartum psychosis, and the role of race and racialised discrimination within their recovery, addressing the current gap for a synthesis of this topic. The hope is that this synthesis will raise analysis to a more nuanced and meaningful conceptual level, with women's experiences at the centre. The more immediate and pragmatic objective is to consider the findings in relation to the current study's subsequent data and themes, implications for service policy and design, and for future research exploring the relation between Black identity and postpartum psychosis.

Meta-ethnography was selected as the synthesis for this research due to the aim of developing a conceptual, opposed to combined comprehension of the relevant studies. Interpretive methodology, opposed to aggregative logic, is more appropriate for this study in order to better understand how structural and pervasive racism could influence Black mothers' experiences of postpartum psychosis and healthcare systems. Meta-ethnography allows the opportunity for cultural critique, enabling examination of the broader social, political, historical and racial differences that influence Black mothers' situations and thus shape their experiences of postpartum psychosis (Mahoney et al., 2013).

2.2 Method

2.2.1 Design

Noblit and Hare (1988) established meta-ethnography with the purpose of synthesising qualitative research, to explore and understand individuals' experiences of illness, recovery and healthcare. Meta-ethnography focuses on similarities and differences across studies and organises them to provide an inclusive overall representation with explanatory power. Study data are interpreted into key concepts or themes and translated across studies to produce a synthesis. Within the synthesis, studies may be directly comparable as reciprocal translations, or may conflict as refutational translations, ultimately producing a line of argument synthesis. Noblit and Hare (1988) proposed seven phases of meta-ethnography: getting started; deciding what's relevant; reading the studies and assessing quality; determining how studies are related; translating the studies; synthesising translations; expressing the synthesis.

2.2.2. Article Selection

All peer-reviewed articles that were published and employed qualitative methodology to explore Black mothers' lived experiences of postpartum psychosis were included. This was to ensure studies which captured the personal and social experiences of the mother in relation to postpartum psychosis directly were included. Articles which mutually included the experience of a family member, partner or significant other were also included, but excluded if they did not include the mother's lived experience. There were only two studies which focused on Black mothers' lived experience of specifically postpartum psychosis, and a further two which included postpartum psychosis within a broader sample comprising of a range of postpartum mental illness. Therefore, studies which focused on Black mothers' lived experience of postpartum mental illness and focused on racialised experiences within their recovery or healthcare, were additionally included to expand the number of studies included in the synthesis. As the objective of this study was to explore the impact of cultural discrimination, marginalisation and racism on Black mothers' experiences, the similarities and differences of such experiences in relation to postpartum psychosis were attended to.

Studies which comprehensively included minoritised ethnic women’s experiences, including those of Black women’s, were still included due to the dearth in literature focusing on specifically Black mothers’ experiences.

Studies which focused on Western samples of white women were not included. Studies which were deemed not relevant were excluded; for instance, studies that focused on infant loss, or the specific impact of Covid-19, or physical postpartum needs, or lived experience of mental health generically, opposed to perinatal mental health. Studies which did not state or consider the impact of race, racism or cultural discrimination within the dynamic experience within healthcare and recovery for postpartum mothers, or where ethnicity was not depicted within the sample, were all excluded.

Studies which focused on the experiences or perspectives of healthcare providers or researchers were excluded due to the aim of this study in exploring the mother’s lived experience, where it was considered healthcare providers’ perceptions would provide external and potentially biased perceptions, justifying a separate study. Similarly, studies comprising of samples of women under age 18 were excluded, as this justifiably argued a separate study due to alternative social challenges applicable to this group. Quantitative studies were excluded due to the aim of the study in exploring mothers’ personal narratives, accounts and experiences, opposed to objective or standardised outcomes. Studies that were not written in English, non-published, or systematic reviews, were excluded as they were not peer-reviewed.

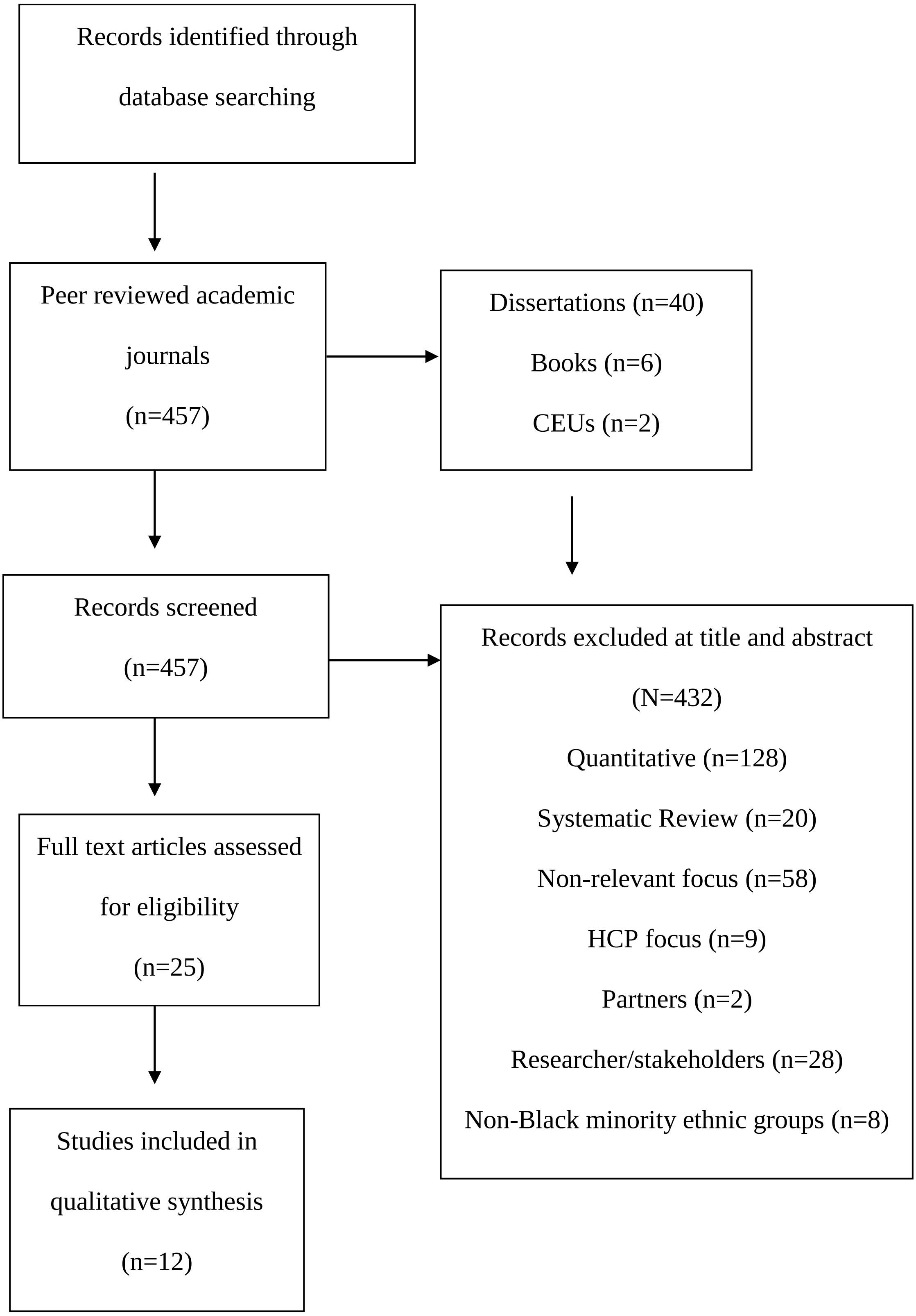
EBSCOhost was used to undertake a literature search of CINAHL Ultimate, APA PsychArticles, APA PsychInfo and MEDLINE Ultimate in January 2021, and again in December 2023 (to uncover the most recent and up-to-date literature) using the following search terms:

1) maternal mental health or postnatal mental health or perinatal mental health or postpartum mental health or postpartum psychosis or postnatal psychosis or puerperal psychosis or post-natal psychosis or postpartum women with psychosis
2) ethnic* groups or race or racial* or people of colo* or underserv* or marginali* or minoriti* or africa* or caribbean*
3) experienc* or view* or perspect* or percept*

Additional citation and hand searching of reference lists of key papers was also carried out. For full details of the search, see Figure 1.

Figure 1

Flow chart detailing the search and selection of papers



The rationale for utilising quality appraisal application for meta-ethnographies has been strongly questioned, with the view that excluding studies for synthesis based on methodology can be limiting (Atkins et al., 2008; Fosse et al., 2014). This review implemented the (CASP) tool (CASP, 2018) and considered the outcomes within the analysis, but included all articles in the synthesis regardless of quality. The decision was made to prioritise exploring studies' contribution to the synthesis, opposed to excluding the current small number of studies based on methodological inadequacies.

Most studies incorporated appropriate purposive sampling methodology and thematic analysis. All studies included demographic data, as well as the aims, objectives and conclusions and implications for further research. A minority of studies did not explicitly indicate women's specific perinatal mental health difficulty or diagnosis, but rather encompassed this more broadly in referring to postpartum mental health difficulty in a generic fashion. The CASP tool highlighted a bias in studies primarily focusing on women who were under perinatal mental health service care, although some studies did include women that had not accessed treatment. The CASP tool additionally revealed several studies did not consider the relationship between researchers, facilitators or participants. It is possible, particularly for studies based in Western settings, that cultural difference impacted minoritised ethnic women's accounts in the data. Three studies were located in African settings, meaning women's experiences varied considerably from women which experienced racial and cultural minoritisation within Western study settings. The participant sample sizes ranged from 1 to 51. The studies were mainly based across the UK, US and Canada. Table 1 illustrates the main criteria for all papers included in the review, and provides a summary of relevant and available descriptive and contextual information for each study.

Table 1

Main Criteria of Included Studies

Study	Setting	Aim	Method	Findings	Clinical Implications
Adeponle et al. (2017)	Primary Care Centres, Traditional and Faith Healing Centres. Oyo State, Nigeria.	To explore the perspectives and lived experiences of PND* for Nigerian women in African contexts.	Purposive sampling. Interviews (14). Women with PND (14). Age (mean) =28. Mixed education.	Perspectives of PMH** influenced by sociomoral concerns of gender roles and women's household position. Internalisation of patriarchal cultural norms of femininity, gender and motherhood influence feelings of shame and guilt in Nigerian mothers with PND.	Clinical assessment and intervention within PMH require consideration of local social context
Alio et al. (2022)	Community Collaborative.	To explore the perspectives and	Snowball sampling. Listening Sessions.	Maternal mental health experiences	Improved maternal health literacy and

	Rochester, New York, US.	experiences of Black mothers <5 years postnatal to understand factors which increase Black mothers’ health disparities	Black mothers (44). Age (mean) =30. Mixed education. Average of 2 children.	influenced by social and systemic factors and mother-provider communication, where provider racialised discriminatory attitudes primarily mediate healthcare experience	provider communication training required, with consideration of implicit racial bias and cross-cultural communication skills
Baiden & Evans (2021)	Community. Southern Ontario, Canada.	To examine sociocultural factors affecting the perception of mental health and the use of mental health services among Black African newcomer mothers living in Ontario	Purposive sampling. Semi-structured interviews (10). Black African newcomer (2-5 years residing in Canada) women <1 year postnatal. None accessed previous PMH services. Age (range) = 25-40 years. Majority	SBW*** schema can be mistaken for resilience in attempts for Black mothers to conceal PMH struggles due to racialised stigmas/discrimination and immigration status. Culturally sensitive treatment,	Increased empathy from HCP**** in maternal health promotion and treatment is required. More resources on culturally sensitive treatment is needed.

			postsecondary education.	incorporating spirituality and non-medical approaches indicated as helpful.	
Conneely et al. (2023)	Various Community PMH NHS services, UK.	To understand how Black and Asian women experience access to, and care received from PMH services	Purposive sampling from PMH NHS services. N=37. 51% = Black; 49% = Asian. Framework analysis.	Highly varied experiences on: self-identity, social expectations, differing attributions of distress, which defer help-seeking; hidden services impede access; role of curiosity, compassion and flexibility in validating mothers' experiences; shared cultural background may hinder or improve trust and rapport.	High quality of care which is inclusive of diverse experience and understandings of PMH problems, and greater transparency of PMH and available support, is helpful.

Edge (2011)	Community/NHS services. North-West England.	To examine perspectives on what might account for low levels of consultation for PND among Black Caribbean women.	Purposive sampling. Black Caribbean mothers (n=42) and HCP (n=42). Majority of Black mothers with children <2 years. Age (range) = 18-43 years. Focus groups (N=5). Framework analysis.	Practitioners' lack of compassion and lack of trustful relationships were perceived as barriers to access for PND specifically, and health needs generally. Mono-ethnic and culturally sensitive community models within treatment would be helpful.	New care pathways to address spectrum of PMH need required. More collaborative community-based models of care required.
Hoang et al. (2023)	Perinatal Connect, Illinois, US.	To describe the experiences of perinatal Black, Indigenous and People of Colour women in healthcare interactions	8 focus groups. N=41. Age (range) = 19-45 years. 49% = Black; 24% = Latina; 20%=Asian). Antenatal/<1 year postnatal. Mixed	Anti-Black bias, dismissal of Black pain, withholding of care, consistent lack of bodily autonomy, and deferral to White HCP for decision	More transparent and empathic communication required, with specific need to address Anti-Black bias and systemic

			diagnoses (none PP*****) Reflexive thematic analysis.	making, led to racial trauma.	racial disparities in healthcare.
Ling et al. (2022).	Community, UK.	To explore the lived experiences of first-generation Nigerian mothers who suffered PND, their coping behaviours and treatment experiences	Purposive and snowballing sampling. N=6. Recruited from organisations/social groups (n=5) and GP surgeries (n=1). Majority married. Majority healthcare professionals. Interpretive phenomenological analysis.	Sociocultural factors: inter-generational transmission, cultural perceptions, shame and stigma, adjusting to new culture; neglected nurturer experience of treatment, pretending to be SBW; loneliness where lack of partner support	Self-reliance becomes a coping strategy in the context of neglect from family and healthcare. Attempts to help-seek were dismissed by HCP. Implication is to improve patient-centred and culturally sensitive healthcare approach in earlier stages of perinatal period.
Nakku et al. (2016).	Community. Kamulu, Eastern Uganda.	To explore the barriers and facilitators, as	Focus groups. N=6. Pregnant women	Unmet need within PMH care. Negative	Need to improve maternal mental

		well as perceptions about accessibility, of PMH care in primary care settings in low income rural district of Uganda.	group (n=24), postpartum group (n=24), village health teams (n=20), key informants (HCP; n=8). Majority Christian. Structured, open-ended. Thematic analysis.	attitudes experienced from HCP and lack of knowledge. Poverty and poor access to transport hinders access. Poor partner support and stigma hinders access.	health service planning, and to develop more integrated services for low income rural settings.
Nakigudde et al. (2013).	Hospital. Butabika, Uganda.	To explore how family psychoeducation can be made culturally sensitive for postpartum mothers with a psychotic illness (PP) in a Ugandan setting.	Purposive sampling. Postpartum women <6months (n=6) and their caregivers (n=6), psychiatric nurses (n=5), Clinical Psychologists (?). Mixed methods. Evaluation of an adapted family psychoeducation intervention.	Effective communication, cultural background, appropriate dress, literacy and practical flexibility important process factors to consider for facilitators. Considering lay perceptions of mental illness, family	Facilitation of family psychoeducation intervention for Ugandan mothers with PP and their caregivers, must consider the social, cultural and gender realities of the attendees/population.

				planning, income and personalities (premorbid and morbid) of patients, is important for content factors.	
Pilav et al. (2022).	Community PMH NHS Service, UK.	To explore ethnic minority women's experiences of access to and engagement with PMH care.	Purposive sampling. N=18. Antenatal or <1 year postnatal and receiving PMH NHS care. Black (n=8); Other (n=10). Age (mean) = 33.4. Schizophrenia type (n=2); Bipolar Affective disorder (n=2); PND (n=6); PTSD/EUPD (n=5); Anxiety (n=3). Thematic analysis.	Expectations and experiences of womanhood as an ethnic minority: shame and guilt in motherhood, women as caregivers, SBW schema leads to dismissal; family and community influences: blind faith in medical profession, family and community beliefs about PMH, intergenerational	Barriers for ethnic minority women are individual, familial, community and societal levels. PMH services are required to be more aware of cultural difference in presentation and need.

				trauma and dynamics; cultural understanding, empowerment and validation: importance of understanding cultural differences, power of validation and support.	
Sheikh and Singsit-Evans (2020).	Hospital, UK.		Case study. Black African migrant woman. Age = 29 years. First episode of psychosis in the postpartum period.	Lack of adequate contact with nurse/midwife following birth, immigration status, unstable social context, previous trauma of sexual abuse and racialised discrimination impacted mother's experience of illness.	Over-medicalisation, social isolation, and racial discrimination must be considered for at-risk women in this population, or poorer outcomes/longer treatment delays likely and greater, prolonged marginalisation.

Watson and Soltani (2019)	Maternity and parenting online groups. UK.	To investigate minority ethnic women's experiences and opinions of PMH problems and the provision of support services.	Convenience sampling. Survey (N=51). Mixed methods. Pakistani (n=21/6%); Indian (n=19.6%); other (inc. Black: n=60.8%). Mixed ages. Thematic analysis.	Women from minority ethnic groups face barriers to seeking PMH support as a result of stigma, poor attitudes of HCP, and inappropriately designed services.	Future interventions should focus on providing adequate cultural competency for HCP and ensure all women can access culturally appropriate spaces to be listened to in community settings and services.

*PND: Postnatal Depression; **PMH: Perinatal Mental Health; ***SBW: Strong Black Woman; ****HCP: Health Care Providers; *****PP: Postpartum Psychosis

2.2.3 Determining how the Studies are Related

The 12 studies were examined to identify key and recurring concepts. This process involved familiarisation with each study, and interpretation of the findings and implications. Studies were directly compared, and similarities and differences were identified, leading to the development of substantial themes and concepts.

2.2.4 Translating the Studies into one Another

The themes and concepts identified in the original studies were checked to ensure these were encompassed in the relevant key concept in the translation. The researcher completed tables for each respective study, including demographic and contextual information, key concepts and second-order interpretation, to ensure the concepts identified across all studies were incorporated into one of the key concepts produced in the meta-synthesis. Key concepts for all studies are illustrated in a comparison table in Table 2 in the results. The left column shows all eight lower level concepts included in the synthesis, with each study across the top row. The table conveys how many concepts are identified across each study.

Appendix A shows a sample study demonstrating the key study details and methods and the key concepts identified. The first four rows illustrate the key contextual study details for the synthesis, such as the purpose, setting, sample and data collection method. The subsequent rows illustrate the key concepts identified and the final row depicts the central explanation arising from each study, or second-order construct (Britten et al., 2002).

2.2.5 Synthesising the Translations

Common themes were identified throughout the interpretations and concepts produced within the 12 studies. The researcher interpreted the relationships between the studies to be generally reciprocal, with minor refutational relationships. The key concepts distinguished were synthesised into three interpretive categories: patriarchy of Black motherhood; multi-layered systemic racism; social support and negotiating identity norms and inequalities. The lower level concepts included: patriarchal norms of Black motherhood; intra-community and external stigma; racialised treatment; racism; healthcare system neglect; power of partners; cultural identity; posttraumatic growth.

2.3 Results

Table 2

Cross comparison of studies by concept

	Adeponle et al (2017)	**Alio et al (2022)**	**Baiden & Evans (2021)**	**Conneely et al (2023)**	**Edge (2011)**	**Hoang et al (2023)**	**Ling et al (2023)**	**Nakku et al (2016)**	**Nakigudde et al (2013)**	**Pilav et al (2022)**	**Sheikh & Singsit-Evans (2020)**	**Watson & Soltani (2019)**
Patriarchal norms of Black motherhood	✓		✓	✓			✓	✓		✓		✓
Intra-community and external stigma	✓		✓	✓	✓		✓	✓	✓	✓		✓
Racialised treatment		✓	✓	✓	✓	✓	✓			✓	✓	✓
Racism		✓	✓			✓					✓	
Healthcare system neglect		✓	✓		✓	✓	✓			✓		✓
Power of partners	✓	✓					✓	✓	✓		✓	
Cultural identity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Posttraumatic growth		✓			✓				✓	✓		

2.3.1 Patriarchy of Black Motherhood

2.3.1.1 Patriarchal norms of Black Motherhood. Patriarchal norms of Black motherhood manifested within the findings of most studies (Adeponle et al., 2017; Baiden & Evans, 2021; Conneely et al., 2023; Ling et al., 2023; Nakku et al., 2016; Pilav et al., 2022). This broadly incorporated the 'Strong Black woman' narrative that many felt was endorsed across women's social and medical systems and internalised by mothers and their communities (Baiden & Evans, 2021; Conneely et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). Women described intergenerational norms in relation to being Black, and a mother, in maintaining self-sufficiency and resilience, meaning reaching out for help, and notably professional support, felt stigmatised and shameful (Adeponle et al., 2017; Baiden & Evans, 2021; Coneely et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Solanti, 2019). This additionally led to women experiencing difficulty accepting postpartum mental health difficulty, significantly delaying treatment access (Conneely et al., 2023). This led many women to suffer in silence as a result, leading to greater isolation and the prolonging of difficulties (Baiden & Evans, 2021; Conneely et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). Many women reported experiencing guilt and shame around not coping, which was felt to be expected from them within their communities (Adeponle et al., 2017; Pilav et al., 2022).

In the studies based in African settings, patriarchal norms were elicited differently, centring on social and gender roles and women's position in the household (Adeponle et al., 2017; Nakku et al., 2016). Women described an internal conflict between adhering to patriarchal norms of femininity (i.e., submission) and motherhood (i.e., primary nurturers) and needing to ascertain power in polyamorous households, where many voiced experiencing tension from 'rival wives' and felt they had to assert some form of aggression for fear of exclusion (Adeponle et al., 2017). Even in Western samples, traditional nurturer roles for

Black mothers were understood as fixed and indisputable (Pilav et al., 2022). Several studies, including Western and African samples, indicated cultural norms around ‘psychosis’ to be understood as a ‘spiritual attack’ or ‘witchcraft’ (Adeponle et al., 2017; Nakku et al., 2016). Some women felt their families and communities attributed the development of postpartum psychosis to be due to non-adherence with the required post-birth rest period which was culturally endorsed; yet this felt impossible when they also had to fulfil the household and motherhood duties prescribed within the primary nurturer role (Adeponle et al., 2017).

2.2.1.2 Intra-Community and External Stigma. Stigma was widely ascribed to mental illness, diagnosis and accessing psychiatric help by Black mothers across studies (Adeponle et al., 2017; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Ling et al., 2023; Nakku et al., 2016; Nakigudde et al., 2013; Pilav et al., 2022; Watson & Soltani, 2019). Fear of judgement and family expectations around motherhood led to delayed help-seeking for many women (Conneely et al., 2023; Pilav et al., 2022). One study identified the importance of facilitating mono-ethnic peer support groups for mothers, where women voiced feeling this could reduce the stigma associated with mental health within Black communities specifically (Edge, 2011). Several women spoke about accessing psychiatric help to be seen as ‘taboo’, or ‘weak’, where it was felt being strong and resilient were endorsed within their Black cultural communities as well as the white dominant systems they belonged to (Ling et al., 2023). The possibility of being shamed within women’s communities was found to inhibit help-seeking and increase the risk of postpartum difficulty, particularly in African settings (Adeponle et al., 2017). Cultural beliefs around postpartum mental health, and specifically ‘psychosis’, were experienced as highly negative and significant barriers to help-seeking (Nakku et al., 2016). However, this was mediated by effectively communicated education provision within community intervention for postpartum psychosis in one African-based study (Nakigudde et al., 2013).

2.2.2 Multi-Layered and Systemic Racism

2.2.2.1 Racialised Treatment. Multiple women spoke about experiencing racialised treatment across nearly all studies (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Pilav et al., 2022; Sheikh & Singsit-Evans, 2020). Many voiced this manifested within clinicians' assumptions about their mental and physical states due to race; for instance, where concealment of their difficulties was assumed to be resilience due to being Black (Baiden & Evans, 2021). Thus, the implication is that the 'strong Black woman' narrative is maintained by racialised approaches within healthcare. Others reported over-medicalisation, and little offer of alternative intervention, which was identified for mothers expressing a range of postpartum mental health problems (Ling et al., 2023; Sheikh & Singsit-Evans, 2020). Furthermore, women broadly emphasised a fear of medication and preference for alternative treatment approaches, yet these needs were not met (Ling et al., 2023; Pilav et al., 2022). Experience of over-medicalisation seemed exemplified in a case study of a Black mother with a diagnosis of 'psychosis', who experienced becoming institutionalised in the context of a lack of wider social support and socioeconomic disadvantage, being of migrant status, and where previous racialised experience with Western healthcare deterred her in approaching services (Sheikh & Singsit-Evans, 2020). Interestingly, this mother only eventually accessed help once at crisis point, through arrest and the criminal justice system, which echoes the high rates of Black men admitted to psychiatric wards with a diagnosis of schizophrenia, typically through adverse pathways such as the criminal justice system (Sheikh & Singsit-Evans, 2020; Morgan et al., 2005). Multiple women reported mistrust of services due to previous racialised healthcare experiences, ultimately inhibiting their likelihood to seek and access help (Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Pilav et al., 2022; Sheikh & Singsit-Evans, 2020). Many voiced how, they felt they were treated significantly differently due to being Black, leading women to feel unsupported by services (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Hoang et al., 2023; Pilav et al., 2022).

2.2.2.2 Racism. Several studies described overt and covert experiences of racism within the healthcare women received (Alio et al., 2022; Baiden & Evans, 2021; Hoang et al., 2023; Sheikh & Singsit-Evans, 2020). Some women reported experiencing implicit racial bias, through being dismissed by healthcare providers due to their race, which was in addition to dismissal due to their insurance and immigrant status and religion, which led to increased isolation and exuberated symptoms (Alio et al., 2022). Others reported explicit racist experiences, where healthcare providers assumed ‘Black bodies don’t feel pain’, reflecting racialised stereotypes aligning with Black women being overly strong and resilient compared to their white counterparts (Hoang et al., 2023). It was found that racism was experienced as an additional layer of discrimination to the gender bias reported in healthcare (Alio et al., 2022). Women felt that race-based stressful interactions took an emotional toll in the context of already experiencing constant racism in their every-day lives (Hoang et al., 2023). Furthermore, studies illustrated being Black meant mothers faced greater marginalisation explicitly due to their ethnicity, regardless of higher socioeconomic status and education levels (Alio et al., 2022; Hoang et al., 2023). Racism, or in other words, ‘Anti-Black Bias’, was reported highest by Black mothers specifically amongst a number of minoritised ethnic groups within a study which explored the experiences of racial trauma within perinatal mental health services (Hoang et al., 2023). Such experiences were identified to trigger race-based trauma and emotional distress, ultimately reducing trust and leading women to feel ‘dehumanised’ and ‘dismissed’ (Hoang et al., 2023).

2.2.2.3 Healthcare System Neglect. Many studies reported insufficient healthcare experience and negative healthcare provider interactions has a detrimental impact on women’s wellbeing (Alio et al., 2023; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et el., 2023; Ling et al., 2023; Pilav et al., 2022). It was broadly mentioned how poor communication of available services and support routes severely delayed help-seeking, indicating healthcare needs to be made more accessible (Alio et al., 2022; Ling et al., 2023; Watson & Soltani, 2019). Whilst some studies reported mixed experiences of service care, and some positive outcomes, the majority described a lack of compassion and validation from healthcare providers (Alio et al., 2023; Conneely et al., 2023; Edge, 2011; Hoang et el., 2023; Ling et al., 2023; Pilav et al., 2022). Aligning with this, women spoke about feeling dismissed in routine appointments with medical professionals, ultimately generating further mistrust and reducing engagement (Edge, 2011; Ling et al., 2023). Many studies emphasised that women felt staff did not have the time or resources to provide them with appropriate support, potentially due to high workloads, leading to reduced treatment retention and experience of a ‘checklist approach’, where women did not feel heard (Edge, 2011; Ling et al., 2023). Women ultimately voiced feeling not considered in the decision-making of their treatment or support, which led to reduced agency, feeling unsupported, and negatively impacting their sense of identity in relation to motherhood (Alio et al., 2022; Hoang et al., 2023; Ling et al., 2023).

2.2.3 Social Support and Negotiating Identity Norms and Inequalities

2.2.3.1 Power in Partners. Studies strongly conveyed the power in women having a significant other in their recovery from postpartum mental health difficulty, primarily a partner in most instances (Alio et al., 2022). In studies where women did not have a partner, this was voiced as damaging to recovery, where women felt unsupported and experienced greater isolation (Ling et al., 2023; Sheikh & Singsit-Evans, 2020). In cases where women experienced relationship problems, or a lack of care from partners, this was also deemed harmful to recovery (Adeponle et al., 2017). More so in non-Western based studies, women internalised patriarchal cultural norms of male authority and domination, in addition to gender norms of men leading and women following (Adeponle et al., 2017; Nakku et al., 2016). This meant where men provided for the household financially opposed to offering emotional support to mothers and care for the family, women which were struggling ultimately became marginalised further. However, Nakigudde et al. (2023) highlighted the importance of incorporating a significant other within psychological intervention for postpartum psychosis for mothers located in Uganda, so as to enable a close person to be equipped with the appropriate and relevant knowledge and skills to aid recovery and reduce isolation for the woman. This suggests reforming intervention and service approach to include significant others, such as partners, whilst providing education, could help challenge some of these norms which inhibit recovery.

2.2.3.2 Cultural identity. Most studies indicated incorporating social, cultural and spiritual factors within intervention for postpartum difficulty to be crucial for Black mothers (Adeponle et al., 2017; Alio et al., 2023; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et el., 2023; Ling et al., 2023; Nakigudde et al., 2013; Nakku et al., 2016; Pilav et al., 2022; Watson & Soltani, 2019). Nakigudde et al. (2013) reported healthcare communication must consider individuals' and families' socioeconomic background, literacy skills, education level, personality, and social and cultural interpretations of mental illness. This was echoed by other studies indicating the importance of considering low income, poor social support and isolation for mothers (Sheikh & Singsit-Evans, 2020). Considering barriers relevant to cultural norms and needs were emphasised, including barriers to information and knowledge (Nakku et al., 2016). Furthermore, socioeconomic difficulties which could impact access practically, such as poverty, transportation and location difficulties, and cultural stigmas in various communities, were also considered important (Nakku et al., 2016).

Many women in Western-based studies argued that there was a theme of a lack of cultural awareness across healthcare systems, in addition to a lack of cultural representation among healthcare providers (Alio et al., 2022; Baiden & Evans, 2021; Pilav et al., 2023). Conneely et al. (2023) conveyed mixed responses from women around cultural representation being important in healthcare provision; some women indicated shared cultural identity with healthcare providers enhanced rapport, which was essential for validation and treatment engagement and retention, and others felt the behaviour of the professional was more crucial comparative to ethnicity.

Some women reported experiencing ‘blind faith’ within healthcare provision, where there was no acknowledgement of religious or spiritual practices aligning with women’s personal and cultural values, which women felt could have been collaboratively reflected on and incorporated into care to increase validation and connection with treatment (Pilav et al., 2022; Watson & Soltani, 2019). Overall, there was consensus that incorporating cultural competency within facilitation of healthcare intervention was required (Baiden & Evans, 2021; Edge, 2011; Watson & Soltani, 2019).

2.2.3.3 Posttraumatic Growth. Posttraumatic growth was indicated as important in enhancing recovery, and in promoting cohesion for Black mothers (Alio et al., 2023; Edge, 2011; Nakigudde et al., 2013; Pilav et al., 2022). Incorporating shared lived experience within peer support and/or community groups was argued as incredibly validating for women, and necessary for posttraumatic growth (Pilav et al., 2022). Edge (2011) reported that incorporating a community-based approach is highly beneficial for Black mothers, particularly in contexts where women feel racially and cultural marginalised, or have experienced race-based discrimination. This was emphasised in other findings, in contexts where community values and cultural norms for Black mothers were not considered, which led to a lack of cohesion within recovery and isolation (Alio et al., 2023). In mothers which had recently emigrated to a Western country, it was found a loss of community culture meant posttraumatic growth was less likely, additionally due to less connectedness with others with lived experience (Ling et al., 2023). In contrast to the mixed findings around cultural representation and positive healthcare provider relationship indicated by Conneely et al. (2023), Ling et al. (2023) implied the loss of community connection and validation from shared experience and identity, was more important to consider over perceived cultural stigmas associated with shame and mental health diagnosis and psychiatric care. This suggests posttraumatic growth is viewed as increasingly beneficial, potentially when incorporated into a community-based approach to support. This contrasts with the dominant medical model as most helpful and suggests experience of cultural community stigma can be mediated by connectedness and community.

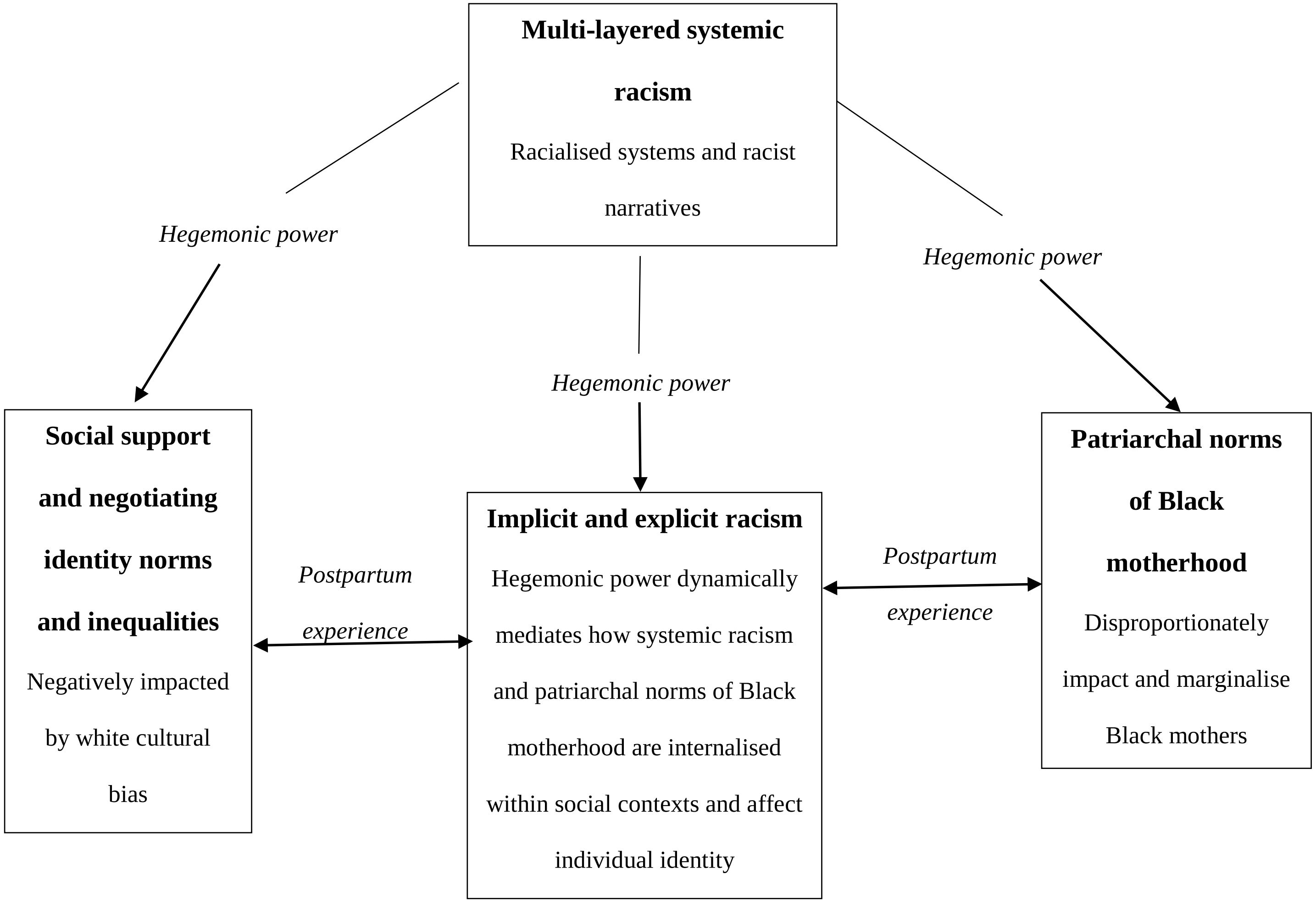
2.4 Line of Argument Synthesis

A line of argument synthesis is the interpretation of the relationship between the themes, with the hope to expose key concepts which may be hidden within individual studies in order to discover the whole from a set of parts (Noblit &Hare, 1988). Recovery from postpartum mental health difficulty for Black mothers is strongly impacted by healthcare access, experience, and relationships. The studies highlight the differences between Western and African community culture, and how patriarchal norms of Black motherhood are experienced by women and influence recovery. In African studies, patriarchal norms of Black motherhood, femininity, and gendered roles, in addition to community stigma, can lead to internalised shame around experiencing mental health difficulty and significantly delay help-seeking (Adeponle et al., 2017; Nakku et al., 2016). In Western studies, where Black mothers are ethnically minoritised, shame is internalised in contexts where women endure implicit bias which manifests in racialised narratives and treatment approaches by providers, and where explicit racist experiences are debilitating for recovery and further marginalise women, in addition to socioeconomic factors (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Pilav et al., 2022; Sheikh & Singsit-Evans, 2020). The stigma and racialised discrimination Black mothers face across studies and contexts negatively impacts their hegemonic power, sense of agency, coping, and relation to identity as a Black mother, as well as isolating them further in their difficulties and personal and social contexts and cultural communities.

The line of argument for this review is that implicit and explicit racism influences how Black mothers experience and recover from postpartum mental health difficulty, including postpartum psychosis, by dynamically mediating their access to and experience of hegemonic power. Four inter-related domains are conceptualised in Figure 2, with racism occupying a central position. Racism is expressed implicitly in healthcare services, via white cultural bias, leading to mistrust towards medical professionals and clinicians and harmful relationships. Explicit racism within healthcare increases emotional distress and social isolation, leading to potential re-traumatisation and perpetuating mental health difficulties. Multi-layered systemic racism maintains harmful racist systems and endorses racist narratives at top and bottom levels. Patriarchal cultural, social and gendered norms which disproportionately impact and marginalise Black mothers, increase feelings of shame and guilt. Increasing women's access to power through negotiating identity norms and inequalities within lived experience, alongside improved social support, increases help-seeking and access, and improves recovery, particularly for women in minoritised contexts with shared experience of racial inequality. This can reduce the sense of shame women feel due to their difficulties, which aligns with existing literature (Burgerhout et al. 2017; Nager et al. 2013; Plunkett et al. 2016; Robertson et al. 2005; Wittkowski et al. 2014). The overview of key concepts and the synthesised categories is available in Appendix B. The interrelated domains for Black mothers' lived experiences of postpartum mental health problems and services are illustrated in Figure 2.

Figure 2

Contingencies for Black mothers' experiences of postpartum mental health difficulties, in relation to race and cultural difference, and racialised treatment and racism



2.5 Discussion

This synthesis highlights how racial structures and cultural biases influence how healthcare is experienced by Black mothers. There is a clear divide in how Black mothers experience marginalisation in Western contexts comparative to African. Black mothers residing in the UK, US or Canada, are ethnically minoritised within the white-dominated medical and social systems they are required to navigate, where there is little consideration of cultural, social or personal factors within treatment (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). Despite studies indicating the benefits of a community-focused approach, peer-groups with lived experience, and incorporating spirituality and cultural factors within intervention for Black mothers; this was frequently omitted within the medical model women were predominantly offered. Whilst Conneely et al (2023) indicates some mixed responses to healthcare experience, the majority describe neglect, dismissal and racialised treatment (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). For most women, this ultimately deters progress in recovery and perpetuates symptoms. Many women reported negative prior experience of general healthcare which acted as a preventative to them reaching out during the postpartum period (Edge, 2011; Ling et al., 2023; Sheikh & Singsit-Evans, 2020). Those which did reach out were often dismissed, maintaining the cycle of mistrust with providers (Ling et al., 2023). This seems a common theme throughout studies, where Black mothers felt not listened to by providers, ultimately rejecting and isolating them further in their experiences (Alio et al., 2022; Baiden & Evans, 2021; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). The narrative around Black mothers maintaining self-sufficiency, strength and resilience, felt endorsed within healthcare systems for mothers, only ostracising women further within the white-dominated societies they resided in (Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). Mothers' potential concealment of difficulties was interpreted as Black resilience (Baiden & Evans, 2021); arguably perpetuating the cycle of non-disclosure. Increasingly racialised experiences were demonstrated further within explicit racist incidents where providers assumed 'Black bodies don't feel pain', leading to re-traumatisation and severe emotional distress (Hoang et al., 2023). This suggests healthcare experience is fundamentally detrimental to recovery for some Black mothers, indicating there is a chronic need for healthcare reformation. It is evident that harmful experiences and relationships with healthcare reduce women's power, sense of agency and identity as a mother, and increase debilitating emotions such as shame and guilt, which clearly ostracises women further within recovery. This aligns with previous literature conveying the dire consequences of increased shame in the postpartum period, such as inhibiting help-seeking and treatment access, and increasing isolation, risk to self, and poor outcomes (Burgerhout et al. 2017; Nager et al. 2013; Plunkett et al. 2016; Robertson et al. 2005; Wittkowski et al. 2014).

The synthesis shows intra-community and external stigma is paralleled across cultural context and location for Black mothers. Ling et al. (2023), conveyed women felt able to overcome this stigma, yet still were not met with appropriate or helpful responses from healthcare providers. This indicates it is crucial available information that is specifically relevant to personal and clinical need is provided, even in contexts where healthcare is considerably advanced and arguably accessible. Additionally, the implication is that inadequate healthcare access and experience cannot be fully attributed to cultural norms, and there is a clear gap in appropriate support for Black women.

African studies highlight multiple practical barriers to treatment access, including knowledge of postpartum mental health and available services, location, transport and poverty (Adeponle et al., 2017; Nakigudde et al., 2013; Nakku et al., 2016). It is clear that patriarchal norms of Black motherhood and femininity are intensely experienced by mothers residing in these cultures, comparative to Western cultures, and this creates tension within help-seeking and openly expressing psychological adversity and need for psychiatric intervention for these mothers (Adeponle et al., 2017). The gendered roles these mothers are subjected to and expected to adhere to, for risk of intense shame and communal rejection, is increasingly isolating for women, suggesting a need for improved education around postpartum mental health and a normalisation of symptoms. Recently emigrated women's narratives support these experiences, whereby expressing the need for greater partner involvement to reduce isolation (Ling et al., 2023). This aligns with existing literature reporting the power in partners and social support in mediating recovery, with emphasis on the need for the relationship to be secure and supportive, with acknowledgement partners may likely lack postpartum knowledge (Coleman, 2009 Engqvist & Nilsson, 2013; Forde et al., 2019; Forde et al., 2020; McGrath et al., 2013; Plunkett et al., 2016; Wyatt et al., 2015). Whilst Western samples indicate patriarchal norms are experienced to a lesser extent, studies consistently convey the commendation of such norms within the racist expressions and assumptions of healthcare provider, aligning with previous literature indicating traditional nurturer roles for women lead to a sense of failure, shame, guilt and increased isolation (Lewis & Nicholson, 1998; Robertson & Lyons, 2003). This implies the patriarchy is maintained across white-dominated systems and is detrimental for Black mothers in the context of postpartum adversity across countries.

This review interestingly highlights how Black mothers experience 'Anti-Black Bias predominantly within their healthcare experience, increasingly more so comparative to other ethnic minoritised groups (Hoang et al., 2023). Black mothers experience specific racist experiences which inhibits their recovery, regardless of socioeconomic advantage, or higher income and/or education levels (Alio et al., 2022), suggesting there is a significant disparity based on race which increases risk and poor outcomes for specifically Black mothers. Black postpartum women evidently require increased support within healthcare, in the context of racial disparities unique to their ethnicity, greater risk of shame due to exposure to racist narratives and treatment, enhanced cultural stigma, which feels endorsed in their own cultural communities in addition to White dominated society, and the severe marginalisation and racial biases they endure across social and medical systems.

The ‘weathering’ hypothesis proposes that Black people experience early health deterioration as a result of consistent experience with socioeconomic adversity and political and racial marginalisation (Geronimus, 1992). This indicates Black mothers are at severe disadvantage due to their racial, cultural and ethnic status, predisposing them to worse outcomes and negative experiences in the postpartum period. Implications include a need for healthcare reformation, in the context of improved cultural competency and knowledge of health disparities for clinicians, and cultural and trauma-informed intervention, community-based approaches, and further research into the individual and collective impact of racism and cultural bias on Black mothers. This theory supports the line of synthesis that indicates racism and hegemonic power to be at the centre of the experience of postpartum mental illness for Black mothers.

2.6 Limitations

Due to the limited amount of literature, some flexibility was needed in the inclusion criteria. The aim of this review was to explore Black mothers’ lived experiences of postpartum psychosis, in relation to the unique nature and severity of this illness in the context of motherhood (Di Florio et al., 2013; Forde et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003), and the severe dearth in the existing literature connecting this illness with the experiences of ethnic minoritised women, specifically Black women. Due to the very limited number of studies focusing exclusively on Black mothers and postpartum psychosis, this was unfortunately not possible. The decision to focus on race and racialised experience within postpartum mental health meant the most comprehensive accounts of Black mothers were included, with a unique focus on inequity and racism, offering much clinical and social relevance for this ethnic group. However, the evidence suggesting postpartum psychosis to be a uniquely distinct experience, separate to postpartum depression, which the majority of studies focused on, among other postpartum mental health difficulties, meant that it was not possible to comprehensively and distinctively explore lived experience of ‘psychosis’ in the postpartum period for this ethnic group. On the contrary, this gap in the existing literature merely provides an appropriate platform for further research exploring Black mothers’ lived experience of postpartum psychosis, with attendance to the racial disparities, social injustice and implicit and explicit racist experiences and biases Black women are predisposed to.

Further limitations were that several studies focused on minoritised ethnic experiences broadly, indicating non-Black women’s accounts were included within the themes. This could mean that some of the findings might not reflect Black women’s experiences specifically. One study included in the review was Mixed-Methods, although the quantitative analysis was not included (Watson & Soltani, 2019). However, this was not in line with the traditional meta-ethnography approach (Noblit & Hare, 1988). Several studies included healthcare provider and stakeholder experience and perception of postpartum mental health, in addition to mothers with lived experience, although this was not attended to.

The diverse locations of study settings meant a variety of cultural and social experience was attended to, with mothers originating from various African countries and Western societies. However, as the studies indicate, there are significant differences between such countries, particularly Western and non-Western, meaning it is difficult to directly compare mothers' experiences of healthcare and access, given the vast cultural disparity. Stuart Hall depicted ''Race' as a floating signifier', and argued that rather than paying attention to the objective facts of a situation alone, we must instead examine the discursive position that surrounds and is told by a particular culture, about what physical racial differences mean (Hall, 2021). Thus, it is possible that incorporating samples of Black women across cultural settings within this review potentially homogenises the women included, without enabling more comprehensive discussion of the relevant and specific cultural discourse associated within the separate environmental contexts the women reside in. Furthermore, a future review could benefit from examining cultural difference more elaborately across study settings and locations, with a view to avoid homogenising Black women due to race.

Involving service users has been found to ensure that questions asked by the interviewer more authentically reflect what is considered most important for the population in question (INVOLVE, 2015). Only one study utilised a participatory research design, where the findings illustrated greater experiences of racism and race-based trauma (Alio et al., 2022). It is possible, in the other studies, the lack of researchers with lived experience affected how willing participants were to describe sensitive and personal experiences that they may have felt did not align with the social and cultural norms that were endorsed in their environments. It is possible in cases where researchers were of white ethnicity, interviewers were experienced as representing the dominant white group which historically and currently oppresses Black women, meaning this affected participants' responses. It is also possible that individuals that did consent to participate were more likely to provide extremer stories or accounts, whether positive or negative.

Due to the nature of this review being conducted by one lone researcher, there could be potential methodological bias in how self-interest may have shaped the analysis. An additional colleague's interpretations may have differed and factored into the synthesis. There could be some logistical bias in that unpublished work was not included, yet due to the tentative nature of the topic and lack of appropriate studies relating to postpartum psychosis specifically, it might have been helpful to include these.

2.7 Conclusion

This synthesis provides the perspectives of Black mothers directly impacted by postpartum mental health problems and associated healthcare experiences, revealing how underlying racism in the healthcare system influences relationships, power and recovery. Implicit and explicit racism influences how postpartum mental health is experienced by Black mothers and communities. Reforming healthcare provision to meet Black mothers' cultural, social and physical needs is essential to improve access and relationships with services. The issue of racism is complex and multifaceted yet begins with those living with the experience, and further research that explores Black mothers' experiences of postpartum psychosis specifically would be helpful.

2.8 Justification for Current Study

Following on from this synthesis, the current study aims to explore how Black mothers with lived experience of postpartum psychosis relate to their experience of recovery, and how discrimination, racism and hegemonic power may have played a significant role. This aligns with the literature that indicates women's wider external systems heavily impact the experience of motherhood and mental illness, particularly for such a severe and potentially devastating postpartum illness as psychosis (Engqvist & Nilsson, 2013; Roxburgh et al., 2022). It is difficult to navigate how to challenge such factors and organisational defences that are so entrenched in Western society, but starting with the mothers with lived experience and that identify with an experience of racism or discrimination could pave the way, in conjunction with CRT principles (Delgado & Stefanic, 2001).

The controversy around diagnosis and the complex relationship between the medical framework and the concept of motherhood is considered, and women that may not have directly accessed services are included. The hope is to explore how potentially marginalised women, which may or may not have accessed current services, or had negative experiences of healthcare, may relate to these experiences. By focusing on women that identify as Black, this study will follow the evidence that conveys Black women as at higher risk of developing worse perinatal mental health outcomes, developing postpartum psychosis, and of worse associated consequences (Anderson et al., 2017; Anderson et al., 2019; Edge, 2011; Prady et al., 2013; Prady et al., 2016; Womersley et al., 2021). This is also with consideration of the complex and severe isolating nature of postpartum psychosis as a distinctive and separate maternal mental illness, with higher associations of societal stigma in relation to motherhood and greater severity of symptoms (Di Florio et al., 2013; Forde et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003).

The hope is to build on the current findings that indicate the importance of incorporating cultural factors and clinician self-reflection within healthcare (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Declercq et al., 2021; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). Additionally, the hope is that the findings from the current study can build on the implications for healthcare to acknowledge how cultural barriers and discrimination impact the women most disproportionately affected, with consideration for improving current healthcare provision, including psychological intervention.

2.9 Chapter Overview

The following chapter illustrates the method undertaken by the researcher, in terms of the current study's design, sample, data collection, analysis and relevant procedures. This chapter additionally includes relevant epistemology and reflexivity, in line with qualitative research.

3. Method

3.1 Reflexivity

My time working in a Perinatal Community Mental Health Service in the East of England was my starting point for developing an interest and passion within postpartum mental health. Working with Black mothers that attended some of the therapeutic groups that I co-facilitated, helped me understand the range of complex and severe mental health difficulty many women had endured, including postpartum psychosis around the birth of their infants. This experience highlighted for me some of the systemic challenges and cultural barriers these women faced within their recovery. This led me to wonder how, if the current treatments and care offered for this group of women did not necessarily align with their personal, social and cultural values and experiences, this could detrimentally impact their recovery. I became curious about how these women experienced and interpreted racialisation and implicit and explicit racism as factors within the processes and experiences of recovery and healthcare. I became particularly interested in the experiences of mothers that were not accessing healthcare, and why this was, and how much this might align with existing inequities identified within the literature, including experiences of structural and interpersonal racism.

My passion for addressing social injustice led me to think about race more specifically within this process. Familiarising myself with Critical Race Theory (CRT; Delgado & Stefancic, 2023), helped me in thinking about racism as potentially a social construction, which maintains political and social inequity, and how this plays out in healthcare systems such as the NHS. I wondered how I could apply this thinking to racially minoritised mothers' accounts of postpartum recovery, and how much implicit racial bias is overlooked within current service design, with the interest of serving the dominant white medical system. I am interested in how intersectional racism maintains the hegemonic power within dominant white medical society, and oppresses Black mothers with severe mental health diagnoses and/or experiences. I decided to focus on Black mothers’ accounts as a result of my experiences in working clinically with this ethnic group of women. I wondered how much the challenges Black mothers face within recovery from postpartum psychosis could be attributed to racial marginalisation.

I recognised that my personal, social and cultural position would be inevitably influential within the interpretive process, particularly as I symbolise the dominant white oppressive group. I hoped continuous reflexivity around cultural, racial, social and occupational difference, the power imbalance as a researcher and clinician with participants, and explicit communication of my own position, would help somewhat in navigating the dynamic as a white researcher interviewing Black mothers around intricate and sensitive topics, including racism. Reflecting on my epistemological stance in relation to my choice of methodology, led me to believe that for me, I am positioned between social constructionist and alethic relativist when thinking about phenomenology. I feel that I align more so with the view that racism can be viewed as a social construction, yet also agree with a more realist approach which indicates racism exists to serve the privilege of the dominant white group. When thinking about the experience of ‘psychosis’ in the postpartum period, I lean towards the viewpoint that Black mothers’ realities, or the ‘truth’ of their experience is relative to their conceptual, cultural and linguistic framework (Einheuser, 2005), which can be understood in the context of various strains of racisms as well as their individual experience. I am conscious that my position has evolved throughout the study and thus it is important to consider personal reflexivity as a dynamic process.

3.2 Phenomenology and Lived Experience / Epistemology

Phenomenology, as formulated by Husserl (1931) in the early twentieth century, is concerned with the world as it is experienced by individuals within certain contexts and times, rather than as separate to people (Willig, 2008). ‘Intentionality’ refers to how meaning of a phenomenon varies depending on the stance of the perceiver, such as their emotional and/or psychological state, motivation, context, angle of perception or desire (Moustakas, 1994, cited in Willig, 2008). This is particularly relevant for the current study, where the aim is to explore Black women’s lived experience of postpartum psychosis and the impact of discrimination and racism. The meaning of an experience of ‘psychosis’, is likely different for Black mothers that may feel racially and culturally marginalised and ostracised within society, at a social disadvantage, or rejected within white dominated society and/or their own communities and families, comparative to white mothers. Similarly, the meaning of ‘recovery’, ‘support’, ‘diagnosis’ and ‘services’ may generate stigma and mistrust for marginalised Black women, comparative to white mothers with sociocultural privilege. How a Black mother’s, or any group of mother, relates to the phenomenon explored in this study would also influence and be influenced by their personal feelings, experiences, and social contexts in the contexts of such phenomena; thus, it was deemed essential to acknowledge difference at a systemic and individual level for the participants in this study.

Phenomenological research focuses on the experience of the participant, to which the researcher engages with and gains meaning from (Schleiermacher, 1998). Phenomenological approaches have been widely used in qualitative research, as they tend to focus on and give meaning to the lived experiences and perceptions of individuals, providing a rich and comprehensive description (Willig, 2008). A phenomenological research design helped clarify and interpret lived experience of Black women for this study, by giving the women involved a voice and meaning to their stories. The detailed nature of women’s accounts provided an in-depth insight into their personal, social and cultural context within their experience of postpartum psychosis and healthcare, arguably indicating the current study participants’ interviews align with naturalistic inquiry and ‘transferability’ to other Black mothers’ experiences (Lincoln & Guba, 1985; Seale, 1999).

There are two main types of phenomenological research, descriptive and interpretive. Descriptive is positioned more firmly in the notion that ‘description is primary, and that interpretation is for a special type of description’ (Giorgi & Giorgi, 2008). One advantage to descriptive phenomenology in relation to exploring Black women’s lived experience of postpartum psychosis, would be that the researcher must ‘bracket’ or distinguish between any pre-existing assumptions about how race might influence the participants, based on the researcher’s own personal experiences, values or beliefs. This could be helpful particularly to avoid potential bias in the interaction exchange, or questions asked in the interviews with participants.

Interpretive phenomenology does not separate description and interpretation as such, but rather follows on from the hermeneutic approach that argues all experience is given meaning by an interpretive process, or that understanding is based on preliminary assumption (Van Manen, 1990; Schleiermacher, 1998). Interpretive phenomenological analysis (IPA) is based on the assumption that people’s accounts produce knowledge about their thoughts and feelings of lived experiences, yet recognises how researchers’ also bring their own experiences and interpretations to the research process. The kind of knowledge produced by IPA is therefore reflexive, as it acknowledges the researcher’s viewpoint throughout the interpretive process.

IPA assumes that individuals can experience the same events in very different ways, depending on their own thoughts, judgements and beliefs that bring meaning to the event or experience for them (Willig, 2008). Thus, IPA is not in line with a positivist view that proposes social or material events directly define individuals’ experiences, or may be considered ‘true’ or ‘false’, and is consequently more in line with a relativist ontology: the belief reality is a ‘finite subjective experience’ and that nothing exists outside of our thoughts (Willig, 2008; Denzin & Lincoln, 2005; Guba & Lincoln, 2005). This is opposed to the view of ‘disorder’ as objectively measurable, that indicates individuals’ experience is not ‘normal’ and consequentially ‘false’ (Keuth, 2015).

IPA also acknowledges that shared social interactions and processes ultimately influence subjective interpretation, indicating interpretation is not entirely an idiosyncratic process (Willig, 2008). Thus, IPA can be understood within the ‘symbolic interactionist’ framework that indicates the interaction process as a creation of symbolic worlds between people and that shapes subsequent behaviours; it is the interpretation process that creates and recreates meaning (Hall, 2007). IPA was chosen for the current study due to the purpose of understanding the processes, interactions, and interpretations that arose from the discourse and discussion within the interviews (in addition to the content), with attendance to the dynamic meaning the researcher and the interviewee created and understood within the conversations at hand.

3.3 Design

The study was a qualitative phenomenological research design and 17 participants were recruited. Participants self-identified as Black, were over 18, and self-reported having lived experience of postpartum psychosis. Women that were under 18 were not recruited as younger individuals’ experiences could justify a separate study due to teenage mothers facing alternative social and financial challenges and associated stigmas. Women did not need to speak fluent English, with the hope women which were newly residing in the UK, or which had not had opportunity or experience of learning English but still had valid and important stories to tell, could be included. Only women which self-reported no longer being symptomatic of ‘psychosis’ were considered, due to women potentially being too unwell to participate, or not in a personal or emotional stage to reflect on their experiences, as expected if they were still experiencing symptoms. There was no specific timeframe depicted, as the researcher felt it was the women’s decision as to whether they were ready to reflect on their experiences, which they would be their own expert in judging (as long as this didn’t ethically impact potential symptoms). The decision was made to recruit women with varied experience of recovery, the time since onset, and its related factors, to gain insight into a variety of women’s experiences across time.

As this is a qualitative research design, the objective was to understand participants’ experiences through their subjective accounts. Participants were recruited via purposive sampling, and third sector organisations or charities which focused on offering support to postpartum women in the UK were contacted, and the study was promoted on the researcher’s personal social media accounts. The decision was made not to recruit through NHS perinatal mental health services directly, so as to recruit women that potentially might not have experienced standard NHS care. This was to ascertain insight into whether Black women that did not access services, how they experienced available support, and if not, why this was, and what personal, social and cultural barriers did they face in regards to communication and access. For this reason, a formal diagnosis was not deemed necessary. The researcher additionally recognised the importance in women self-identifying their difficulties, specifically in contexts where access to ‘professional’ help and a subsequent diagnosis wasn’t possible. Furthermore, the hope was that the women no longer under service care could potentially be in a different, more reflective stage of recovery from postpartum psychosis, that wasn’t so close to the experience. However, the researcher was interested in a range of recovery experience, so women still under service care were considered, although eventually this included only 1 participant. Semi-structured interviews were facilitated, to encourage participants to describe their experiences in their own words, whilst still offering some structure to cover necessary topics and questions (Morse & Field, 1995). Interviews occurred over Microsoft Teams at a mutually convenient date and time. This was to be able to reach women residing all over the UK, and to overcome practical and economic barriers around travel/childcare, that could arise from face-to-face meetings. Ethical approval was obtained from the University of Essex before recruitment commenced. Women were reimbursed for childcare costs with a £20 Amazon voucher, as agreed within the ethics application. Upon completion, the study will be disseminated to a perinatal journal, such as the Journal of Prenatal and Perinatal Mental Health.

3.4 Procedure

The research topic was selected based on the personal and professional interests of the researcher in perinatal mental health, specifically postpartum psychosis, and qualitative research. Following a review of the literature, the research question, aims and objectives were developed. Semi-structured interviews as a primary data collection method were selected, in line with a phenomenological qualitative design to obtain an in-depth and rich understanding of participants' experiences. Semi-structured interviews were recorded and transcribed, following strict ethical procedures according to the University of Essex. IPA was carried out.

The researcher made efforts to co-produce their interview schedule (see Appendix C for a template), demographic questionnaire (see Appendix D for a template), participant information sheet (see Appendix E for a template) and consent forms (see Appendix F for a template of the consent form and Appendix G for a template of the interpreter consent form), by contacting various third sector organisations and charities. Unfortunately, no responses were received by any charities or third sector organisations. The researcher composed a promotional summary for the Experts by Experience group website, but received no responses. The researcher had also liaised with Community Perinatal Mental Health Services in the East of England, including Mother and Baby Units, and the lead clinicians fed back that they felt it would be unfair for women in services to feel a responsibility to participate in the research whilst under the care of the NHS and whilst experiencing their current difficulties. Subsequently, the researcher made the decision to go ahead with their research due to time and resources constraints. The researcher did present their research to their cohort of trainees at the University of Essex and obtained valuable feedback and reflections on their methodology, analysis and the process of the research, which the researcher has incorporated into their approach. These included thinking about where and how to disseminate their study following completion, whilst simultaneously reflecting on how to reach marginalised Black communities in this process. The researcher additionally managed to meet with women belonging to their collaborating postpartum charity, which included one woman with lived experience of postpartum psychosis and who identified as Black, which helped them in the initial stages of recruitment. This led to the expansion of the inclusion criteria to help aid data collection, from ‘postpartum psychosis’ to ‘postpartum mental health difficulty’. This was with the hope that a broader more generic label would feel less stigmatising as a potential barrier to participation.

All interviews were recorded on the researcher’s laptop, password protected, and with participants’ informed consent. Participants’ names were not used, to maintain confidentiality. Participants were given the choice to complete the demographics questionnaire over email, or answer within the interview. Once all data was analysed, interviews were deleted, and transcriptions were given a unique number to identify each participant’s data whilst protecting anonymity. Participants were encouraged to attend the interview, whilst online, in a space they felt comfortable and safe in, and that they could speak openly in. The researcher offered numerous breaks to ensure participants could hopefully feel comfortable, particularly due to the sensitive and emotional nature and context of the interviews. All participants were provided with as much information as possible about the study using the participant information form, with the opportunity for questions and further information if required. All participants provided written consent before the interview commenced.

The interview agenda was carefully considered by the researcher, including the nature of and order of questions. Spradley (1979) proposed several types of interview questions, including ‘descriptive’, ‘structural’, ‘contrast’ and ‘evaluative’, for semi-structured interviews. The researcher used questions in a style that they felt had meaning relevant to each participant in terms of their cultural and social background. The researcher built a rapport with participants first, and asked demographic information at the beginning, including, age, ethnicity, employment status, education history, sexual orientation, living situation, gender, age of their infant and the infant’s living situation. The researcher considered these factors in how they might influence how the participant preferred the interview, such as whether a more formal or less formal approach was most helpful. The researcher used their clinical judgement during the interview, and also checked in with each participant about how they were feeling regularly, so as to ensure participants were as comfortable as possible with the current approach. Whilst the researcher adhered to an approximate hour time-based limit, an agenda, and their own role within each interview, questions remained open-ended, with capacity for necessary expansion and exploration of participants’ answers if considered relevant and appropriate, in line with the semi-structured interview procedure. The researcher began with more general questions to build on rapport, before going on to pursue more personal topics. The researcher followed the subsequent main subjects for the interview agenda: experience of postpartum psychosis and recovery; the impact of postpartum psychosis on participants, their infant, and their social world; experience of postpartum psychosis and recovery in relation to social support, standard care/treatment, and mental health services, including of perinatal and Mother and Baby services; experience of cultural and/or social discrimination and the role of racism in relation to postpartum psychosis and recovery. The researcher made every effort to encourage participants to express assumptions and experiences as explicitly as possible, asking for elaboration and further information and examples where needed. This was to gain as rich an understanding of the participants' descriptions of their experiences as possible. The researcher aimed to think about how to manage all possible disruptions which could impact the process or conversation during interviews, in order to maintain the most sensitive and ethical negotiation of rapport.

Interviews were video-recorded and material transcribed verbatim (see Appendix H for an anonymised example participant transcript), so the researcher could engage as effectively as possible with the participant, their content of their world and the process of the interview, without distraction via note-taking. All participants were given assurance about confidentiality, so as to enable participants to feel as comfortable as possible about being recorded (especially if this was a novel experience for them). As the researcher was interested in the subtleties of the style of the communication, and how the process seemed during the interview, they transcribed pauses, interruptions, intonation, volume of speech, and so on. The researcher adhered to guidance of this style of transcription (Potter & Wetherell, 1987). The researcher made this decision as they are interested in far more than just the content or the words of the interview, but the process and nature of the interaction.

3.5 Participants

This study recruited 17 participants, all of which self-identified as Black British, including 11 which identified as Black British African, two as Black British Caribbean and four as Mixed Race (Black and White heritage). All participants reported English to be their first language and did not require an interpreter. Participants' age ranged from 18-51 years, with the majority aged between 26-34 years. Most of the participants identified with a Christian faith, the remainder with no faith. Nearly all participants had completed undergraduate education, with several completing up to A-levels/college, and one postgraduate. Nearly all participants were employed at the time of interviews. All participants identified as heterosexual and most were married, with a minority reporting co-habiting or divorced. All participants referred to their experience of perinatal mental health difficulty as 'postpartum psychosis', although 12 reported accessing healthcare for their experience. Five participants had not accessed any formal healthcare. Six had accessed community groups within recovery, some of which had also accessed professional support, with three having not accessed any formal group or healthcare. Participants' recovery timeframe considerably varied, with the earliest at 6 months and the latest at 20 years, and the majority falling between one-four years at the time of interview. Several women were recruited through advertising of the study through the third sector organisation, with the majority through the researcher's personal social media, and several through word of mouth of previous participants. Most were recruited following the change of inclusion criteria, with only three recruited prior to the expansion. Despite this change to the criteria and a minority reporting no formal diagnosis, all women reported experiences and symptoms consistent with postpartum psychosis.

3.6 Analysis

IPA was developed by Jonathan Smith (1997) and is a form of the phenomenological method that acknowledges how we cannot directly understand or access the participant's life as they experience it. IPA is the chosen form of analysis, as it is widely and effectively used for qualitative research that focuses on lived experience and understanding of perceptions of participants, which applies to the current study's aims and objectives which focus on Black mothers' lived experiences of postpartum psychosis and racial/cultural discrimination.

The following stages of IPA were followed, according to (Smith & Nizza, 2022). The initial stage involved reading and re-reading the interview transcription, including the non-verbal comments, such as tone and volume of speech, pauses, observed body language, and making notes of personal reflections or thoughts around the content in the left margin. The second stage required the researcher to identify themes that categorised each part of the transcription, which were completed in the right margin. The third stage required thinking about the relation the themes had with one another, and then forming 'clusters' of themes, either that were related due to meaning or due to structure. The fourth stage of analysis involved creating a summary table that illustrated an overview of the connected themes, including the location of quotations and keywords, and which reflected the participants' accounts.

The analysis was continued until the full integration of themes was achieved. The researcher integrated cases by using the summary table for the first participant when analysing the subsequent transcripts. This was done by comparing and elaborating on the first participant's themes, and subsequently checking and analysing later emerging themes to all transcripts. The decision to follow this strategy was made so as to be as thorough as possible in checking for new concepts, meanings and recurring themes throughout the transcripts.

The level of the interpretation within the analysis, and whether to adhere to a 'descriptive/empathic' or 'interrogative' approach in the interpretation process (Eatough & Smith, 2008), was thoroughly reflected upon. The descriptive/empathic level of interpretation requires the researcher to try and be part of the participant's world, whereas the second interrogative level requires the researcher to tentatively speculate and formulate about the participant's world, with the hope to enrich the data with new insights on meaning of the participants' accounts.

Eventually, the researcher has made the decision to adopt a more 'interrogative' approach, as it was felt this would be important to draw on their own interpretations about each participant's story, their social context, and personal experiences of 'psychosis' and racialised discrimination, and how this might relate to participants' experiences individually and collectively, and the wider population of Black mothers in similar contexts. The researcher was aware of the importance of consistently reviewing the ethical issues relating to this approach. For instance, it was crucial the researcher did not endorse their own biases, or let their own assumptions and beliefs take over from the participant's, or let their interpretation of meaning take away the participant's voice and their own meaning. The researcher maintained every effort to be thorough and take care to reflect on elicited emotions for themselves and the participants, reflecting on the language used and non-verbal processes observed. Whilst the interrogative approach allows for speculation, if any interpretation takes away the participant's voice, then it could lead to the role of discrimination being enacted in the study, which was incredibly important to avoid for moral and ethical reasons.

3.7 Ethical issues

Ethical approval was obtained through the University of Essex before the study commenced. All necessary rules and regulations in accordance with the University guidelines were followed at all times. The emotional, psychological and physical needs of the women and their infant/children were always considered as the ultimate priority throughout the study. All participants were given an information sheet that included the purpose of the study, the procedure, contact details, risk information and the right to withdraw. All participants provided consent before beginning participation. The utmost care was taken to ensure no pressure was placed on women to participate in the study and all were informed that it would not affect their current care or involvement within any services or organisations, including with the NHS.

Potential ethical issues that could have arisen from conducting the interviews, could be that for some women, discussing very difficult emotional experiences or mental health difficulties in relation to their pregnancy or experience of becoming a mother, could be potentially re-traumatising. For some, talking about these experiences might have felt triggering of difficult memories, or potentially uncomfortable. All women were assured they had the right to withdraw without giving a reason, but that if the interview had been completed this data would still be included. Women were assured they could discuss anything difficult that comes up with their GPs or highlight to the researcher for them to pursue and provide the relevant guidance or resources for appropriate support. All women were signposted to the relevant out of hour crisis numbers and helplines in a follow-up email, along with links to UK postpartum charities. They were assured that their data was confidential, but if any information surfaced that indicated they or their infant were at risk of harm, or that they seemed to pose a risk to others, this information would be discussed within the researcher’s supervisory team and appropriate steps considered, which would include discussion with the third sector postpartum charity involved in recruitment for this study. Fortunately, no concerns or reports surrounding risk to the mother, infant or any other person, arose from the interviews.

Practical issues that were anticipated included time, employment and childcare difficulties that may hinder participation. All participants were encouraged to bring their infants to the interview if they felt happy to do so. If women's children were over one year of age, they were encouraged to carry out the interview separate to their child. This was to protect the child and mothers' wellbeing when the mother may be recalling a distressing or difficult experience relating to their child, or the birth, or the postpartum period generally. However, this decision was ultimately at the discretion of the participant and researcher.

All efforts were taken to ensure that the researcher was transparent and reflective about their reasons and motivations for conducting the study. It was acknowledged with participants that the researcher is from a white background and not a mother, and does not consider themselves to be an expert in any sense on Black women or Black mothers' and Black communities' experiences or those with experience of perinatal mental health, and more specifically postpartum psychosis, or around racialised marginalisation. Information about the researcher's qualifications and stage in training were explicitly provided. All efforts were taken to protect the mental health of the researcher, as a lone researcher collecting data on a sensitive topic, alongside other time commitments due to being a trainee psychologist. The researcher attended regular supervision with research and personal tutors for support.

3.8 Quality Criteria and Considerations

It is important to acknowledge the motivations and reflections of the researcher in this study, due to the sensitive aims and objectives in exploring the description and impact of racialised experiences within Black mothers' recovery from postpartum psychosis The cultural and social position of the researcher as a white woman, whom is not a mother, in relation to white privilege, was thoroughly reflected upon and consistently acknowledged. The researcher maintained transparency during all interviews about their personal experience of research and clinical cases of working with Black mothers in perinatal mental health services, which inspired them in commencing this research. The researcher explicitly acknowledged to all participants they are not an expert in Black women's experiences, particularly around racialised treatment or marginalisation, or in Black mother's experiences around motherhood and experiencing perinatal mental health difficulty, and how this was impacted by healthcare experience, whether racialised or otherwise.

The researcher acknowledged their interpretations of women's style or content of language, body language, or other cultural presentations, may not necessarily or consistently reflect the intentions of participants. Every step was taken for meaning to be appropriately obtained from interviews, by consistently checking in with participants, appropriately feeding back during interviews and by building rapport. The researcher considered the benefits of reflecting with participants upon their own considerations of the transcriptions and themes, with the view to offer participants the opportunity to provide feedback. This was discussed with the researcher's supervisors and the decision was made not to engage in a triangulation method due to the time constraints. The researcher reflected with participants about sending a summary of the research; all agreed for this to be sent. The researcher planned to send summaries following submission of the study for examination.

It is possible that the researcher's historical experiences and personal reflections may have inevitably influenced and potentially biased their interpretations of interviews and women's accounts, particularly in relation to race, whether this was unconscious or not. It was understood how it would be difficult to completely bracket all assumptions, as the researcher was aware that some of the women's stories elicited certain emotional responses. The researcher reflected on this throughout the study through the use of a reflexive journal, within supervision, and included reflections within the discussion chapter. The researcher considered and recorded their feelings, thoughts and reflections at various stages. These stages most importantly included prior to and following the interviews, before and after listening to the transcriptions, and throughout the analysis and write-up.

The researcher reflected upon the counter-transference and transference that occurred, due to emotional experiences being discussed. The researcher reflected upon and acknowledged the defences which arose for them as a result of the topic and the interview process. The researcher was aware their efforts to reflect and consider difference and the emotional processes experienced would be limited within their own personal capacity to do so. This was particularly in the context of being a lone researcher, where they worked alone within the data collection and analysis processes. This meant it was crucial to utilise supervision effectively and participant feedback where possible.

The researcher reflected upon and additionally recorded the anxieties they experienced throughout the research process and particularly the interviews. The researcher also reflected on their experience of how these anxieties may have come about, how they felt the person in the room presented emotionally and physically and whether they were anxious. Reflections at each stage of the study and any interaction with participants were included, in addition to the process of how the researcher related to their epistemological stance throughout the research, and how this evolved as a result of their experience and interactions with participants. This was considered important in the context of working with women describing emotionally and racially traumatic experiences. The researcher reflected upon who was bringing what to the interview room, as this would crucially affect the interpretive process within the data analysis.

The researcher reflected on how appropriate collaboration could potentially help with the study, by enhancing the understanding of meaning and language used interchangeably, in the recruitment, interview and all communicative stages throughout the study. It was reflected between the researcher and their supervisors how, perhaps by thinking critically about the language used to construct meaning for the participants, this could help with forming the relationship between the researcher and the participant that would start from the first point of contact. The researcher reflected how collaboration could help promote understanding and connection, and also help participants feel safe and comfortable in the process of the study, particularly in the interviews.

An interpretive phenomenological approach was opted for, following reflection upon the phenomenon of both lived experience and the meanings involved as inevitably an interpretive experience. The researcher read how interpretive phenomenology, or interpretive phenomenological analysis (IPA; Smith & Nizza, 2022; Smith et al., 2022; Willig, 2008), aims to gain an understanding of how participants view and experience their world, and is thus suited for this study, where considering participants' individual experiences of potential racism and racialised healthcare treatment was deemed essential to understand from the lens of Black mothers. Whilst the researcher recognised it is not possible to gain a direct and unmediated connection to individuals' experience, they hoped to engage with the aim of IPA and adopt an interpretive approach, to enhance the process of 'immersion' (Geertz, 1988, cited in Willig, 2008) within participants' accounts, and so as to be able to obtain insight into women's worlds and better understand their experiences from their perspective. The researcher understood that their personal, social and cultural position would be inevitably influential within the interpretive process, particularly as they arguably symbolise the dominant white oppressive group. The researcher hoped reflecting on the psychological and emotional processes occurring within interviews, and addressing countertransference and transference which arose, would be helpful to consider in relation to meaning. The nature of the interactions and the dynamic processes within the conversation, in addition to the content of participant responses, would enable the process of 'thick description' (Lincoln & Guba, 1985; Seale, 1999).

3.9 Overview of Results

The following results chapter presents the findings of this study. The demographics, experiential/contextual information, group experiential themes with participant quote examples are illustrated in detail. The first overarching theme identified was ‘the debilitating impact of postpartum psychosis on emotions’, including the subthemes: extreme sadness; terrifying beyond belief; intense anger. The second overarching theme was ‘disconnect with the external world’, including the subthemes: disparity between the internal and external; withdrawal is a means of protection; Black women are outcasts. The third overarching theme was ‘acceptance is the hardest process’, with the subthemes: accepting I need help; accepting this diagnosis. The fourth overarching theme developed was ‘power in the advocate’, with the subthemes: significant others are the force of hope; power in self-advocacy; rejection from significant others leads to internalised shame. The final overarching theme identified was ‘Black motherhood as a collective: empowerment vs ‘mythologies’’, including the subthemes: power in Black motherhood community; ‘mythologies’ of Black communities; ‘mythologies’ of Black motherhood.

Findings

4.1. Demographics

The research sample comprised 17 women, all of whom identified as Black British or Mixed Race, with English as a first language. 14 participants identified with Christianity and the remainder did not identify with any religion. Most participants were 26-34 years of age. Educational attainment ranged from college to postgraduate, with the majority having completed an undergraduate degree. Most participants were employed and married, with 3 co-habiting, and 1 divorced. All 17 participants identified as heterosexual. The demographics table recorded for participants can be seen in Table 2.

All women referred to their experience of being unwell in the postpartum period as ‘postpartum psychosis’, regardless of whether they had received a diagnosis or accessed treatment. In terms of accessing treatment, whether this was through the NHS or privately, or both, 12 women reported having accessed healthcare within their experience of recovery from their postpartum illness. Five women reported having not accessed any professional postpartum mental health support; despite this, all women’s experiences were consistent with postpartum psychosis. Six women had accessed community groups within recovery, some of which had also accessed professional support, with three having not accessed any formal group or healthcare. All women reported having accessed a general hospital at the time of the birth.

All women reported not currently experiencing symptoms of psychosis, with the earliest participant having six months since their experience of postpartum illness, and the latest having 20 years, indicating a breadth of recovery experience. Most participants reported their psychosis experience to have occurred between one and four years prior to the interview date. The contextual and experiential information is in Table 3, where ‘PP’ refers to ‘postpartum psychosis’, and ‘Y’ refers to ‘yes’ and ‘N’ refers to ‘no’. All names used in this study are a pseudonym to protect confidentiality. The time occurred since participants’ postpartum psychosis experience was recorded as at the time of the interview.

Table 2

Demographics table

Demographic		**Frequency**
Ethnicity	Black British African	11
	Black British	2
	Caribbean	4
	Mixed race	
Age	18-25 years	1
	26-34 years	14
	35-44 years	1
	45-54 years	1
First language	English	17
Religion/Spirituality	Christian	14
	None	3
Education	School	
	A-levels/college	3
	Undergraduate	12
	Postgraduate	1
Employment	Yes	15
	No	
	Prefer not to say	2
Sexual orientation	Heterosexual	17
Living situation	Married	13
	Single	0
	Co-habiting	3
	Divorced	1

Table 3

Contextual and experiential information

Pseudonym	**Amara**	**Aurora**	**Emma**	**Izara**	**Jean**	**Jessica**	**Kelly**	**Lorna**	**Megan**	**Nemy**	**Polly**	**Sally**	**Shelly**	**Sophie**	**Tamara**	**Tula**	**Zora**
Accessed NHS services	x			x	x	x		x	x	x	x		x	x	x		x
Accessed private services										x							
Accessed community groups	x		x						x	x	x					x	
Onset of PP since birth	1 month	Birth	Birth	<1 month	Birth	Birth	<1 month	Birth	1 month	<1 month	<1 month	Birth	Birth	Birth	<1 month	Birth	Birth
Duration of PP	1 month	12 months	2 months	12 months	20 years	8 months	5 months	<1 week	3 months	3 months	3 months	12 months	6 months	<1 month	5 months	3 months	4 months
Time since PP	30 months	22 months	18 months	24 months	20 years	36 months	5 years	6 years	18 months	24 months	24 months	6 months	16 months	30 months	36 months	24 months	18 months

4.2 Summary of findings

The group experiential themes and subordinate themes developed can be seen below in Table 4 (see Appendix I for the full table of experiential statements aligning with the group experiential themes and subordinate themes).

Table 4

Group experiential themes, subordinate themes, and experiential statements

Group Experiential Theme	Subordinate Themes
1. 'The debilitating impact of postpartum psychosis on emotions'	1.1 Extreme sadness
	1.2 Terrifying beyond belief
	1. 3 Intense anger
2. 'Disconnect with the external world'	2.1 Disparity between the internal and external
	2.2 Withdrawal is a means of protection
	2.3 Black women are outcasts
3. 'Acceptance is the hardest process'	3.1 Accepting I need help
	3.2 Accepting this diagnosis
4. 'Power in the advocate'	4.1 Significant others are the 'force of hope'
	4.2 Power in self-advocacy
	4.3 Rejection from significant others leads to internalised shame
5. 'Black motherhood as a collective: empowerment vs 'mythologies''	5.1 Power in Black motherhood community
	5.2 'Mythologies' of Black Communities
	5.3 'Mythologies' of Black motherhood

4.2.1 ‘The Debilitating Impact of Postpartum Psychosis on Emotions’

The first group experiential theme, ‘*the debilitating impact of postpartum psychosis on emotions’*, referred to the debilitating emotional impact of enduring such a uniquely severe mental illness within early motherhood. Participants spoke about the terrifying nature of the symptoms, the confusion and emotionally painful experience. This seemed linked to experiencing birth trauma for many, and how the experience of postpartum psychosis became additional trauma. The processes in the room during the interviews suggested an enduring sense of extreme sorrow, intense guilt, and ultimately a sadness and feeling of loss that felt as though it could never be undone. It felt in the room that these women had gone through something unimaginable and unanticipated, and that they had had to grieve and process the impact of this for themselves and for their infants, partners and families.

4.2.1.1 Extreme sadness. There were broad similarities in how participants made sense of the emotional impact of postpartum psychosis, many indicating the experience left them with feelings of deep sorrow, in addition to the intense sudden sadness they felt as part of the original symptoms. Shelly implied the change in her mood and behaviour was part of the alarming and sudden sadness she experienced:

> “*When I began experience that symptoms of postpartum psychosis, after giving birth 16 months ago, I noticed a significant change in my mood, behaviour, and thought… that… um… feeling of extreme sadness and anxiety, I’ve never experienced before”.*

Sally expressed her sadness in the vulnerability, tearfulness and loneliness within her interview: “*…they really abandoned me and like, uhh… you know… they helped me choose* *between the two. Actually, they were there for the abortion and I was not for it".* This felt increasingly exemplified for Sally, when she went on to talk about the longer term impact on her mood, in the context of receiving no support from her family when having her baby:

> *"And then, er, I lost appetite, like completely lost appetite. I even lost appetite for the people around me. I don't see anyone around me and, up till for that lonely life to stay alone, to keep my distance away from people".*

Kelly spoke about the real sense of despair and isolation she experienced, in what felt like overwhelming sadness:

> *"I remember I was in a very dark hole at that time"* and *"…but I was not in a good place mentally. And I think that gave the whole situation a very dark, dark cloud around it, and some sort of misery, and, and lack of happiness in such a time. Yeah".*

The visceral narrative Kelly elicited in her interview created a vivid picture of the sadness that experiencing postpartum psychosis ultimately entails. This was felt throughout many of the interviews, but the researcher noticed differences in how some participants brought their emotions to the room more so than others. In interviews such as Kelly's, the researcher noticed how during the interview they felt the transference of the intense emotion of the participant in their recalling of their traumatic experience. It is important to acknowledge how participants who described their experiences as painful to remember, seemed determined to tell their story, indicating that sharing what has happened and how they have coped to be important for posttraumatic growth (Alio et al., 2023; Edge, 2011; Nakigudde et al., 2013; Pilav et al., 2022; Wyatt et al., 2015).

4.2.1.2 Terrifying Beyond Belief. Tamara indicated how emotionally painful and frightening her experience of postpartum psychosis was:

> *"I started feeling like I can see people in the house. But they… [tearful] okay. They were not actually people from what I know now. But at that moment, I felt like there were people, like three people, walking around in the house, and they want to kill me and my baby… I started feeling the shift… the shift changed from people wanted to kill my baby, I just felt like my husband is the one who wants to kill me and the baby. So I actually started seeing him as a threat".*

Tamara insinuated feelings of guilt and shame for the impact on her husband of her feeling threatened by him:

> *"I felt like I was being a bad person. I was being a bad mother. I was being a bad wife to my husband… It was a difficult time for him. Actually, I feel bad… [cries] Actually feel bad about it [sobs]".*

It feels clear for Tamara, the terrifying impact of postpartum psychosis had long-lasting effects on her emotions, including guilt, shame and anxiety. She spoke further about how the fear for her baby's safety when she was admitted to hospital, and the nurses took him to feed him, had stayed with her: *"Um. When the time that they were taking the baby, it had a bad, bad effect on me".*

Other participants spoke about the emotional pain in literal terms of multiple trauma they experienced and the relationship of this with the development of postpartum psychosis. Lorna described how previous miscarriages impacted her anxiety in pregnancy:

> *"I'd had recurrent miscarriages, so I was very, very anxious in the pregnancy with [name], but I hadn't, I don't think I'd realised how anxious I was. And no medical practitioners picked up on it. Yeah, so I wasn't sleeping, and I wasn't relaxing at all throughout the pregnancy. And I was kind of consuming as much information as I could… I was being… over-prepared really".*

Lorna went on to report how her birth felt traumatic:

"I had a very difficult labour… so my birth plan completely changed then. It went from me hopefully having a nice kind of like unmedicated calm birth in a birthing pool, to needing to have it on the delivery suite, with loads of doctors around, and, um, loads more intervention than I had planned for… And that was really making my anxiety heightened".

Kelly was able to articulate further how she felt her traumatic painful birth led to postpartum psychosis:

> *"I think it was because of the whole trauma and the whole pain, and the whole situation of, um, childbirth, and the pain and whatever it entails. I think that is what caused it [postpartum psychosis]".*

Not all women explicitly described experiencing their birth as traumatic, but all appeared able to knowledge how difficult, painful and life-changing the experience of the birth and of postpartum psychosis was. The researcher noticed how, in many of the interviews, they experienced an embodiment of the intense fear the women had felt, and how this had engulfed the women and their worlds at the time of their experience, and it seemed something they would never forget.

4.2.1.3 Intense Anger. Several women spoke about experiencing intense anger within their symptoms of postpartum psychosis, which many felt was uncharacteristic for them. Some spoke about this with a feeling of disgust, something they felt within themselves, or from others at their angry behaviour. For several participants, it seemed that there was an intense anger represented in their symptoms of postpartum psychosis, that led the researcher to wonder about how this might be an expression of repressed anger and rage, something shared between the women due to likely experience of racial oppression throughout their lives, and that had marginalised and silenced them in some way. It is possible that this anger became ignited when women felt the severe debilitating impact of the psychosis in the context of the medicalised UK healthcare system and white-dominated society that they didn't feel they belonged to, and that wasn't necessarily accessible to them.

Aurora described:

> *"I remember I could get very, very depressive, and very, um, sad, very angry outbursts. And, um, people around me, I almost became repulsive… what is happening to me… My friends tended to keep a distance, because, um, at that time, I became very rude and had very angry outbursts. And, um, I could tell… the distance… so I was angry with them. And then, I could not understand why they, they chose to keep a distance at such a time when I needed them the most".*

The sense of "repulsion" Aurora speaks about implies an internalised sense of disgust and rejection towards their expression of anger, and it appears their experience of perceived rejection from friends only perpetuated these difficult and intense emotions. It seems for Aurora, whilst they could acknowledge their anger caused discomfort for others, they still felt isolated in their illness as a result of their friends distancing from them, which felt understandably perplexing and frustrating.

Kelly also spoke about: *"I could, I could have extreme cases of anger and, I could do tantrums and fits, and everything of that sort. Um… I could lose contact with, um, I could lose contact with reality. I could, I was literally in my own world. So, yeah."* It is possible that for Kelly, she felt a relative disconnect with her anger, and almost refers to it in within a child-like lens through the use of 'tantrums'. There seems to be a consistent theme, where women felt the anger as being uncomfortable or difficult to tolerate. The visceral narrative for the emotion of anger that women used also indicates how, when anger is supressed so individuals can survive in an oppressive world, it seemingly becomes ignited during severe mental illness, where control over emotions must be near impossible.

4.2.2 Disconnect with the External World. The second group experiential theme, *'disconnect with the external world'*, encapsulates how nearly all mothers felt a huge disparity between their own beliefs, perceptions, and experiences of their internal world and the external realities that others appeared or reported believing or living in. This seemed to separate mothers from their families and infants, and significantly isolate them in their postpartum illness. In the disconnection with their external world, all mothers regardless of specific symptoms, socially withdrew from the people close to them and their wider social networks, with many describing how a shutting out of the outside world achieved some sense of safety and means of protection. Finally, this disconnect seemed only further perpetuated for the women of this study due to their race, where many implied an initial disconnect prior to their psychosis. Women described how, being Black meant they felt like 'outcasts' within their wider communities, due to experience of racialised treatment and a lack of Black representation within the healthcare they received, leading to further segregation due to a sense of lacking belonging to their current systems.

4.2.2.1 Disparity between the Internal and External. For many participants, their experience of psychosis seemed a 'vividly real' experience that simply, yet confusingly, did not align with others, including partners, families and various services. Jean indicated how much they believed their baby's father was out to harm their child:

> *"I was beside myself with, umm, nightmares and delusions about him being harmed by his father. And that became quite an obsession, that I thought he was being harmed by his dad, and I would call the police and social services, who'd come in to investigate. And then eventually, they, they worked out that I was ill. So they knew there was no, um, foundation to it".*

Holding a belief that felt distinct from partners and families was also held by Tamara: *"So, after that, er, my sister forcefully [chuckles] took me to the hospital because I couldn't go to hospital. I was saying 'I'm not sick'".*

For others, they felt more of an internal struggle between their thoughts and perceptions of their reality, and that of an objective external reality, as indicated by Shelly: *"I began to have hallucination, and paranoid heavy thoughts, making it challenging to differentiate between reality and my imaginations".* The battle between what was real was also experienced by Lorna:

> *"And within a few hours, I was sort of hallucinating that my husband's head was changing shape… I said, 'what's wrong with your head?' I think it was real.* And then *I sort of stopped myself thinking, no, that can't be right…. So then, there was like, the whole night really, it was a battle between… is what I'm experiencing real, or am I really losing it".*

In contrast, Sophie spoke about how her disparity between her own and others' experiences felt less separate:

> *"So the doctors knew about it, then my husband, I can say he never knew about it. So after I was diagnosed with postpartum, he was confused like, 'what is wrong with my wife', like, 'what is happening?' Then the doctor has told him just calm down it is normal, like something which can be treated, it happens".*

It is important to note that Sophie went on talk about how they found their experience in hospital, the medication, and the normalisation of postpartum psychosis by the doctors, incredibly helpful, leading them to feel fully supported: *"So I can say I felt fully supported."* This experience differed to nearly all other participants, in terms of how they felt postpartum psychosis was normalised within the care they received, and how supported they felt by healthcare providers. This suggests there could be a role in how support is experienced, and how this may influence the level of disconnect participants feel from their internal states to others' external templates, including in relation to experienced racial and social dynamics.

4.2.2.2 Withdrawal is a Means of Protection. All participants spoke about withdrawing socially, often becoming more internalised in their behaviours, spending more time alone, and feeling overwhelmed with being around others or their infants, or with even leaving the house. Sally reported:

> *"It's, sometimes, I felt like… okay. There are so many instances that I couldn't even want to hear the baby cry. I could just close the door and go and leave the baby crying, and just come back and find that maybe the baby had just cried for a long time and fall asleep. Like, uhh… everything about me used to judge me".*

The internalised self-criticism and shame Sally had felt in the context of being abandoned by her family and rejected seemed to lead to withdrawal as a means of coping. This was despite her apparent desperate need for some connection and support:

> *"Uhh… I didn't have a lot of connection from the outside world… I guess, for the many times that I used to sit down and cry out my problems, in that… Sometimes I felt like giving up. Maybe if I could have gotten someone I could share with, maybe it could, it could have been different".*

Aurora spoke similarly about the challenges of wanting support, yet feeling unable to reach out to the people she did have support from:

> *"I also, um, withdrew myself socially from people, I could not stand the sight of people… I could not wait until they could leave… Many times I would just lock the door and um… pretend I'm not in the house… Just… I did not want to see anyone. I did not want to talk to anyone. Yeah… I was actually suffering and I could not even tell any one of them".*

This suggests that participants often felt desperate for support, but whether they have access to this or not, withdrawal becomes a means of coping in a desperately overwhelming and difficult time. Amara described experiencing criticisms from her friends:

> *"I used to feel like I didn't have a baby. I was never really pregnant… maybe they [friends] thought I was pretending. That I didn't want a baby. And so one of them actually said that, if I never wanted to get a baby, I shouldn't like, have had her".*

She then went on to say about the impact this had on her: *"And I felt guilty. And this made me not seek for help immediately".* This further illustrates how support can mediate the emotional responses and need to withdraw for participants within their experience of postpartum psychosis.

4.2.2.3 Black Women are Outcasts. Nearly all participants spoke about feelings of not belonging in the healthcare that they received, whether this was due to feeling barriers to accessing care were disproportionate to them because they were Black, or due to a lack of Black staff members represented within services. Izara spoke about her experience of healthcare: *"Mostly white people… I feel a little bit sad. Because, I hope that Black people should also get the same opportunity as the white people".* This suggests that there is a lack of equity for Black people within accessing standardised healthcare, potentially only perpetuated within the lack of racial and cultural representation, which has been broadly reported in previous literature (Alio et al., 2022; Baiden & Evans, 2021; Pilav et al., 2023). Izara went on to say: *"Because most Black people considered not having money. So, some of they… of the workers there, they will think that when you go there, you will burden them. So,* *they might not end up treating you well. Yeah".* This indicates how, for Izara, as a Black woman, she experienced being a burden within the healthcare system she received care from. It is interesting to note how feeling a burden likely impacts how Black mothers feel they can access care, and how they relate to healthcare providers within their wider communities, and ultimately, the feeling of how they don't belong within their current systems.

Jean spoke explicitly about her experiences around feeling 'outcast', including in response to accessibility to and the treatment of the healthcare she received:

> *"None of it [was accessible]. No, it was the first time in my life, um, apart from when I was very small, when I first came to this country, it was the first time in my life where I really felt like a Black person. They made me feel very Black and very much, foreign. And I just feel that the minute I... shown the psychotic experiences, I was just force fed drugs... My friend who was actually White English, has post, postpartum psychosis... and she's not on, as, er, heavily medicated as me. And we often talk about the discrimination there, how you're more, put on more serious drugs if you're Black, and more heavily medicated".*

Jean's experiences illustrate how the potentially debilitating label of 'psychosis' combined with being Black, meant she was ostracised further in her care and treated differently to her white friend, who potentially also went through postpartum psychosis. This highlights the devastating impact on mothers in systems where they feel they don't belong, not just because of a severe and stigmatised mental illness, but even more so due to their ethnicity. Jean said:

> *"Umm… I think that the whole system is very white and middle class orientated. I think that the idea of motherhood is very white and middle class orientated. That what the perfect baby looks like, what the perfect mum looks like. Yeah, yeah".*

4.2.3 'Acceptance is the Hardest Process'

The third group experiential theme, *'acceptance is the hardest process'* referred to how acceptance of having postpartum psychosis in the context of many women's racialised experiences and systemic adversities, was part of the biggest challenge within recovery. Most women spoke about how accepting that something was wrong, that they may even have a mental health problem, felt like the hardest and certainly the first part of the recovery process. This seemed intertwined within the stigmas around help-seeking for a severe illness such as postpartum psychosis, in addition to how, for many women, the nature of their experience of the illness meant they felt that nothing was actually wrong. Others found acceptance of the diagnosis to be specifically difficult in relation to the multifaceted stigmas surrounding 'psychosis', leading to many describing feelings of shame, embarrassment and confusion, with the majority questioning how this could and had happened to them. These feelings seemed prominent for women that spoke about their diagnosis not fitting with the 'strong Black woman' narrative they felt was endorsed within the healthcare services and wider communities they resided in. Finally, feelings of not being accepted within the context of being Black mothers living in segregated and racialised systems, where they already felt a lack of cohesion and acceptance.

4.2.3.1 'Accepting I Need Help'. Whilst the concept of 'normality' or 'reality' is broadly considered controversial and certainly subjective (Denzin & Lincoln, 2005; Guba & Lincoln, 2005; Willig, 2008), many women found accepting that their beliefs about themselves, others and their current experiences as not shared with others, and that something was wrong with their health, to be particularly challenging. Nemy reported: *"It can… be lasted for about like two months. Before I could actually sit, and like, you know, first before even you can accept that part, you need to accept that you are undergoing these things".* This potentially only further highlights how the lack of available knowledge about postpartum psychosis can further delay help-seeking, due to the unawareness of what symptoms can look like. Izara reported: *"Actually, I thought that it was something that was normal that first, first time mothers, all first time mothers… it was something they all experienced".* This brings light to the lack of available knowledge for mothers about the signs of postpartum psychosis, and how this could potentially be experienced more strongly in marginalised communities many participants identified as being part of.

Tamara described how it felt so confusing when others felt she needed help:

> *"I was very confused because I had never experienced anything like that. I didn't know what was going on in my body. I was, everyone is just, everyone is saying I have a problem, but I don't feel the problem. I didn't even understand what was actually going on".*

This indicates how hard it must have felt for these women to acknowledge and accept needing help, when they did not necessarily identify with being unwell. Izara spoke about how she felt acceptance was hard due to certain expectations she felt were placed on her:

> *"Because it was to me something that was somewhat embarrassing. And I didn't want people to judge me differently. So… I chose to keep it to my past… It was hard because people are judging by when someone looked at me, I'm a Black woman. So…*

> *like, they thought it's something that I was able to like, manage by myself. And I didn't feel really need that… that hospital support. So, I felt like they thought I'm supposed to be that strong person who can… is not supposed to complain about that. Yeah".*

This indicates that the internalisation of the 'Strong Black woman' narrative can be damaging for women, in that it inhibits help-seeking by inducing shame about not being 'strong enough'. How much this narrative is endorsed by Black and white communities, in an overarching dominant white society, is important to question, particularly in the context of each mother's own social and personal experiences of such narratives and stereotypes. Shelly described how these narratives felt internalised for her and impacted her in help-seeking:

> *"Yes, stigma around my mental health, in Black community. In the Black community, mental health issues are often stigmatising… Treatment challenging for me to openly discuss my struggle with my families. And it also affected my decision to seek professional help… Yeah, and seeking help from psychiatry condition can be perceived as a sign of weakness".*

4.2.3.1. Accepting this Diagnosis. Whilst the majority of women indicated it was challenging to accept they needed help, accepting the diagnosis of postpartum psychosis felt like another tremendous chapter to process in their journey of recovery. For some, this felt intertwined with the stigma and shame associated with 'madness' that felt socially imposed upon them. Tamara said:

> *"Although from family members, that's, that's why I felt a bit, it made me feel, umm, like insufficient of a human being. My, my, my husband's side of the family, they used to say I'm, um, I'm a mad woman [cries]… It's not something common that many people have experienced, and they have interacted with [tearful]. So when he actually told them that, er, it was a psychiatry case, if I may say that… for it's, it's a misconception in Africa. They just assume you, you're crazy. And you're, you're mad… It yeah… It kinda took a toll on me".*

Tamara's experiences highlight the severe stigma surrounding postpartum psychosis, and the debilitating impact of this on self-worth for women that internalise shame and guilt around their experiences. It is easy to understand how such a diagnosis could induce such intense and devastating emotional responses in women, one which can inhibit acceptance and progress in recovery. There is also the sense that misconceptions, when embodied collectively across cultures, and subsequently imposed upon the mother by family members, can have a devastating impact on self-esteem. This brings light to how misconceptions are currently maintained in a culturally segregated society, where there is inequity in access to postpartum information and support.

Despite the difficulties and trauma women experienced in their journey of acceptance, there seemed a consensus in the process of acceptance being essential in itself. However, for Jean, receiving multiple diagnoses across their lifespan since their initial experience of postpartum psychosis, meant they could never truly align with and accept healthcare providers' interpretations:

> *"They looked at lots of different diagnoses, and the most consistent one – I mean, at one point, they even said schizophrenia, and then they said, no, you definitely don't*

> *have that. And a lot of Black people get labelled with that. And then, umm, schizoaffective disorder, and again, not what I identify with. They said bipolar, again, bipolar isn't something that I recognise in myself. I definitely recognise PTSD though, and I definitely recog- recognise episodes of psychosis".*

Jean's experience indicates how multiple diagnoses, that don't necessarily align with an individual's understanding of their experiences, can have long lasting harmful effects. It is clear each woman's experience of postpartum psychosis is unique to them, and impacted by many other personal and social factors, but the role diagnosis can play within this seems critical in the recovery process, particularly around the process of acceptance. It also seems that there is a racial factor within diagnosis for participants. Many spoke about feeling 'labelled', as Jean did, because they were 'Black'. This implies that there is an additional layer to experiencing 'psychosis' in the context of mothers' racial and cultural background. For Jean, it seems that multiple diagnoses were given, and she wasn't offered autonomy or choice within their healthcare providers' medicalised interpretations. For Tamara, the negative associations with being given a 'crazy' diagnosis, led to a feeling of rejection and judgement from her own community, potentially perpetuating the long-term impact on self-esteem and how she related to motherhood. Izara reported: *"Izara is running mad.... Somebody who has experienced that cannot be a good parent".* Tamara also implied this rejection of their diagnosis felt sustained within the predominantly white medical system that she ultimately felt they were not accepted in: *"Some of them, will say negative things about me. They say, er, you know, she's Black. So it happens to them anyways. They should [cries], they should go back to their country".*

The researcher noticed how during and subsequent to the interviews, reflecting on how acceptance played a role in participants' experiences ignited many mixed emotions in them, including anger and sadness, and how racialised treatment played such a significant role in the acceptance of an already debilitating illness such as postpartum psychosis. It felt clear that such emotions must be so raw and impactful for these women, effecting how they were able to process their experiences, be accepting of postpartum psychosis, and how they were able to relate to the support they did or did not receive.

4.2.4. ‘Power in the Advocate’

It is clear that for some women, the terrifying and confusing experience of postpartum psychosis really impacted their sense of self, and feelings of shame and anxiety. For others, the experience of having a child felt life-changing, but the impact of postpartum psychosis felt less long-lasting and severe. The fourth group experiential theme is ‘*power in the advocate’*, and refers to the power in participants having a significant other that can support and advocate for them in their recovery. For the majority of participants, this would be in the form of a partner, but for many this included a close friend or family members. There seemed congruence in the notion that having personal, emotional and practical support, aid with accessing help, and feeling heard and their struggles validated, all made a huge difference to their sense of self and improved recovery. Participants that did not have the support of a significant other felt that this had been detrimental to their recovery, and still viewed an advocate as essential. This suggests the significant other, or advocate, has a powerful role in enhancing recovery for mothers, consistent with the literature (Alio et al., 2022; Engqvist & Nilsson, 2013a; Forde et al., 2019; Forde et al., 2020; McGrath et al., 2013; 2015; Nakigudde et al., 2023Plunkett et al., 2016; Wyatt et al., 2015).

4.2.4.1. Significant Others are the ‘Force of Hope’. Significant others seemed to offer a ray of hope in a dark and otherwise unsupported experience for many participants. For instance, Sally mentioned: *"Uhh. He was supportive. And the fact that the family were not supportive, he was the only help I had. The only force, the only hope, our only strength that we have that time".* This felt similar in a sense for Tamara, where she felt she would never have known anything was wrong. She reported:

> *"Because I was just, it was me and my husband. So I was just put in a situation, where if it's a single mother who just gave birth and she's all alone… These symptoms, it's mostly the other person who sees them. You don't really see them yourself because you feel as if you're normal".*

This implies for, in cases where women may hold onto the compelling nature and intensity of their subjective experience, understandably without realising there is a disconnect to others, the time period before being able to understand, accept and access help could be significantly delayed. Whilst most participants in the sample were married, this raises the question of how single mothers may likely face a greater struggle in the initial stages of their recovery.

Other participants conveyed how having an advocate was more important than available information on postpartum psychosis. Nemy described:

> *"Ok, at first when I started experiencing things, um, um… my husband, so I told him and he also had noted it, so we discussed it. He paid for my bed, for me to go to the treatment. So I went to the hospital for two weeks with my tiny baby then after that, I was, we went back home".*

Nemy’s experience potentially suggests that having an assertive advocate that has the financial stability to help fund faster healthcare access, made all the difference to her recovery. This shows the power in a significant other in overcoming multiple challenges that have acted as barriers for most of the other participants. Nemy’s experience also suggests, despite the fact she did not have prior knowledge of postpartum psychosis, this mattered less in the context of having a powerful advocate.

Others spoke about how their advocates instilled hope and positive change through persistence and kindness. Kelly described:

> *“So, um, that friend of mine… She was like, ‘you should come to church tomorrow’. I just laughed it off. And she was so serious about this. She was like, ‘no you have to come to church tomorrow’. I tried to fight my way out of that. She told me ‘I’ll be here in the morning, you should be ready, get the baby ready’. This actually scared me so much. It was the first time in like, five, or more months, I had gone out of the house… So it was very scary… But she came way earlier because she, she didn’t want me to have an excuse to not come to church… And we actually left for church… And I remember, I enjoyed it very much. I was happy the whole time”.*

For Kelly, it appears that having a significant other as an advocate was particularly helpful as their values were aligned; in this instance, their faith and attending church. This indicates the importance of the connection to significant others for mothers, and in circumstances where mothers may be isolated and even racially or culturally marginalised, this could be even more challenging.

4.2.4.2 Power in Self-Advocacy. In contrast to having power through an external advocate or significant other, a minority of participants spoke about power in advocacy through their own personal resources. Lorna said: *"But luckily, because… or unluckily, because I used to work in, as a drug and alcohol counsellor, I had quite a lot of first-hand experience with psychosis… So I was recognising the symptoms".* For Lorna, this meant she was able to secure an assessment with a psychiatrist that enabled her to get the necessary antipsychotics she knew she needed, and this paved the way for her shift in recovery. However, she still reflected:

> *"But, um, yes, it took hours and hours, and hours and hours, and hours. And nobody was listening. And, I think because on reflection, because I was showing insight that I was losing it, they didn't believe me that I was losing it".*

This suggests that self-advocacy holds a power, but can be a double-edged sword within postpartum psychosis, where insight is automatically presumed to be non-existent. For Shelly, it was her own independent action that led to her help seeking: *"I start read through the information and listen to the story of other women's. I started to realise that my experiences aligned with the symptoms of postpartum psychosis".* This suggests that where mothers are able to be a self-advocate for themselves within the recognition of symptoms and help-seeking stages of recovery, this could be broadly helpful. However, the debilitating nature of the illness and the potential lack of personal, social or financial resources many may have, or due to lack of awareness/knowledge, stability, low mood and motivation to seek help, could likely hinder help-seeking for the majority. This is particularly relevant for the mothers in this study that identify as already feeling marginalised, not accepted, and unable to meet the 'strong' cultural expectations placed upon them.

4.2.4.3 Rejection from Significant Others leads to Internalised Shame. For some participants, rejection from those considered to be most important to them, particularly in the context of caregivers and families, but also with partners and infidelity, led to extreme feelings of shame and low self-worth. Sally spoke about:

> *"My family, had really abandoned me. They were not ready to be associated with me, they felt like I was too young… Oh, the feeling of, the feeling like unwanted and unnecessary. Like you're not even enough. You're not worthy before people. Yeah".*

This shows how devastating being rejected by significant others can be for mothers in their recovery from postpartum psychosis. This also indicates how, particularly for young mothers, rejection from family members who had potentially been considered as nurturers, leads to a feeling of being abandoned, internalised shame, and ultimately, or at least for Sally, inhibition of seeking help at all. This brings to light how, for many women, depending on their cultural background and personal values, lack of support from family and communities could be more or less impactful.

4.2.5 'Black Motherhood as a Collective: Empowerment vs 'Mythologies''

The fifth group experiential theme, '*Black motherhood as a collective: empowerment vs 'mythologies'',* in part, referred to the powerful impact that Black community had within recovery for mothers. All participants spoke about the importance of Black community in creating a validating space to feel heard and understood within recovery. For many that had been able to access local community groups, mostly for Black mothers, they had found the shared identity and shared lived experience as essential dual components to feeling secure and safe within support. Cohesion was felt by many to be missing from standard healthcare.

For some, it was going beyond cohesion; it was feeling appreciated and wanted which enabled them to share, reflect on, and process their experiences. Those that didn't have a positive experience of community support, still acknowledged this would have been helpful if this would have been possible. Secondly, participants acknowledged that 'mythologies' of Black women all having communities to hand to help, needs to be challenged as a potential stereotype. Others went onto speak about the power in rejection from their wider predominately white communities due to their race, and how they felt this contributed to marginalising them further in gaining cohesion and safety within their recovery from postpartum psychosis. The researcher noticed how, it seemed that racialised experience is a collective experience for Black mothers and should be acknowledged as such in their recovery from postpartum psychosis.

4.2.5.1 Power in Black Motherhood Community. Most participants spoke about how their real connection with recovery came from attending local community mothers' groups, where all stages of postpartum recovery where discussed, and a validating space provided. Amara described this:

> *"Yeah, I guess this group, it's just our, for, yeah, we, it's mothers', um, mothers' group. So they literally talk about everything that happens, it, er, because of pregnancy, childbirth, and all that. So I joined that group, and we talked about it. Uh.. truly… some of the people that had also experienced the same kind of thing [postpartum psychosis]. So it was really helpful. I, and, I, got support… Uhh… I felt, uh, loved and appreciated and that they, and, and, that they can understand me. And… yeah, I stopped with the feelings of… feeling guilty and shame. Yeah".*

This suggests that cohesion is so important for recovery, and there is something in feeling understood by others, which is crucial for mediating the debilitating shame and guilt that many mothers experienced. This was further emphasised by participants describing how, having shared identity as well as experience in local community motherhood groups to be helpful. For instance, Polly:

> *"Mostly, it was a group whereby it was for only Black British. So, er, we used to feel at home. I used to be like, you know, there is this feeling that comes from your token person, who, who, who… you are in the same ways, and maybe, you know, you are going the same challenges…".*

For Polly, feeling cohesion came from the shared understanding of adversity, not only from postpartum difficulty, but from systemic challenges imposed upon Black mothers within racialised medical systems: *"… The mothers suffer in silence, they don't know who to call, don't know where to find help".* The researcher noted from the interviews, how connection with racial identity appeared crucial for Black mothers within these community groups, in addition to shared experience, in order to feel heard, understood, and valued.

It is clearly demonstrated how important community is for recovery from postpartum psychosis for participants, particularly in validating their experiences of trauma related to postpartum psychosis, acceptance of their experiences, and in reducing the accompanying burden of emotional pain. Megan was able to depict how posttraumatic growth derives from the power in shared identity and experience within community support definitively: *"I've been a voice of hope to them since I passed the same situation".*

4.2.5.2 'Mythologies' of Black Communities. Whilst women broadly spoke about the strength, hope and acceptance they acquired from local community support groups for Black mothers, there were many that did have access to these. Some also spoke about how they felt there is a 'mythology' in dominant society that depicts Black women to have large supportive families and communities, potentially linked to the 'strong narrative', all which seem to be harmful when endorsed within medical systems. Jean described:

> *"And, um, looking at the lack of support, that there's a mythology of a Black community, that's always there to pick people up. And that's a bit of a mythology. And I think that's sometimes why we fall through the net as well, because there's the assumption that that there's this Black community, with your brothers and sisters and friends, girlfriends, who are there to look after you. So that's the mythology. And I'm sure that's the same in Asian, um, communities as well. Yeah".*

This illustrates the powerful detriment to individual Black mothers arising from presumptions of available community support, which are upheld and maintained within dominant healthcare systems and society. Jean also infers that these harmful assumptions could be maintained across cultures and races, suggesting the problem is widely systemic. Furthermore, Jean talks about 'falling through the net', indicating how endorsed racial 'mythologies' can lead to Black mothers becoming completely lost in healthcare systems, which for Jean, had an extreme and devastating long-term impact on her mental health.

Other women spoke about experiencing a concrete racial divide in hospital settings during their recovery from postpartum psychosis, and how this perpetuated feelings of low mood and shame for them. Megan described:

> *"Racism… it was whereby those serving in the hospital, in the healthcare, were not able to attend to me, you… because we don't belong to the same race. Then, about the discrimination, it was because of the social classes, I think. It was me, a lower a class person. And the higher class people. Now, that, they tend to the other people, and leave me behind… It was very embarrassing… I was feeling low... the same time".*

Megan's account suggests classism, in addition to racism, had a harmful impact on their emotions during their treatment. The researcher noted how, it felt that their experience of discrimination was intersectional, with multiple factors playing a role in how they related to how they were treated and received by white healthcare providers and systems.

Other mythologies around Black communities, including stereotypes around Black people generally, were also highlighted by participants: *"They used to talk, well, vulgar language. Looking at you, like, bit suspicious. Yes"* [Megan], and Jean:

> *"Again, I think it's being seen as a Black mother, not seen, being seen, as vulnerable. Yeah, and in a lot of ways, I don't know why I get that feeling, when I was talking to white professionals, there's kind of a fearfulness of, of me, as somebody with mental health problems and being Black female".*

This suggests that stereotypes around Black people being 'threatening' or 'dangerous' by healthcare providers and wider societal systems can be extremely harmful, and can greatly impact Black mothers receiving appropriate and helpful care from services. The researcher noted how both participants mentioned above belonged to distinctively different generational age groups, which inspired reflection around how much has really changed in relation to racism and discrimination across generations, and how this potentially hinders help-seeking and maintains racial segregation for Black mothers of all ages. Aligning with this, Emma reported: *"Because of... I went there [hospital] and there was some discrimination, so… I felt a bit uncomfortable. So it's like they didn't believe what I told them. So they thought I was telling a lie… It was hard".* Emma's story indicates a lack of credibility ascribed to them, in the context of their experience of being discriminated against. This suggests that even where women can feel able to access healthcare, or ask for help, their experiences of not feeling valued can be very difficult within the care they receive.

These accounts surrounding the 'mythologies' of Black communities, and of Black people, clearly have had a harmful effect on several of the Black mothers in this study. Whilst it remains evident that local Black motherhood community groups, if able to be accessed, are incredibly supportive and helpful; there appears a power in the 'myth' of community existing in how services and 'others' relate to these women, influencing the care they receive and how well they can recover from postpartum psychosis.

Divergently, several women spoke about how they feel there are 'mythologies' that are maintained in their own Black communities surrounding postpartum mental health. One example was expressed by Aurora:

> *"Okay. So um, many tend to associate, um, tend to, okay, many Black people tend to associate, um, mental illness and being mentally unstable with, um, okay, people, rich people. People like to say that people who are financially stable, even having some problems, cannot, um, affect it, what you see, some, some diseases are for the rich. Um, they ask why you're getting depressed. Um, depression is for the rich. Postpartum depression and whatever is for the rich, not um, not for your kind. So you need to work hard to, to… you need to work hard, you're only idle, and um, your*

> *idleness is causing you to maybe think that you're mentally unstable to maybe think you're depressed and everything like that. So, yeah".*

4.2.5.3 'Mythologies' of Black Motherhood. Other participants spoke about 'mythologies', or stereotypical narratives surrounding fixed roles required for Black mothers specifically, which many felt were harmful and hindered help-seeking within postpartum psychosis. For instance, Shelly described:

> *"Cultural norms around motherhood, and caregivers, can place immense pressure on Black women to tough it out and prioritise the, the needs their family over their own mental health, delaying or avoiding help-seeking".*

This suggests that such narratives that are sustained across various cultural communities, impacts how Black women relate to help-seeking, particularly in the context of motherhood, where prioritising and privileging the needs of infants, children or families over their own needs, tends to occur. There seems to be a clear impact of such harmful narratives, as identified by Nemy: *"And, then I was feeling guilty. 'Maybe I'm the one with the problem?' So I should accept what people are doing to me. Yes".* These thoughts from participants correspond with prior literature that highlights how stigma around motherhood and mental illness can perpetuate harmful emotions such as guilt and shame, prevent help-seeking, access to treatment and ultimately hinder postpartum recovery (Bondi & Burman, 2001; Dolman et al., 2013; Edwards & Timmons, 2005; Forde et al., 2019; McGrath et al., 2013; Robertson & Lyons, 2003). In terms of how race and cultural difference impacts such stigmatising cultural norms around motherhood, it is easy to see how navigating support must feel impossible for marginalised Black women.

4.3 Overview of Discussion

The following chapter is the discussion chapter, focusing on summarising and discussing the findings, critically relating these to the existing literature, considering the study limitations, the clinical implications for service policy and design and relevant populations, and a section on reflexivity.

Discussion

5.1 Summary of Findings

The findings indicate that the disorientating and distressing elements associated with postpartum psychosis correspond to previous studies, but are all complicated and influenced by participants' experiences of multi-systemic racism and their racially minoritised position. All women reported having experience of severe postpartum difficulty that greatly impacted their lives and included symptoms of postpartum psychosis. Many described the symptoms as: 'hallucinations', 'delusions', 'paranoia', confusion, sudden and intense sadness, anger, extreme fluctuating moods, withdrawal from others, shame, guilt and intense loss, changes in their normal behaviour, and tiredness and insomnia (Burgerhout et al., 2017; Di Florio et al., 2013; Forde et al., 2020; Heron et al., 2008; Nager et al., 2013; NHS England, 2020; Plunkett et al., 2016; Robertson & Lyons, 2003; Sit et al., 2006; Wittkowski et al. 2014). The five that had not accessed services had not received a diagnosis, and their description of the symptoms often felt more centred around the impact on them, comparative to a list of medical terms, such as 'hallucinations' or 'delusions'. The lack of power due to racialised mythologies and narratives endorsed within mothers' treatment experience only intensified their internalisation of rejection, shame, and disconnect associated with the experience and potential diagnosis of 'psychosis' in the postpartum period. The findings largely convey how, for Black mothers, acceptance of their illness, and for many their diagnosis, was an extremely challenging and complex process, worsened by the marginalisation within the white dominant system they resided in. However, the findings indicate that recovery experience was mediated by social support from significant others and community groups, primarily groups where participants shared lived experience and identity norms with members. The findings show that a validating space to feel heard was essential, with strong clinical justification for reformation of healthcare to prevent isolation.

All women describe experiencing severe and debilitating emotional states at the time of postpartum psychosis, and for many with a long lasting impact. The role of accompanying intense emotions such as guilt and shame, to the reported experiences of terror and confusion, where some women felt severely threatened and frightened of others (including partners whom they would otherwise have had incredibly strong positive relationships with), aligns with other findings indicating intense emotions, such as guilt, shame, and fear, are prominent within postpartum psychosis for non-minoritised white women (Burgerhout et al., 2017; Forde et al., 2019; Heron et al., 2012; Nager et al., 2013; Plunkett et al., 2016; Robertson et al., 2005; Wittkowski et al., 2014). Extreme sadness was reported by all women, and the researcher noticed how this was experienced within the visceral narratives of the interviews. The researcher reflected that for many women, despite recalling arguably traumatic experiences, it was important to have their story heard. This seemed particularly the case for women that hadn’t accessed healthcare, and potentially hadn’t experienced feeling heard by professionals. Even for the women that had accessed healthcare, there was still a distinguishable importance to feel heard, particularly as the majority of participants reported they had been discriminated against or not offered an equitable space within their treatment. The need to process, and for many, to grieve the loss of the time where they experienced postpartum psychosis and lost time with their infants and families, seemed essential for participants. This finding aligns with previous studies, which portray how feelings of multiple losses can endure long after the episode of postpartum psychosis for white and non-minoritised mothers (Di Florio et al., 2013; Forde et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003). For marginalised mothers, with hindered access and potentially detrimental healthcare experiences, the current study findings suggest the essential processing of sadness and loss are increasingly delayed. The findings convey the importance of being given such a space within the healthcare provided for mothers to process their experiences of losses.

All women reported a severe disconnect to their external world, which many indicated felt like a disparity between their internal perceptions and interpretations of their feelings, relationships, experiences, and that of others'. This left women feeling isolated in their feelings and experiences, something which seemed to perpetuate the severity of their situations and emotions. Previous literature aligns with this, whereby indicating non-minoritised women with postpartum psychosis experience a separation from 'reality' and confusion (Engqvist et al., 2011; Heron et al., 2012; McGrath et al., 2013; Roberstson & Lyons, 2003). For some, it felt difficult to comprehend how their 'reality' might be different to their partner's, or significant other's. In line with phenomenological thinking, this suggests it is important to consider women's 'realities' as a 'finite subjective experience', where mothers' 'realities' still exist as subjective truth, opposed to their experience being perceived as medically wrong and not 'normal'. Unlike most participants, Sophie was the only mother to feel connected during her experience, potentially due to her understanding of how 'psychosis' felt from healthcare providers. This appears to be a novel finding, highlighting how, if the illness can be normalised for some, this can improve how mothers relate to support and the experience overall, as well as any disparity between their internal templates and the external templates of others. This could suggest that normalisation of the illness, with careful consideration to still validate mothers' experiences, could be helpful for some.

The conceptualisation of acceptance seems a multifaceted, dynamic and a somewhat abstract process for all women to connect with. Most participants speak about how accepting they needed help to be specifically challenging, and a crucial initial step for recovery to commence. Not believing something was wrong seemed the case for many, as indicated by Nemy and Tamara, for example. For others, accepting they needed help was difficult due to the internalised stigmas around having mental illness, which many indicated felt heightened due to the nature of postpartum psychosis specifically. This aligns with previous literature indicating the stigmas surrounding severe mental illness, particularly postpartum psychosis, can be debilitating in the context of motherhood (Dolman et al., 2013; Edwards & Timmons, 2005; Robertson & Lyons, 2003). However, mothers in previous findings report the impact of stigma on emotions such as shame; the current study participants indicate how these stigmas impacted their capacity to reach for help, suggesting there is an increased effect on recovery in the context of marginalisation. Izara's understanding of her experience to be 'normal' for first time mothers, arguably reflects the majority of participants' lack of awareness that postpartum psychosis exists. This supports previous studies with Black postpartum women, which found a significant lack of available information around maternal mental health, and additionally a lack of culturally appropriate postpartum psychological information (Alio et al., 2022; Ling et al., 2023; Watson & Soltani, 2019).

It is clear each woman's experience of postpartum psychosis is unique to them, and impacted by many other personal and social factors; however, diagnosis clearly factors into the recovery process in a highly critical manner, particularly within the process of acceptance. Previous findings do indicate diagnosis to be helpful for some in the right contexts, as it can facilitate understanding of an unknown, confusing and stigmatising condition (Hayne, 2003; Mauthner, 1999). Despite this, where a diagnosis is accompanied without contextual and relevant information, this can increase powerlessness (Robertson & Lyons, 2003). Previous literature suggests the label of a psychotic illness within the context of motherhood can be highly stigmatising (Bondi & Burman, 2001; Forde et al., 2019; Robertson & Lyons, 2003). However, where such studies have focused on white Western mothers only, this fails to account for the racialised stigmas, cultural differences and negative associations with diagnosis that primarily Black individuals can face, and how diagnostic labels such as ‘psychosis’, can have harmful adverse effects on healthcare access and recovery. This has been highlighted by studies illustrating the high rates of Black male admission with diagnoses of schizophrenia, and increased likelihood of admission through adverse pathways including the criminal justice system (Morgan et al., 2005). Several participants described feeling ‘labelled’ with postpartum psychosis because they were ‘Black’, indicating diagnosis did not feel helpful in the context of already feeling racially marginalised. This highlights how experience of diagnosis can differ for Black and white mothers, and how healthcare is separately experienced.

There was broad consensus from participants that they felt a lack of belonging within the healthcare for postpartum psychosis they received, building on the marginalisation many had previously experienced. This felt voiced by nearly all participants, where there was comprehensive agreement of a lack of Black representation across healthcare provision, and many described experiences of racialised treatment towards them. This aligns with previous findings within the synthesis that indicate Black postpartum women experience racialised treatment, whether their experiences related to postpartum psychosis, or other postpartum mental health illnesses (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Pilav et al., 2022; Sheikh & Singsit-Evans, 2020). Many participants felt racialised experiences included medical providers’ assumptions around racial stereotypes, such as Black people having less money. Izara indicated the impact of such assumptions led her to feel like a “burden” within the healthcare system. Others felt providers’ associations of Blackness and lower socioeconomic status (or lower class), led to inferior treatment, particularly in comparison to their white counterparts receiving treatment for postpartum psychosis. Jean articulated explicitly how her 20 years experience of receiving racialised treatment within a white middle class orientated medical system had contributed to her feeling ostracised and outcast, not only as a result of the diagnosis of such a stigmatising and debilitating illness, but for her ethnicity and the associated racialised assumptions surrounding this. Jean was able to name how, comparative to her white friend who had also endured psychosis in the postpartum period, she had experienced more heavily medicated treatment, multiple unhelpful diagnostic labels with little clarity on what this would mean for appropriate treatment, and less validation and support. This aligns with multiple studies within the synthesis, indicating that Black postpartum women, who may experience a range of postpartum mental illness, are treated differently within healthcare for being Black (Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Hoang et al., 2023; Pilav et al., 2022). The current participants' accounts highlight how the added layer of racism and cultural discrimination to such a stigmatising postpartum diagnosis as 'psychosis', arguably more stigmatising than other postpartum mental health diagnoses, experience greater marginalisation and rejection.

The current study findings illustrate how Black mothers typically cannot meet societal idealised assumptions around motherhood, where expectations are racialised, and current healthcare systems are not accepting of Black mothers. The internalisation of the lack of belonging and acceptance within society can be understood in the context of Critical Race Theory (CRT; Delgado & Stefanic, 2023). Arguably, these processes of non-acceptance in the medical system due to race reflect 'interest convergence', and exist to serve the dominant white group. This inevitably maintains unconscious racism and implicit white cultural bias, leading healthcare providers and others within Black mothers' systems to perpetuate systemic and interpersonal racism and broader discrimination within their practice. The view that racism is largely economic in nature, indicates that the medical system and 'public' NHS serves the profits of the dominant and racially privileged white society and hypercapitalist culture arguably present in the UK. The Diagnostic and Statistical Manual of Mental Health (DSM; DSM-5-TR, 2022) derived from male white psychiatrists, without lived experience, indicating a heavily flawed system. A system which, as illustrated by participants, does not offer adequate space for minoritised ethnic groups. The numerous ‘co-production’ initiatives, heavy promotion of ‘diversity’ trainings, and reformation of various Trust values to incorporate ‘equality’ and ‘empowerment’, were not reflected within current participants’ lived experiences. This suggests that recent NHS developments to increase access and representation for minoritised groups has been ineffective. Furthermore, this prompts critical speculation around for whom such initiatives are for, and whether recent reformations only exist to promote a positive image of dominant white society and medical systems. The current study indicates Black mothers are more likely to suffer in their medical treatment for a more severe mental illness, such as postpartum psychosis, than the dominant white group. Feelings of burdensome, rejection, over-medicalisation and detrimental labelling and stereotypical categorising of Black mothers can be explained in the context of interest convergence within the current medical system, which failed to meet the quota for equitable care for current participants.

Building on this, some participants identified from their experiences of care how there are distinct ‘mythologies’ around Black communities and Black motherhood, which many felt were strongly promoted within their experiences and ultimately were extremely harmful. Participants indicated these ‘mythologies’ include Black women having large families, support and communities, and that the maintenance of such narratives within the healthcare they received impacted the quality of their care, where professionals regularly and incorrectly assumed they had appropriate support already. This means that Black mothers are potentially predisposed to not being offered the standard, or at least sufficient healthcare; the same care that is considerably more routinely offered to white mothers with corresponding psychological presentations. The endorsement of Black mythologies within healthcare systems only further serves to segregate minorities due to white cultural bias. As identified by

Jean in the current study, such experiences can lead to Black mothers ultimately being dismissed and lost in the system, a system where is not possible for Black women to meet the criteria for necessary acceptance.

Other harmful mythologies identified in the current study include the broadly evidenced and unfortunately predictably inevitable ‘strong Black woman’ schema (Baiden & Evans, 2021; Conneely et al., 2023; Ling et al., 2023; Pilav et al., 2022; Watson & Soltani, 2019). There is a clear impact of internalised shame identified across participants’ accounts, arguably as a direct result of such consistent narratives which further endorse severe mental diagnosis to be unacceptable for Black women. Several participants discussed seeking help as not aligning with cultural norms around Black motherhood within the Black community; this reflects other studies indicating potentially harmful patriarchal cultural norms maintained within traditional Black culture may contribute towards delayed help-seeking for Black mothers (Adeponle et al., 2017; Nakku et al., 2016). However, for the majority of participants this seems broadly derived from their wider white dominated communities and healthcare systems, where many felt like they didn’t have the right to “complain”, or in reality, seek the essential help they needed, for fear of being perceived as “weak”, which would oppose such cultural and social norms of strength and resilience. This suggests there is a clear failure in the advocation and facilitation of healthcare for Black mothers, where racialised narratives have deterred women in seeking support. This finding reflects the broader maternal mental health findings for this ethnic group endorsed across location and cultural context surrounding help-seeking (Adeponle et al., 2017; Alio et al., 2022; Baiden & Evans, 2021; Conneely et al., 2023; Edge, 2011; Hoang et al., 2023; Ling et al., 2023; Nakku et al., 2016; Pilav et al., 2022; Sheikh & Singsit-Evans, 2020).

Racialised mythologies can be understood in the context of the ‘differential racialisation’ tenant within CRT (Delgado & Stefancic, 2023). The consequences of the way dominant society racialises different minority groups at different times, in response to shifting economic, social or political needs and events, means Black mothers can be potentially positioned in a way that serves the interests of the white oppressive medical system. Misconceptions of Black women being strong, resilient and surrounded by community and family support, means grave implicit assumptions are being made which ultimately affect the opportunity and potential quality of care provided. This highlights that current healthcare systems chronically require redressing. This additionally supports the notion that white cultural bias, whether unconscious or explicit, has become ‘ordinary’ and harmful. In the context of acceptance feeling increasingly challenging for racially marginalised women, it is clear that where there is inequity in access to postpartum information and support for experience of psychosis, recovery remains extremely complex and difficult.

Other participants, such as Tamara, voiced experiencing racialised misconceptions around being the “mad Black lady”, which she felt had been embodied by her own culture, but also within the wider white community she belonged to and that of the white-dominated medical system she received care from. This was reinforced by Izara, who indicated that doctors dismissed her symptoms in the context that “this just happens to them”, ‘them’ meaning ‘Black people’. This implies detrimental stigmatising of being ‘mad’ and of being ‘Black’, reinforces the marginalisation of Black mothers experiencing postpartum psychosis. It is possible that healthcare providers referring to Black mothers with psychosis as an ordinary and expected racial phenomenon, only serves to maintain egregious and othering stereotypes within broader society, and segregates Black and white mothers further within prominent systems such as medical healthcare. This process of understanding ‘psychosis’ as ‘madness’, is documented as historically stigmatising (NICE, 2014; The World Health Organisation, 2019), and the additional layer of interpersonal and systemic racism for current participants, such as Tamara, Izara and Jean in this specific context alone, is only increasingly destabilising within recovery. It is inevitable that Black mothers will consequently have severely redacted hegemonic power in these contexts, with impact on help-seeking and access to treatment. It is arguable these mothers have little control over such power in these environments, where delayed help-seeking cannot be single-handedly attributed to the internalisation of cultural norms and narratives maintained within Black culture; it is the endorsement of explicit racism within healthcare systems which majorly contributes to such outcomes.

For some participants, it appeared mythologies around the “angry Black woman” felt endorsed where professionals elicited fearfulness, as indicated by Jean and Megan. This aligns with narratives that Black women cannot be vulnerable in the context of presumed strength and resilience. According to CRT, differential racialisation of Black women, where they are viewed as ‘angry’ and ‘unreasonable’, means inequity is maintained for women in a system where they can be continuously dismissed and devalued to serve dominant white culture. However, it is important to consider how anger can be perceived as a shameful emotion for women, particularly in the context of power inequalities such as race, gender, or class (Cole & Luna, 2010; Hemmings, 2012; Luna, 2010). Comparative to depression or sadness, anger is seen as more socially unacceptable for women comparative to men, often eliciting unhelpful personality labelling of being ‘difficult’, ‘less competent’, and ultimately less of an empathic response from others (Brescoll & Uhlmann, 2008). This was reflected in Kelly’s experience where she felt rejected from her friends as a result of angry outbursts, which were potentially received as undesirable emotions from others. The notion of rejection experienced by participants for their overwhelming emotions, particularly with anger, aligns with studies indicating pathologisation of emotions generally following the acute symptoms of postpartum psychosis to be increasingly isolating (Robertson & Lyons, 2003). It is possible that within the context of postpartum psychosis, anger due to the isolating confusion about ‘reality’, in addition to the extreme sadness, is increasingly disruptive to recovery comparative to other postpartum mental illness, and more so for Black racially marginalised women.

Several participants explicitly referred to mental health being a “luxury for rich white people”, implying Black people cannot afford the luxury of support due to their ethnic background. This supports CRT tenants on the intersections of Black ethnicity and poverty, where historical oppression of social, educational and economic opportunity means Black people experience various disproportionate disadvantages (Delgado & Stefancic, 2023). Furthermore, Jean’s reflections on Western society’s view of motherhood as white and middle class, illustrates a broad, powerful and systemic issue, that is larger than the healthcare system. These systemic issues can have severely damaging effects on a Black mother’s wellbeing and recovery from maternal illness, potentially perpetuating the disproportionate barriers to accessing help, and additionally impacting their identity as a mother. Even for the minority of current participants which may not have considered their experience of postpartum psychosis or of the birth as traumatic, all felt the experience was undoubtedly life changing in terms of how they related to their identity as a mother. This finding was similar to other research where the process of understanding the experience of postpartum psychosis, and adjusting to and accepting the self, was considered crucial (Frank, 1993; McGrath et al., 2013). Several studies have found there to be harm internalised within traditional ‘perfect mother’ roles, where mothers feel they fail to meet necessary expectations (Lewis & Nicholson, 1998; Robertson & Lyons, 2003). The ‘perfect mother’ concept relates to the current participants’ experiences around identity, not only as a mother, but as a Black mother. Aligning with findings in the synthesis (Adeponle et al., 2017; Baiden & Evans, 2021; Conneely et al., 2023; Ling et al., 2023; Nakku et al., 2016; Pilav et al., 2022), the patriarchal norms around motherhood are arguably internalised further for the current participants. This suggests the current participants' hegemonic power is increasingly reduced due to explicit racism and the patriarchy in the context of 'psychosis' in the postpartum period.

CRT, and the 'intersectionality' framework, proposes how multiple social identities, including, class, gender and race, play a role in the oppression of Black mothers (Delgado & Stefanic, 2023). This means that in Jean's case, her experiences of overarching oppression indicate her experience of recovery from postpartum psychosis was predisposed to be inhibited, due to her various intersectional identities. Examining events and experiences from a particular individual's perspective enables the framing of approaches to be applicable to a broader range of people impacted by injustice, and redacts over-simplification. However, it is crucial to overcome essentialism, where the search for universals means standards of care ultimately fail to address the needs of various sectors in populations. This implies it is important to consider all relevant aspects of intersectional identity when addressing the experiences of Black mothers. However, arguably not all aspects of motherhood as part of broader identity concepts are considered sufficiently within CRT. There needs to be further incorporation of feminist CRT ideas and colloquy when considering the patriarchal oppression of motherhood and how this relates to gender identity norms in the context of race.

Critical Race Feminism (CRF) builds on CRT and draws insights from several foundational Black feminist scholars (Delgado & Jean, 2012; Forde, 2016; Forde & Airhihenbuwa, 2018; Solorzano, 1997; Zamudio et al., 2010). CRF offers a more nuanced explanation for the experiences of Black postpartum women, with greater discussion of how motherhood intersects with other social identities. Similarly to CRT, CRF depicts racism as 'ordinary', or greatly embedded within every-day interactions, social structures and institutional systems, including healthcare. CRF supports the notion that race is a socially constructed label, which racially differentiates various groups in society, creating a hierarchal system which serves the dominant white group. Structural determinism serves as a core principle which highlights how inequities within current policies and services are sustained on a systemic level. CRF additionally draws on feminist bell hook's 'Centring at the margin's theory' (hooks, 2014), which proposes that for any defined group, particularly when considering power, influence and control, there is a centre and a margin, whereby the centre has higher power, influence and control than the margin. This theory indicates that it is the power of exclusion which defines and separates the centre, and it is this which retains the power for the centre; in other words, the dominant white and privileged group. Furthermore, it is the responsibility of the centre to have awareness and to move out of this position. This suggests that, regardless of discussion around the responsibility residing with the margin, or in this case the oppressed Black mothers with postpartum psychosis, to improve their access to support and treatment; it is the responsibility of the larger, more powerful and oppressive white group which controls various systems including healthcare. Aligning with Bell Hook's developments, other tenants to CRF, are that action and commitment is required to eradicate racial inequity, and that counter-narratives must be utilised as a tool to challenge negative stereotypes and schemas. Simultaneously, CRF indicates that privileging the voices of historically marginalised individuals is also crucial. These ideas allow for greater reflection around current participant experience of racialised mythologies and narratives, in the context of social environment and healthcare interaction.

However, the process of becoming a mother is majorly and inevitably affected within the context of 'psychosis'. The negotiation of identity norms in relation to motherhood are required for Black mothers in the context of severe psychological distress, where space must be given to how identity is experienced and impacted within the extremely unique experience of postpartum psychosis. Whilst CRF enables space for thinking about how current healthcare systems oppress Black women in the postpartum period; there is room for expansion on how motherhood relates to various intersectional identities within the dynamic 'reality' shift of 'psychosis'. Arguably, understanding 'psychosis', the associated severe psychological disruption, and how this can be mediated by the constructions of race and racism in not just recovery, but in the development of this illness, requires further discussion and advancement of feminist ideas.

The majority of participants had no prior knowledge of 'psychosis'; they had extremely limited personal and social resources, and all felt this hindered recovery. Despite this, participants were able to comment on how having the support from a relative or partner essentially helped them in the longer-term recovery, aligning with Alio et al. (2022) and the systematic review by Forde et al. (2020). Participants highlight how having someone with aligning values, for instance in Kelly or Auroras' cases, their faith and attending church, were the factors which ultimately helped them overcome the barriers to help they experienced and the intense isolation and withdrawal. This indicates how powerful having an advocate with shared values and cultural background can be for mothers recovering from postpartum psychosis, and how this can mediate a lack of knowledge about the illness, and reduce stigmas around accepting and accessing support as impeding barriers. As a variation of this theme, Lorna, who had support but felt there was a lack of emotional understanding and validation, appeared to embody power by becoming her own self-advocate. However, Lorna was able to reflect on how her occupation offered personal resources in the form of prior knowledge about 'psychosis'. Regardless, Lorna was able to reflect further, and describe how she felt she wasn't listened to or heard in asking for help with a psychiatric assessment. She waited for "hours and hours" for an assessment, leading her to wonder whether "insight" was beneficial in this instance, and whether her race played a role in being taken seriously by predominantly white doctors. In the context of Black mothers experiencing marginalisation from the oppressive dominant white society, having a significant other with shared cultural beliefs and values appears crucial for validation, connectedness and acceptance. This builds on the findings in the existing review on the power of a significant other in recovery from postpartum psychosis for white women in Western settings (Forde et al., 2020). With this in mind, it would still be critical for assumptions about racial stereotypes to not be made in relation to values and cultural norms; for instance, in regards to Black mothers being religious or attending church. The current participants convey mixed adherence to a spiritual faith (in the current study context this was identified as Christianity), indicating spiritual or religious values are not applicable to all Black women and communities, particularly in Western settings where identity is likely more complex due to women potentially identifying with dual cultures. Consequently, negotiation of individual personal values is crucial within healthcare provision and further research exploring identities in the context of race is required.

All participants spoke about the importance of community in creating a validating space to feel heard and understood within recovery. Of those that had been able to access local community groups, mostly for Black mothers, many found the shared identity and shared lived experience as essential dual components to feeling secure and safe within support. This finding is consistent with previous studies which indicate a community approach helpful within the postpartum period for Black mothers (Edge, 2011; Nakigudde et al., 2013); however, contrasts with the finding that Black postpartum mothers preferred mono-ethnic community groups (Edge, 2011). The current findings suggest cohesion and acceptance require connection to identity within community groups for postpartum psychosis specifically. This is particularly the case for those that already feel a lack of connection or acceptance within their current communities and wider systems. This interestingly highlights that shared identity norms within lived experience community groups may be more important for Black mothers with experience of 'psychosis' in the postpartum period, comparative to Black mothers experiencing postpartum 'depression', or other less uniquely severe and arguably detrimental maternal mental illnesses. This could be due to the predominant element of 'reality' change, confusion, and disconnect, within 'psychosis', opposed to alternative features within 'anxiety' or 'depression', where 'reality' is less affected.

Participants' representations indicate the Black motherhood community groups symbolise and advocate interpersonal and multi-systemic power for Black postpartum women. The researcher noticed how personal power and strength felt embodied by participants within the interviews, as they spoke about how their stories had helped other Black mothers who had experienced postpartum psychosis. This aligns with the literature indicating posttraumatic growth to be an extremely helpful part of recovery from postpartum psychosis for white and non-minoritised women, as this promotes resilience and connectedness to others, and offers immense value to those with lived experience in various stages of recovery (Wyatt et al., 2015). Furthermore, posttraumatic growth seems increasingly important for mothers that may feel racially marginalised, where connectedness to others with shared identity and experience is crucial in the context of isolation and rejection due to being Black. This aligns with findings in the synthesis for Black mothers with a range of postpartum mental health difficulty (Alio et al., 2022; Edge, 2011; Nakigudde et al., 2013; Pilav et al., 2022). Those that did not have access to any experience of community support, still acknowledged that this would have been helpful if it were possible. Despite the clear benefits of a community approach, the current findings indicating participants experienced and continue to experience multi-systemic, interpersonal and unconscious racism, suggests community support alone is insufficient to improve recovery for these women. Racism, and its many forms, clearly reduces Black mothers' hegemonic and personal power in their recovery from postpartum psychosis, and arguably more so for women without any community support. The implication is that it is the egregious systems, including medical healthcare and racist narratives, behaviours and culture, which requires immediate redressing for significant change in Black mothers' recovery experiences from postpartum psychosis.

5.2 Critique of Methodology/Design

A key controversial limitation of this study, is that the researcher is a white middle class woman that is not a mother. This is with the aims and the study content in mind: Black mothers' experiences of a severe and debilitating postpartum mental illness (postpartum psychosis), and how their experiences were impacted by implicit and explicit racism within the care received from white-dominated medical systems and the wider communities they belonged to. Arguably, the researcher symbolises the oppressive white dominant group that many participants voiced feeling marginalised by, and which immensely impacted their recovery. This essentially reflects the inequities participants are describing, such as predominantly white healthcare providers and researchers, where there is a lack of shared identity and understanding. The researcher aimed to manage this by maintaining a reflexive journal throughout the process of the study, and being explicit about their own cultural and personal position as a white woman, and their aims and reasons for conducting the study, with the hope this facilitated a safer space for participants to tell their story. However, this issue reflects the broader systemic issue participants describe, and cannot be resolved with reflexive thinking alone.

The researcher made every effort to contact various charities and third sector organisations for postpartum mental health, including organisations which focused on the experiences of minoritised ethnic mothers and families. Unfortunately, only one organisation was able to collaborate with the study, primarily due to lack of resources or capacity. The researcher had initially aimed to co-produce the interview questions and ethical considerations, to enable Black mothers' with lived experience to share their voice in the development of the methodology and study design. However, this was not explicitly possible within the timeframe for data collection and analysis, meaning that essentially, the study was unable to be co-produced. The researcher managed to discuss recruitment ideas within a meeting with their collaborating charity, which included one charity member with lived experience and that identified as Black, meaning there was some input from individuals that reflected the ethnicity and experience of participants. However, potential cultural and personal biases surrounding race and motherhood could have impacted how the researcher phrased the questions, facilitated the interviews, and interpreted the findings. With co-production in mind, the researcher hopes to disseminate the findings to the participants of the study, and utilise the implications highlighted within interviews to disseminate to Black communities and families through word of mouth, maternal mental health conferences, and private and NHS maternal mental health services.

The researcher maintained every effort to openly reflect on their cultural, social and personal position throughout the study and specifically within interviews with participants. However, this doesn't exclude the fact that they represent a lack of diversity, which participants specifically identified as unhelpful in healthcare. It is possible that participants felt this within the interviews, and this potentially impacted their accounts and capacity to feel comfortable and understood. Despite this issue, participants appeared to respond to questions and provide rich and detailed, and ultimately, very personal stories within the interviews, offering much clinical relevance and importance for healthcare policies and future research. This suggests that communicating of cultural position and open reflexivity can help with offering an emotionally safe space for feeling heard for some. The researcher noticed how participants embodied the power in telling their story, particularly for those that identified as feeling marginalised, in the context of being ‘lost’ or ‘not listened to’. This implicates that there needs to be space offered for support and emotional validation despite a lack of cultural and social diversity, but with cultural difference and an individual focus always held in mind.

The researcher noticed how it was extremely difficult to recruit participants in the initial months of data collection. Arguably, this could have been because the researcher did not share potential participants’ ethnicity or any part of their lived experience. The initial stall in recruitment led to amendments of the ethical application, to expand the inclusion criteria from specifically ‘postpartum psychosis’ to ‘postpartum mental health difficulty’, to increase participation. Arguably, creating a broader label for postpartum mental health difficulty within the criteria, enabled participants that potentially felt ostracised and rejected for their diagnosis or symptoms, to feel more able to come forward. This indicates the importance of reflecting on how ‘diagnosis’ is positioned and how diagnostic labels may be experienced. It is possible that the manner of how the inclusion criteria was initially positioned inhibited women reaching out. It is also possible that the women that did reach out and that had not accessed healthcare, would not have been given an official diagnosis of postpartum psychosis had they been formally assessed. This suggests that this study may not reflect the experiences of some Black mothers with a formal psychiatric diagnosis of postpartum psychosis. However, in the interest of reaching mothers that had not accessed care, likely due to the multifaceted complex dynamics surrounding cultural norms, discrimination and racism, and impaired access to and experience of healthcare treatment, the researcher felt it was essential that mothers without a label should be included. The hope was this could increase understanding about why access was impacted for these individuals, and ultimately this informed the implications for this study. This was with the additional view to remove the critical focus from the marginalised individual, and explore what can be changed within current service culture and improve the current statistics for Black women (Anderson et al., 2017; Anderson et al., 2019; Cooper et al., 2007; Edge, 2011; Prady et al., 2013; Prady et al., 2016; Womersley et al., 2021).

One strength of the study is the number of participants that were recruited, and the ‘thick description’ that arose during the interviews (Lincoln & Guba, 1985; Seale, 1999). Whilst some participants did not explicitly share experiences of discrimination in their recovery from postpartum psychosis, the majority did experience this, and those that did offered extremely co-operative, in-depth and iconic narratives and reflections, with clinical relevance and importance, aligning with ‘thick description’ as a potential positive resulting from IPA (Lincoln & Guba, 1985; Seale, 1999). However, it is possible that the sheer number of participants meant there was less capacity for in-depth interpretation and analysis of the findings, and a smaller sample might have been favourable for this methodology, particularly given the limited timeframe. Regardless, IPA has been broadly used with varying approaches and methods, supporting the benefits of variable flexibility around sample size and design, which additionally aligns with the assumption that IPA does not claim to be superior in its stylistic in-depth interpretation of data, similarly to other qualitative analyses. Due to the rich and invaluable description elicited from the findings and substantial clinical and structural implications, this adaption of IPA was arguably appropriate for this study, and it is thus reasonable to presume that ‘thick description’ did evolve from the data and that the amount of participants’ included was helpful.

The sample consisted of participants that identified primarily as Black British, or Mixed Race (Black and White ethnic background). All participants were asked which ethnicity they identified with, and the majority responded with Black British. Most participants reported identifying as either Black African or Black Caribbean within the Black

British category, however, further cultural difference was not explored. Gaining a more in-depth understanding into participants' ethnic background would have been helpful to ascertain cultural differences within participants' experiences. Whilst the study aimed to not 'other' minoritised ethnic women by including a range of ethnic backgrounds, by ignoring the difference in cultural features for Black mothers overall, could potentially be experienced as othering for participants. Future research should aim to explore cultural difference more explicitly to negate potential assumptions and biases around Black culture and avoid othering of this ethnic group within this clinical field.

The majority of the sample of participants were married or co-habiting, meaning only one participant was divorced. There are immense challenges single mothers face, and the statistics indicate prevalence of single motherhood for Black women (Census, 2011). It could have been helpful to explore the impact of this further, although this could have arguably justified a separate study. It is possible that the participants in this study experienced greater support from a significant other than is reflective of this population, meaning the experiences may be considerably variable for women without partners.

There was considerable variance in the recovery timeframe for participants. Arguably, this enabled a richer insight into recovery experience across time for a range of participants, facilitating understanding into the difference in access to help and what delayed help-seeking for this population. However, a greater timeframe could mean that participants were in extremely varied positions in their recovery and this impacted their recollections, and how they related to the experience and the overall impact. Despite this, the commonalities across participants' accounts and the rich description that arose from participants with varying recovery timeframes, indicates that the experience is something that was impactful, and arguably unforgettable, regardless of timeframe since the experience of the positive symptoms of 'psychosis'. Furthermore, the findings indicate that women's experiences of the ‘system’, the associated racialised structures that maintain such systems, and even becoming lost, or dismissed within the system, was far more a prevalent issue, regardless of the timeframe in recovery since the experience. This suggests that exploration of experience of racialised healthcare systems is predominantly important comparative to time since onset of postpartum psychosis or other postpartum mental health difficulty.

The assumption that pharmacological intervention would be the most helpful approach, in connection with existing literature that emphasises the requirement for Mother and Baby Units, remains controversial for minoritised ethnic mothers (Cazas & Glangeaud-Freudenthal, 2004; Connellan et al., 2017; Gillham & Wittowski, 2015; Green et al., 2016; Jones & Smith, 2009; NICE, 2018). However, the fact that participants identified a community based approach as helping them reach a turning point, such as with having an advocate with shared values that helped them re-access their faith (for those that identified with a faith), community and wider social network, which additionally aligns with what has been found helpful for Black mothers within postpartum mental illness recovery more generally (Edge, 2011), suggests that the current standard recommended medical treatment may not be as broadly applicable across ethnic groups as findings typically suggest. The literature which currently informs clinical practice and intervention are based upon Western samples of white, middle class, and educated women that are typically in a financially and practically privileged position to participate in research, meaning that such studies potentially reflect what is helpful for these populations, without consideration of ethnically diverse women in different sociocultural positions. It is possible that facilitating greater access to medical healthcare systems might not be helpful for some Black mothers, in instances where medication is actually unhelpful and might hinder recovery, which several participants indicate. Thus, incorporating understanding of personal and cultural difference within support when offering systemic and medical intervention is vital to providing the most helpful recovery experience for mothers, regardless of the statistics and culturally and socially biased literature and current UK treatment recommendations.

5.3 Clinical Implications

The interview schedule consisted of questions which enquired about participants' thoughts and views around what could be improved within perinatal healthcare, and specifically what could be improved or changed to meet the cultural needs of Black mothers in the postpartum period. The following implications are based upon participants' answers and narratives in response to these questions, and ultimately offer recommendations for reaching equity in recovery from postpartum psychosis for Black mothers.

5.3.1 Increasing Available Education

The first implication identified is improvement of available education around postpartum mental health, including postpartum psychosis. The majority of participants reported having no prior awareness or knowledge of such a severe postpartum mental illness. This meant that, for most participants, the early signs and indicators of them becoming unwell were likely missed or misunderstood. Some participants felt their experience must be 'normal' or typical for first-time mothers. Others felt dismissed by healthcare providers, where they weren't believed or taken seriously, leading them to question their symptoms. Whilst much of these elements were felt and depicted to be racialised experiences; participants' descriptions suggest a lack of awareness of the crucial indicators within the healthcare systems and from the providers they received care from. Improved training for healthcare providers is essential, and whilst recent literature and systematic reviews on recovery experience from postpartum psychosis do highlight the importance of this, alongside incorporating social context and systemic factors within formulation (Beck, 2022; Dolman et al., 2013; Doucet et al., 2012; Forde et al., 2020; Heron et al., 2012; McGrath et al., 2013; Roxburgh et al., 2022), there is clearly a dearth of knowledge and training for clinicians in current healthcare systems about postpartum psychosis specifically, and this is an on-going systemic issue.

Many participants indicated education around postpartum psychosis and maternal mental health generally needs to be more readily available in society, potentially starting in school for students. This is arguably justifiable give the statistics for the proportion of women impacted by postpartum psychosis (Howard, 2014; Jones et al., 2014; Royal College of Psychiatrists, 2023; Vanderkruik et al., 2017), regardless of the large quantity affected by postpartum depression and other perinatal mental health difficulties (Maternal Mental Health Alliance (MMHA), 2023). Improvement in wider educational systems would mean a wider population of people could be more aware of postpartum illness, recognise the dangerous signs of health deterioration, and have a greater understanding about the support available. This could ultimately reduce the risk of mothers becoming so unwell, improve recovery and negate the devastating impact on the individual, infant and family members or significant others.

Besides the symptomology of postpartum psychosis, participants indicated how cultural difference needs to be more holistically incorporated into education in schools and in healthcare provider trainings, with specific reference to the devastating statistics on maternal health outcomes for Black mothers and infants (Anderson et al., 2017; Anderson et al., 2019; Edge, 2011; Prady et al., 2013; Prady et al., 2016; Womersley et al., 2021). Participants (Lorna and Jean) reported that they felt conscious that they were more likely to die in hospital giving birth comparative to their white counterparts; yet felt no real acknowledgement of the greater risk they faced within their care comparative to their white counterparts. This indicates that, even before Black mothers are required to navigate difficult healthcare relationships and even racism within their postpartum care, they are already discriminated against. Participants reported greater education on the statistical outcomes for Black mothers is essential for healthcare providers in a range of professional modalities. Participants felt that all professionals within their care should have awareness of the risks they faced and the literature. Participants identified that there are no Black people in the literature, no images, no written experiential stories, and no applicability to their ethnic background, which only further negates the possibility of cohesion and validation. Provision of standardised information around the risks and outcomes associated with postpartum psychosis and being Black, feels reasonably achievable to offer within trainings, and participants insinuated hope that this might encourage clinicians to be more perceptive and open to symptoms and the associated socioeconomic and ethnicity-related risks. However, such information is only recently emerging as generically visible to mothers, and arguably this visibility is not sufficient, particularly for minoritised mothers which are directly affected.

Whilst postpartum psychosis is considerably less common as a postpartum mental illness, participants reported that the devastating outcome and systemic impact needs to be prioritised over the presumption that postpartum psychosis is ‘unlikely to happen’. Participants strongly voiced the need for healthcare practitioners to inform all mothers of the risks, and increased risks where necessary and applicable, for Black women. Participants acknowledged that whilst this information about the risks and symptomology of postpartum psychosis could understandably be frightening for some mothers, the consequences and impact is far worse, indicating a vital need for consistent provision of this information. Participants described the importance of including information around the routes to recovery, what treatments were available, and how to practically access these. This suggests that there is a crucial need for clear pathways around how to access medical treatment, including psychiatric assessment, psychological therapy, community groups, and availability of appropriate services relevant to location. Participants broadly indicated the need for earlier provision of information within their journey of motherhood, starting in the prenatal period, or at least during antenatal classes. Earlier provision of such information would mean greater time for participants to process the risks and outcomes, as well as what treatment would be available to them, ultimately improving treatment access and recovery experience. More widespread information provision about postpartum psychosis and the support available could help normalise the experience and in receiving such a diagnosis. Furthermore, this could help challenge the associated stigmas around postpartum psychosis.

Participants described the importance of providing postpartum education around postpartum psychosis for Black families and communities. This feels particularly relevant where participants identified feeling ostracised due to their race. The lack of trust towards healthcare providers and subsequent segregation and marginalisation many participants described, could be reduced with culturally sensitive and psychologically helpful information that connects Black mothers and communities to available healthcare. Participants spoke about the importance of utilising social media platforms within relevant Black motherhood groups, and clinicians/researchers/advocates attending such groups in person to provide information. Many participants described hearing about community groups through friends or family members, indicating that information could be subsequently passed on from the original group attendees. Increasing access to education feels imperative for Black mothers, as reaching equity can only feel possible with necessary relevant information provision.

5.3.2 Challenging Racial and Social Discrimination in Healthcare

The second implication identified is to challenge racial discrimination within healthcare. Participants voiced that this could be implemented by greater representation of Black individuals, communication of being an ally from white groups within healthcare, making transport to healthcare affordable, and actively challenging stigma through advocating different narratives around equity. Participants felt that the narrative around mental health and mental health treatment is that they don’t belong to such systems, which prioritise and privilege white and socioeconomically advantaged people. Improving opportunity for diversity and minoritised ethnic representation could help challenge these concepts that feel endorsed by the dominant system. Participants voiced this would be helpful across professional modalities, offering a message that racially and socially oppressed people are recognised for their worth and abilities. There is yearly increase in representation of minoritised ethnic groups in across professional modalities within the NHS (NHS Workforce Race Equality Standard Report, 2022); however, meeting a necessary sociodemographic quota (which is arguably still not equitable and remains oppressive for racially minoritised groups) across organisations is not enough in changing the narrative, although it is a start. Consequentially, current policies’ attempts to be more representative clearly requires on-going review and constructive critique so that it does not merely become performative. Increased fostering of further connections, dialogue and partnerships between ‘bottom up’ community movements and mainstream services, in addition to ‘top down’ policy interventions is required to bridge the understandable lack of trust and convince Black mothers that they will be heard, understood, supported, and appreciated.

The communication of being an ally was deemed crucial by several participants, who identified this is particularly important in rural locations where there is less diversity and arguably higher levels of unconscious racism and lack of cultural competency across systems. Regardless of lower levels of diversity, Lorna argued that she still felt there was inadequate Black representation within her healthcare that still did not reflect the lower levels of diversity where she lived. This suggests that despite an increase in overall representation across the NHS and private organisations, this still may not be accurately reflected across sociodemographic locations in the UK. Consequentially, communication of being an ally could help challenge the lack of equitable representation, at least in the interim for such processes to be facilitated. Participants argued that healthcare provider communication of social and cultural position, knowledge of the statistical risks and inequities Black mothers face, and cultivation of cultural and personal difference (coming from a non-expert position), could help improve healthcare provider and service user relationships and build trust and connection. This is particularly relevant for clinicians facilitating longer-term therapeutic interventions for mothers recovering for postpartum psychosis. Whether clinicians communicated this explicitly to participants in the current study, was largely controversial, indicating how communication of allyship is facilitated likely lies within the clinical judgement of the healthcare provider and the nature of their relationship with the service user/mother. Other means of communicating allyship that participants communicated, could be practically, such as with posters in offices/clinics or badges on clinicians' clothing. This suggests that even simple practical changes in how clinicians present in the clinical room could have a strong impact on the therapeutic alliance, and how this makes a positive difference to treatment experience across professional modalities. However, it is arguably easier to facilitate advocacy of equity in regards to communication of being an ally, for therapists, who typically reside in less fast-paced and chaotic environments, comparative to medical teams in hospitals and Mother and Baby Units, where there is significant pressure to make quick clinical decisions around rapid health deterioration and high risk. This highlights that there needs to be a culture shift in communication of equity across teams and services, likely coming from managers and other high-up professionals in power, thus utilising a top-down approach required within services and teams more broadly, stakeholders, and policy makers. This further implicates the issue of a lack of visibility of ethnic diversity, or of women that represent minoritised ethnic backgrounds within leadership roles, and how this matter ultimately comprises a certain message which infiltrates throughout current healthcare systems to the lower levels of professionals.

Participants identified the importance of the alignment of values with significant others', synchronous with previous studies that indicate a community-based approach, which incorporates cultural and personal values to treatment, to be broadly helpful (Baiden & Evans, 2021; Declercq et al., 2021; Edge, 2011; Watson & Soltani, 2019). Clinicians would need to be aware of this evidence and the importance of incorporating cultural and personal values to mothers' support packages. It would be important for clinicians to not make assumptions about these aspects, based on little knowledge or racialised stereotypes, or this could essentially be detrimental to treatment. Additionally, facilitation of various cultural identity tools or measures might be one way of addressing this in a standardised fashion. Ultimately, adhering to an open, flexible and compassionate approach whilst being curious about individuals' personal and cultural experiences and what could be helpful is important. Furthermore, such an approach could positively reduce the inevitable power imbalance between healthcare providers and service users, and hopefully empower the mother and family.

Challenging stereotypical narratives and racism feels more difficult to explicitly manage. Whilst further training on implicit and explicit racism, intersectional discrimination, and the impact of this, feels imperative; it is arguably harder to implement on the floor, with personal factors, biases and assumptions widely dependent on the individual healthcare provider and team culture. Various literature identifies how organisational defences, that can easily manifest in NHS services where there is a high level of stress, clinical and social difficulty, and complex trauma, can mean there is a culture of resistance (Lowe, 2018). Even if access to healthcare is improved, discrimination is difficult to challenge on an individualistic basis. However, findings that suggest a top-down approach for managing workplace challenges and stressors, staff burnout and mental illness, and lack of funding and resources, could help begin to challenge the broader systemic issues within services. It could be helpful for team managers to consider the service and smaller team culture, and what needs to be changed to improve equity and empower minoritised ethnic service users, including Black mothers, with the psychological and systemic needs of staff in mind.

5.3.3 Dissemination of Shared Lived Experience and Identities

The third implication identified is the importance of sharing lived experience of postpartum psychosis within communities, including Black mothers and their closer systems, to improve connection with a shared identity. Additionally, disseminating information and the research to marginalised communities, medical healthcare systems and policy makers is crucial. All participants reported the need for mothers with experience or diagnoses of postpartum psychosis to share their stories. Some participants felt this was essential whether mothers' stories were positive or negative, to enhance understanding and promote positivity and hope in recovery. Aligning with posttraumatic growth implicating great benefits for the individual and wider group (Alio et al., 2023; Edge, 2011; Nakigudde et al., 2013; Pilav et al., 2022; Wyatt et al., 2015), this suggests that sharing to help others in their process of recovery is vital in recovery from postpartum psychosis for minoritised ethnic women. Some participants spoke about mothers facilitating this through the use of social media platforms, to reach a greater number of people. In the context of participants experiencing marginalisation due to their race, class or financial situation, shared identity was also felt to be important, specifically regarding ethnic background. Participants considered cultural difference in beliefs, lifestyle, values and faith to be significant, as well as the mutual understanding of the risks, discrimination and difference that can accompany being Black in a segregated and ostracised community and society for many. Promoting increased awareness and access to

Black motherhood community groups is therefore important, with participants' accounts of the benefits of such groups and the existing literature providing a substantial evidence base to support this (Baiden & Evans, 2021; Declercq et al., 2021; Edge, 2011; Watson & Soltani, 2019). The hope is this would promote the essential experience of validation of mothers' experiences of postpartum psychosis, helping them process the inevitable loss and debilitating emotions that can hinder recovery (Di Florio et al., 2013; Forde et al., 2019; Heron et al., 2012; Robertson & Lyons, 2003), and lead them to feel appreciated and accepted in the context of racial marginalisation.

Challenging the stigmas associated with motherhood and particularly with being Black in relation to help-seeking as a mother, is vital for recovery. Participants indicated the importance of disseminating the research around postpartum psychosis to marginalised communities and specifically Black motherhood community groups. This was with the hope to provide information about clear pathways to support and treatment, and education around the symptoms and available appropriate intervention. Additionally, participants felt promoting understanding of studies on what has been found to be helpful, i.e., the role of significant others as advocates, and a community based approach, could normalise mothers' experiences. However, it would be important to consolidate the severe and potentially devastating impact of postpartum psychosis and also offer choice in their treatment. Interestingly, several participants voiced how they feel that 'discrimination' is incorrect with reference to the endorsed cultural norms around Black motherhood that feel maintained within Black communities, such as around help-seeking and psychiatric care being for the white privileged. Participants described how it is a lack of awareness, due to lack of available information and inaccessibility to services. Whist this unanticipated finding does not align with the research aim, and was hence not included in the findings, the reasons behind this suggestion from participants indicates it is inherent to consider within the context of the implications, further supporting the use of appropriate language when disseminating information to help support Black communities, where cultural norms must be considered compassionately within facilitation of information.

This aligns with CRT argument, indicating that racialised segregation can mean it is impossible for Black mothers to access the necessary information and support (Delgado & Stefanic, 2023). The hope is that increased dissemination of the research that is directly applicable for Black mothers and families, could help to challenge some of these stigmas surrounding postpartum psychosis. This could also bridge the gap between what is available and helpful for white and for Black mothers and families, increasing equity within healthcare by improving Black representation.

Participants felt that it was crucial to disseminate the research to various healthcare organisations and policy makers, to inform those with the overarching power to change and improve service design and structure about cultural difference, and on-going racism and discrimination, which severely inhibits access for many Black mothers. Ideally, offering space for mothers with lived experience to share their stories directly would empower those which have felt silenced for so long, and likely be the greatest form of inspiration for others which have experienced marginalisation to speak out and to access help. Increasing the amount of experts by experience individuals within healthcare systems to inform service design is important. Critically, there needs to be a shift in how experts by experience are embedded and utilised within healthcare services to inform service design, opposed to serving dominant white power (Flinders et al., 2016; Thomas-Hughes, 2018). Just meeting the quota for including lived experience is not enough; there needs to be substantial change in how co-production is facilitated for the benefit of minoritised ethnic groups, with culturally, racially and socially diverse input cultivating real change.

5.4 Self-Reflexivity

I have noticed how my position has been variably influenced throughout the process of this study. The difficulties in initial recruitment highlighted for me the barriers to connecting with people that may feel racially marginalised, and how my own cultural, racial and social position may have impacted this. This primarily ignited feelings of guilt around my own white privilege, and how I represent the oppressive dominant white society. I found myself reflecting upon my own personal motivations for the study, and what I hoped to achieve with the potential clinical implications. My initial literature review and experience of working within perinatal mental health services is what led to my interest and passion for challenging healthcare inequities in the postpartum field. At times, I felt I should not be investigating the experiences of Black mothers, without any shared lived experience of postpartum psychosis, motherhood, or identification as a Black woman. The experience of challenges within initial data collection felt reinforcing of such feelings. I started to think about ‘white guilt’ and how this potentially was playing out, and how much of this was systemic, or my own personal feelings and beliefs influencing the processes at play in the interviews and throughout the study procedure. Whilst this initially all felt relatively disheartening, I found taking such feelings to supervision was helpful, as I noticed there was something about naming things explicitly that felt important in order to proceed.

As I progressed with data collection, and had the privilege of hearing women’s stories, some of which were considerably traumatic, I noticed how I began to embody a sense of responsibility for being part of a shift in research that empowers marginalised women. I noticed how, I often felt very angry or very sad at the end of interviews, where I noticed my own embodiment of the countertransference within the interviews; women were often very sad or angry when communicating their stories. Women that elicited compassion despite experiences of racism; I noticed felt particularly difficult to receive, with the inequity experienced by the women of this study feeling intensely visceral. This left me sincerely hoping that my interpretations of the findings would adequately encapsulate women’s accounts. At times, I noticed discomfort within the interviews, and an awareness of the difference which separated me from the women. This was in addition to, what I experienced as, an uncomfortably significant power imbalance. This led me to reflect how this discomfort must be broadly experienced by these women, throughout their lives, regardless of the debilitating experience of postpartum psychosis. The power that came from women’s stories felt imperative to be shared for equity to be addressed and women’s voices to be heard. I noted how change can feel overwhelmingly challenging to implement, and how my cultural and personal position could impact how the study is helpfully disseminated and received by others. This led me to think about what ‘allyship’ may actually mean, and how whilst I was seeking to embody this, I had to recognise this is not something I could self-assign. My hope is that the kindness and authenticity that transpired throughout women’s accounts will increase dissemination of these findings, thus facilitating power for this group. Furthermore, I hoped that dissemination of the findings would provide a platform to be heard systemically for the women that participated, rather than highlight academic achievement for my position as a researcher and clinician.

I thought about how during interviews, reflecting on the concept of ‘acceptance’, whether this was within women’s experiences, their diagnosis, or within their communities and systems, felt challenging. Reflecting on how racialised treatment and, ultimately, various forms of racism, significantly impacted the process of acceptance, led me to think about how women’s experiences still felt extremely raw and debilitating, with a long-lasting effect. I realised I essentially felt angry about the racial discrimination and marginalisation these women had experienced, and I wanted to make a difference where possible.

I reflected how my perception of qualitative and collaborative research has evolved since I started the study, and how there is a need to be flexible within research aims and objectives, which can inevitably evolve from the data. The importance of collaboration with women with lived experience, was also highlight for me throughout the process of the study. I learnt to acknowledge how collaboration, and essentially co-production, is understandably difficult given the cultural and racial dynamics that play a complex multifaceted role in this research, and with the time and practical constraints I had to work with. Moving forward, I hope to utilise clinical judgement and my experience of the interviews to managing potential discomfort around difference and marginalisation when working with minoritised groups, whether this is within clinical or research-based work. I hope to be able to work with lesser time constraints in the future, so as to increase working collaboratively, and with hopefully an increased chance of co-production.

Reflecting on my own personal and cultural position as the researcher, additionally led me to reflect on the concept of ‘neutrality’, and think about phenomenology in relation to this research, and how it felt so important to acknowledge the impossibility of neutrality within this study, where race and cultural background felt so prominent to the themes and research aims. This experience of adhering to an interrogative interpretative phenomenological analysis, opposed to descriptive, enabled me to feel sure this was the most helpful approach for the analysis within this study, and potentially for future similar research moving forward. I was left wondering, however, if some level of bracketing did occur; for instance, whether I automatically bracketed myself out due to the colour of my skin and relating to myself as racially privileged. I now feel that bracketing is not truly discrete, and there is some overlap when working with people and interpreting relational processes and interactions as to how interpretive one can be, and how much personal factors can be separated.

Within my literature review and synthesis, I made a choice within which elements to focus on with my research aims in mind. There was a significant scarcity of studies exploring Black mothers' experiences of postpartum psychosis specifically, which meant I had to expand my inclusion criteria and examine studies which included Black mothers' experiences of postpartum mental health difficulty more broadly. Some of these studies included women which had endured psychosis of some nature within the postpartum period, but it was not always clear which participant, from which identified ethnic background, had gone through which particular mental health experience, and whether this was diagnosed or self-reported. This meant that it was challenging to ultimately infer how much of the difficulties reported from such studies could be attributed to Black women specifically. This could arguably mean an element of othering was involved within interpretation of experience from minoritised mothers generally within postpartum psychosis. I was left wondering whether I should have chosen to focus primarily on mothers' experiences of postpartum psychosis specifically, with the gap in the literature around Black mothers' experiences, and other minoritised ethnic mothers and groups' experiences, as a highlighting factor to pursue my current research. However, I felt that due to the focus of my research being on Black mothers' experiences in relation to race, racism and discrimination, focusing on postpartum psychosis studies in solidarity would have ultimately excluded the prior findings that Black women have reported around their experience of marginalisation in relation to postpartum mental health. Nonetheless, pursuing this alternative route for the synthesis could have offered different findings and influenced my research aims accordingly. It would be interesting to discover whether this separate approach to the method would implicate my current findings.

I noticed how my experience of facilitating therapeutic intervention as a psychologist in training felt helpful during interviews. I reflected it was important to remain conscious of the emotions and feelings elicited in the countertransference during interviews. I felt aware that I felt a need to reassure and help the women that participated, yet that my role as the interviewer was to not provide therapeutic support. At times, it felt difficult to not implement therapeutic elements, such as with summarising or paraphrasing participants' responses, particularly in the context of being subject to such personal and incredible stories. I felt utilising psychological curiosity to be helpful in encouraging women to expand in their answers, and empathy and unconditional regard in offering something of an emotionally safe space with women that I had never met before; at times it felt controversial, the concept of an 'emotionally safe' place, and whether this could be truly facilitated in this context, whereby an element of bravery would always be necessary. Meeting with women where there was no initial contact and no service referral often felt challenging, as I had no prior indication of risk or of current social context for the women participating. I found that signposting to services and charities, with relevant recommendations for support and managing social and emotional difficulty, left me feeling a sense of failure towards the women, in relation to the limits of what I could helpfully offer as a means of support. Similarly to when concluding therapeutic relationships, this left me with a feeling of a sudden disconnect and discomfort. This led me to reflect on the nature of conducting research, including data collection and interpretation, and the power imbalance as a researcher when exploring complex trauma and discrimination with individuals with lived experience. I found that regular supervision and consistent reflection helped me to process these types of difficulties that arose, and that maintaining ethical boundaries as required facilitated a sense of containment around the emotional responses and nature of interviews.

5.5 Conclusion

This study's findings indicate that the internalisation of harmful racist and discriminative narratives around Black motherhood severely debilitate help-seeking, access to treatment and the systemic experience of recovery from postpartum psychosis for Black mothers. Participants' accounts build on the existing literature that conveys how a lack of trust and facilitation of a cohesive and validating space within current healthcare systems maintains racial segregation and inhibits access for racially minoritised groups. It is essential that greater representation of Black people across healthcare professions and within co-production is implemented, and that the culture of how co-production is facilitated and enables change is challenged and reformed. Dissemination of the research which includes Black mothers' lived experiences to Black and the overarching white communities and systems is required for equitable change. Improving access to education is needed for healthcare professionals and for mothers, to improve understanding and clinician accountability of the existing risks within maternal outcomes that Black mothers face. It is essential that cultural difference is incorporated into intervention, with consideration of community groups and approaches to care, for the relationships between healthcare providers and systems, and Black mothers, families and communities, to be improved. These implications are necessary to challenge the complex stigmas surrounding postpartum psychosis that are inherently experienced by Black mothers within the context of racial marginalisation.

References

Adeponle, A., Groleau, D., Kola, L., Kirmayer, L., & Gureje, O. (2017). Perinatal depression in Nigeria: perspectives of women, family caregivers and healthcare providers. *International Journal of Mental Health Systems*, *11*(27). https://doi.org/10.1186/s13033-017-0134-6

Alhusen, J. L., Alvarez, C. (2016). Perinatal depression: a clinical update. *Nurse Practitioners. 41,* 50-55. https://doi/10.1097/01.NPR.0000480589.09290.3e.

Alio, A. P., Dillion, T., Hartman, S., Johnson, T., Turner, S., Bullock, S., & Dozier, A. (2022). A community collaborative for the exploration of local factors affecting Black mother's experience within perinatal care. *Maternal and Child Health Journal*, *26*, 751-760. https://doi.org/10.1007/s10995-022-03422-5

Ajzen, I., (1991). The theory of planned behaviour. *Organisational Behaviour and Human Decision Processes*, *50*(2), 179-211. https://doi.org/10.1016/0749-5978(91)90020-T

American Academy of Paediatrics. (2014). Many parents don't follow safe infant sleep practices. Retrieved from https://www.healthychildren.org/English/news/Pages/Many-Parents-Don't-Follow-Safe-Infant-Sleep-Practices.aspx

Anderson, F. M., Hatch, S. L., Comacchio, C., & Howard, L. M. (2017). Prevalence and risk of mental disorders in the perinatal period among migrant women: a systematic review and meta-analysis. *Archives of Women's Mental Health, 20*(3), 449-462. https://doi.org/10.1007/s00737-017-0723-z

Anderson, F. M., Hatch, S. L., Ryan, E., Trevillion, K., & Howard, L. (2019). Impact of insecure immigration status and ethnicity on antenatal mental health among migrant women. *Journal of Clinical Psychiatry*, *80*(5).

Baiden, D., & Evans, M. (2021). Black African newcomer women’s perception of postpartum mental health services in Canada. *Canadian Journal of Nursing Research*, *53*(3), 202-210. https://DOI:10.1177/0844562120934273

Beck, C. T. (2002). Postpartum depression: a metasynthesis. *Qualitative Health Research*, *12*(4), 453-472. https://doi.org/10.1177/104973202129120016

Beck, C. T. (2021). Perinatal mood and anxiety disorders: Research and implications for nursing care. *Nursing for Women’s Health, 25*(4). https://doi.org/10.1016/j.nwh.2021.02.003

Bergink, V., Burgerhout, K. M., Koorengevel, K. M., Kamperman, A. M., Hoogendijk, W. J., Lambregtse-van den Berg, M. P., & Kushner, S. A. (2015). Treatment of psychosis and mania in the postpartum period. *American Journal of Psychiatry, 172*, 115–123. https://doi.org/10.1176/appi.ajp.2014.13121652

Bowlby, J. (1969). *Attachment and loss. Volume 1. Attachment.* London: The Hogarth Press and Institute of Psychoanalysis.

Bolton, L. B., Giger, J. N., & Georges, C. A. (2003). Eliminating structural and racial barriers: A plausible solution to eliminating health disparities. *Journal of National Black Nurses Association*, *14*(1), 57-65. https://doi.org/10.1891/0739-6686.22.1.39

Bondi, L., & Burman, E. (2001). Women and mental health: a feminist review. *Feminist Review, 68,* (1), 6-33. https://doi.org/10.1080/01417780122133

Brescoll, V. L., & Uhlmann, E. L. (2008). Can an angry woman get ahead? Status conferral, gender, and expression of emotion in the workplace. *Journal of Indexing & Metrics, 19*(3), https://doi.org/10.1111/j.1467-9280.2008.02079.x

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., Pill, R. (2002). Using meta-ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research & Policy*, *7*(4). https://doi.org/10.1258/135581902320432732

Broussard, D. L., Sappenfield, W. M., & Goodman, D. A. (2012). The Black and White of infant back sleeping and infant bed sharing in Florida, 2004-2005. *Maternal Child Health Journal, 16*(3), 713-724. https://doi.org/10.1007/s10995-011-0768-y

Burgerhout, K. M., Kamperman, A. M., Roza, S. J., Lambregtse-Van den Berg, M. P., Koorengevel, K. M., Hoogendijk, W. J. G., Kushner, S. A., & Bergink, V. (2017). Functional recovery after postpartum psychosis: a prospective longitudinal study. *Journal of Clinical Psychiatry 78*(1), 122–128. https://doi.org/10.4088/JCP.15m10204

National Collaborating Centre for Methods and Tools (2011). Critical appraisal tools to make sense of evidence. Hamilton, ON: McMaster University. (Updated 18 September,

2017) Retrieved from http://www.nccmt.ca/resources/search/87

Cazas, O., & Glangeaud-Freudenthal, N.M-C. (2004). The history of mother-baby units (MBUs) in France and Belgium and of the French version of the Marcé checklist. *Archives of Women's Mental Health, 7*(1), 53-8. https://doi.org/10.1007/s00737-003-0046-0

Census. (2024, March 26). Families and households – GOV.UK Ethnicity facts and figures. Retrieved April 1, 2024, from Families and households - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

Centres for Disease Control and Prevention. (2020). *Maternal and infant health.* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Close, F. T., Suther S., Foster, A., El-Amin, S., & Battle, A. M. (2013). Community perceptions of black infant mortality: a qualitative inquiry. *Journal of healthcare for the poor and undeserved, 24*(3), 1089-101. https://doi/org/10.1353/hpu.2013.0118

Coleman, J. J. (2009). Culture care meanings of African American parents related to infant mortality and healthcare. *Journal of Cultural Diversity, 16*(3), 109-119.

Cole, E. R., & Luna, Z. T. (2010). Making coalitions work. *Feminist Studies 36*(1), 71-98.

Coneely, M., Packer, K. C., Bicknell, S., Jankovic, J., Sihre, H. K., McCabe, R., Copello, A., Bains, K., Priebe, S., Spruce, A., & Jovanovic, N. (2023). Exploring Black and South Asian women's experiences of help-seeking and engagement in perinatal mental health services in the UK. *Frontiers in Psychiatry, 14.* *https://*doi:10.3389/fpsyt.2023.1119998

Connellan, K., Bartholomaeus, C., Due, C., & Riggs, D. R. (2017). A systematic review of research on psychiatric mother-baby units. *Archives of Women's Mental Health, 20*(3), 373-388. https://doi.org/10.1007/s00737-017-0718-9

Comtois, K. A., Schiff, M. A., & Grossman, D. C. (2008). Psychiatric risk factors associated with postpartum suicide attempt in Washington State, 1992-2001. *American Journal of Obstetrics and Gynecology, 199*(2), 120. https://doi.org/10.1016/j.ajog.2008.02.011

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: a Black Feminist critique of antidiscrimination doctrine, Feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989(1).*

Critical Appraisal Skills Programme (CASP). (2018). Qualitative research checklist. https://casp-uk.net/casp-uk.net/casp-tools-checklists/. Accessed 2 April 2024.

Declercq, E., Feinberg, E., & Belanoff, C. (2021). Racial inequities in the course of treating perinatal mental health challenges: Results from listening to mothers in California. *Birth*, *00*, 1-9. https://doi/org/10.1111/birt.12584

Delgado, R. & Jean, S. (2012). *Critical race theory: an introduction.* New York University Press.

Delgado, R., & Stefancic, J. (2023). *Critical race theory: an introduction.* (Fourth Edition). New York University Press.

Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research.* (Third Edition). Sage Publications Ltd.

Di Florio, A., Smith, S., & Jones, I. (2013). Postpartum psychosis. *Obstetric Gynaecology, 15*(3):145–150. https://doi.org/10.1111/tog.12041

Dolman, C., Jones, I., & Howards, L. M. (2013). Pre-conception to parenting: a systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of Women's Mental Health, 16*(3), 173-196. https://doi.org/10.1007/s00737-013-0336-0

Doucet, S., Jones, I., Letourneau, N., Dennis, C., & Blackmore, E. (2011). Interventions for the prevention and treatment of postpartum psychosis: a systematic review. *Archives of Women's Mental Health*, *16*(3), 173-196. https://doi.org/10.1007/s00737-010-0199-6

Doucet, S., Jones, I., Letourneau, N., Dennis, C., & Blackmore, E. (2012). Interventions for the prevention and treatment of postpartum psychosis: a systematic review. *Arch Women's Mental Health 14*(2), 89–98. https://doi.org/10.1007/s00737-010-0199-6

Diagnostic and Statistical Manual of Mental Disorders. (DSM-5-TR; 2022). *American Psychological Association.* https://doi.org/10.1176/appi.books.9780890425787

Edge, D. (2011). 'It's leaflet, leaflet, leaflet then, "see you later": black Caribbean women's perceptions of perinatal mental health care, *British Journal of General Practice, 61*, 256-262. https://doi.10.3399/bjgp11X567063

Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health, 14* (5), 471–81.

Einheuser, I. (2005). "Varieties of Relativism: Indexical, Propositional and Factual", from the Logos conference on RELATIVIZING UTTERANCE TRUTH, Barcelona. Retrieved on 2nd April 2024.

Elkin, A., Gilburt, H., Slade, M., Lloyd-Evans, B., Gregoire, A., Johnson, S., & Howard, L. M. (2009). A national survey of psychiatric mother and baby units in England. *Psychiatric Services*, *60*, 629-633. https://doi.org.10.1176/aooi.ps.60.5.629

Engqvist, I., Ferszt, G., Ahlin, A., & Nilsson, K. (2011). Women's experiences of postpartum psychotic experiences – analyses of narratives from the internet. *Archives of Psychiatric Nursing, 25*(5), 376-387. https://doi.org/10.1016/j.apnu.2010.12003

Engqvist, I., & Nilsson, K. (2013a). Experiences of the first days of postpartum psychosis: an interview study with women and next of kin in Sweden. *Issues in Mental Health Nursing, 34*(2), 82-89. https://doi.org/10.3109/01612840.2012.723301

Ford, C. L. (2016). Public health critical race praxis: An introduction, an intervention, and three points for consideration. *Wisconsin Law Review*, 477–491.

Forde, R., Peters, S., & Wittkowski, A. (2019). Psychological interventions for managing postpartum psychosis: a qualitative analysis of women's and family members' experiences and preferences. *BMC Psychiatry, 19,* 411. https://doi.org/10.1186/s12888-019-2378-y

Forde, C. L., & Airhihenbuwa, C. O. (2018). Commentary: Just what is critical race theory and what's it doing in a progressive field like public health? *Ethnicity & Disease, 28*(1), 223-230. https://doi.org/10.18865%2Fed.28.S1.223

Forde, R., Peters, S., & Wittkowski, A. (2020). Recovery from postpartum psychosis: a systematic review and metasynthesis of women's and families' experiences. *Archives of Women's Mental Health, 23,* 597-612. https://doi.org/10.1007/s00737-020-01025-z

Frank, A. W. (1993). The rhetoric of self-change: Illness experience as narrative. *The Sociological Quarterly, 34*, 39-52.

Flinders, M., Wood, M., & Cunningham, M. (2016). The politics of co-production: risks, limits and pollution. *Evidence and Policy, a Journal of Research, Debate and Practice, 12*(2), 261–279. https://doi.org/10.1332/174426415X14412037949967

Geertz, C. (1988). *Works and lives: the anthropologist as author.* Stanford, California: Stanford University Press.

Geronimus, A. T. (1992). The weathering hypothesis and the health of African American women and infants: evidence and speculations. National Library of Medicine, 2(3), 207-21. Retrieved from https://pubmed.ncbi.nlm.nih.gov/1467758/

Gillham, R., & Wittkowski, A. (2015). Outcomes for women admitted to a mother and baby unit: a systematic review. *International Journal of Women's Health, 30*(7), 459–476. https://doi.org/10.2147/IJWH.S69472

Giorgi, A., & Giorgi, B. (2008). Phenomenological psychology, in C. Willig and W. Stainton Rogers (Eds). *The Sage Handbook of Qualitative Research in Psychology*. London: Sage

Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic Controversies, Contradictions, and Emerging Confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191–215). Sage Publications Ltd.

Glover, L., Jomeen, J., Urquhart, T., & Martin, C. R. (2014). Puerperal psychosis – a qualitative study of women's experiences. *Journal of Reproductive Infant Psychology*, *32*(3), 254-269. https://doi.org/10.1080/02646838.2014.883597

Go, J. (2004). "Racism" and Colonialism: Meanings of difference and ruling practices in America's Pacific empire. *Qualitative Sociology, 27(1).*

Green, D., J., Hofberg, K., Fannernan, T., & Sumathipala, A. (2016). A 10 year history of perinatal care at the Brockington Mother and Baby Unit Stafford. *Archives of Women's Mental Health, 19*, 507-513. https://doi.10.1007/s00737-015-0583-3

Hall, S. (2021). *Selected Writings on Race and Difference*. (Eds.) Paul Gilroy and Ruth Wilson Gilmore Duke University Press.. https://doi.org/10.1515/9781478021223

Hayne, Y. (2003). Experiencing psychiatric diagnosis: client perspectives on being named mentally ill. *Journal of Psychiatric Mental Health Nursing*, *10*(6), 722–729.

Heron J, McGuinness M, Blackmore ER, Craddock N, Jones I (2008). Early postpartum symptoms in puerperal psychosis. *BJOG 115*(3), 348–353. https://doi.org/10.1111/j.1471-0528.2007.01563.x

Heron, J., Gilbert, N., Dolman, C., Shah, C., Beare, I., Dearden, S., Muckelroy, N., Jones, I., & Ives, J. (20120. Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health, 15*(3), 155-165. https://doi.org/10.1007/s00737-012-1267-1

Hoang, T. H., Andi Lee, B., Hsieh, W., Lukacena, K. M., & Tabb, K. M. (2023). Experiences of racial trauma among perinatal women of color in seeking healthcare services. *General Hospital Psychiatry*, *84*, 60-66. https://doi.org/10.1016/j.genhosppsych.2023.06.015

Hooks, B. (2014). *Feminist theory: from margin to center.* (Third Edition). New York Routledge. https://doi.org/10.4324/9781315743172

Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *Lancet*, *384(*9956), 1775-1788. https://doi.org/10.1016/S0140-6736(14)61276-9

Husserl, E. (1931). *Ideas.* Translated by W. R. Boyce Gibson. London: George Allen & Unwin.

INVOLVE (2015) Public involvement in research: values and principles framework, INVOLVE: Eastleigh.

Joanna Briggs Institute. (2016). Summary user manual: Version 5. Retrieved from https://joannabriggs.org.sumari.html

Jones, I., & Smith, S. (2009). Puerperal psychosis: identifying and caring for women at risk. *Advanced Psychiatry Treatment*, *15*(6), 411–418. https://doi.org/10.1192/apt.bp.107.004333

Jones, J., Chandra, P. S., Dazzan, P., Howard, L. M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet*, *384*(9956), 1789-99. https://doi.org/10.1016/S0140-6736(14)61278-2

Keuth, H. (2015). Logical positivism and logical empiricism. In *International Encyclopaedia of the Social & Behavioral Sciences* (pp. 313–318). Elsevier

Knight, M., Nair, M., Tuffnell, D. et al. (2016). Saving Lives, Improving Mother's Care – Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202016%20-%20website.pdf (accessed 7th of February 2021)

Lewis, S. E., & Nicolson, P. (1998). Talking about early motherhood: Recognizing loss and reconstructing depression. *Journal of Reproductive and Infant Psychology, 16*, 177-197.

Lincoln, Y. S., & Guba, E., G. (1985). *Naturalistic inquiry*. Sage Publications Newbury Park.

Ling, L., Eraso, Y., & Di Mascio, V. (2023). First-generation Nigerian mothers living in the UK and their experience of postnatal depression: an interpretative phenomenological analysis. *Ethnicity & Health*, *28*(5), 738-756. https://doi.org/10.1080/13557858.2022.2128069

Lowe, F. (2018). *Thinking space: Promoting thinking about race, culture and diversity in psychotherapy and beyond.* Routledge

Luna, Z. T. (2010). Marching toward reproductive justice. *Sociological Inquiry*, *80*(4), 554-578.

Knops, G. (1993). Postpartum mood disorders. *Postgraduate Medicine, 93*, 103-116.

Mahoney, J. M., Donnelly, T. T., Bouchal, S. R., & Este, D. (2013). Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. *Journal of Immigrant & Minority Health, 15*(2), 300-314. https://doi.org/10.1007/s10903-012-9663-x

Maternal Mental Health Alliance (MMHA). (2023). *Maternal mental health alliance strategy 2023-6.* Retrieved on 2nd April 2024, from Our strategy 2023-26 | Maternal Mental Health Alliance

Mauthner, N. (1999). "Feeling low and feeling really bad about feeling low:" Women's experiences of motherhood and postpartum depression. *Canadian Psychology, 40*(2), 143–161.

McGrath, L., Peters, S., Wieck, A., & Wittkowski, A. (2013). The process of recovery in women who experienced psychosis following child-birth. *BMC Psychiatry, 13*(341), 1-10. https://doi.org/10.1186/1471-244X-13-341

The Mental Health Taskforce. (2016). The five year forward view for mental health. Retrieved on 7th February 2021, from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., Dazzan, P., Boydell, J., McKenzie, K., Harrison, G., Murray, R., Jones, P., Craig, T., & Leff, J. (2005). Pathways to care and ethnicity. Sample characteristics and compulsory admission. Report from the AESOP study. *British Journal of Psychiatry*, 186:281–289. https://doi:10.1192/bjp.186.4.281

Morse, J. M., & Field, P. (1995). Qualitative research methods for health professionals. Sage Publications

Moustakas, C. (1994). *Phenomenological Research Methods.* London: Sage.

Myers, S., & Johns, S. E. (2018). Postnatal depression is associated with detrimental life-long and multi-generational impacts on relationship quality. *Peer Journal, 6*(6) https://doi.org/10.7717/peerj.4305

Nager, A., Szulkin, R., Johansson, S. E., Johansson, L. M., & Sundquist, K. (2013). High lifelong relapse rate of psychiatric disorders among women with postpartum psychosis. *Nord Journal of Psychiatry 67*(1), 53–58. https://doi.org/10.3109/08039488.2012.675590

Nakigudde, J., Ehnvall, A., Mirembe, F., Musisi, S., & Airaksinen, E. (2013). An exploratory study on the feasibility and appropriateness of family psychoeducation for postpartum women with psychosis in Uganda. *BMC Psychiatry 13,* 131. https://doi.org/10.1186/1471-244X-13-131

Nakku, J. E. M., Okello, E. S., Kizza, D., Honikman, S., Ssebunnya, J., Ndyanabangi, S., Hanlon, C., & Kigozi, F. (2016). Perinatal mental health care in a rural African district, Uganda: a qualitative study of barriers, facilitators and needs. *BMC Health Services Research, 16,* 295. https://doi.org/10.1186/s12913-016-1547-7

NICE (2014, February 12). Psychosis and schizophrenia in adults: prevention and management. Retrieved April 1, 2024 from Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

National Institute for Clinical Excellence. (2018). Antenatal and postnatal mental health: clinical management and service guidance. The NICE guideline on clinical management and service guidance. Updated edition. National Collaborating Centre for Mental Health: https:// www.nice.org.uk/guidance/cg192/evidence/full-guideline-pdf-4840896925. Accessed on 12th September 2022.

National Institute for Health and Care Excellence. (2024). Retrieved April 1, 2024 from NICE | The National Institute for Health and Care Excellence

Noblit, G. W., & Hare, R. D. (1988). Meta-ethnography: synthesizing qualitative studies. Newbury Park (UK): Sage.

NHS England. NHS Long Term Plan. NHS England, London. (2019).

NHS Workforce Race Equality Standard Report. (2023, February 22). Retrieved April 1, 2024 from https://nhsproviders.org/media/695151/wres-2023-report-on-2022-data-otdb_final-1.pdf

Ostrom, V., & Ostrom, E. (1977). '*Public Goods and Public Choices*' in E. S. Savas (ed.) Alternatives for Delivering Public Services: Toward Improved Performance. Westview Press.

Peoples, M., Danawi, H. (2015). Exploring racial disparity in St. Louis city foetal-infant death. International Journal of Childbirth Education, 30(2), 39-42.

Pilav, S., De Backer, K., Easter, A., Silverio, S. A., Sundaresh, S., Roberts, S., & Howard, L. M. (2022). A qualitative study of minority ethnic women's experiences of access to and engagement with perinatal mental health care. *BMC Pregnancy & Childbirth.* https://doi.org/10.1186/s12884-022-04698-9

Plunkett, C., Peters, S., Wittkowski, S. (2016). Mothers' experiences of recovery from postnatal mental illness: a systematic review of the qualitative literature and metasynthesis. *JSM Anxiety Depression, 1*(4).

Posmontier, B., & Fisher, K. M. (2013). A narratology of postpartum psychosis in an Orthodox Jewish woman. *Perspectives in Psychiatric Care, 50,* 167-177.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* Sage Publications Ltd.

Prady, S., Prickett, K., Croudace, T., Fairley, L., Bloor, K., Gilbody, S. […]. (2013). Psychological distress during pregnancy in a multi-ethnic community: findings from the born in Bradford cohort study. *PLoS One, 8*(4).

Prady, S. L., Pickett, K. E., Petherick, E. S., Gilbody, S., Croudace, T., Mason, D., Sheldon, T. A., & Wright, J. (2016). Evaluation of ethnic disparities in detection of depression and anxiety in primary care during the maternal period: combined analysis of routine and cohort data. *The British Journal of Psychiatry, 208*(5), 453-461. https://doi.org/10.1192/bjp.bp.114.158832

Prather, C., Fuller, T. R., JeffriesIV, W. L., Marshall, K., J., Howell, V., Belyue-Umole, A., & King, W. (2018). Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity, 2*(1). https://doi.org/10.1089/heq.2017.0045

Quinn, G. P., August, E. M., Austin, D., Keefe, C., Bernadotte, C., Scarborough, K., & Jeffers, D. (2009). High risk community – Men's perceptions of Black infant mortality: A qualitative inquiry. *American Journal of Men's Health, 3*(3), 224-237.

Rattansi, A. (2005), '*The uses of racialization: the time-spaces and subject-objects of the raced body',* in Murji, K. and Solomos, J. (eds.), Racialization: Studies in Theory and Practice, Oxford: Oxford University Press.

Robbins, C., Boulet, S. L., Morgan, I., D'Angelo, D. V., Zapata, L. B., Morrow, B., … & Kroelinger, C. D. (2018). Disparities in preconception health indicators – Behavioural Risk Factor Surveillance System, 2013-2015, and Pregnancy Risk Assessment Monitoring System, 2013-2014. *MMWR Surveillance Summaries, 67*(1), 1-6. https://doi.org/10.15585/mmwr.ss6701a1

Robertson, E., & Lyons, A. (2003). Living with puerperal psychosis: A qualitative analysis. *Psychology and Psychotherapy*, *76*, 411–431. https://doi.org/10.1348/147608303770584755

Robertson, E., Jones, I., Haque, S., Holder, R., & Craddock, N. (2005). Risk of puerperal and non-puerperal recurrence of illness following bipolar affective puerperal (post-partum) psychosis. *British Journal of Psychiatry 186*, 258–259. https://doi.org/10.1192/bjp.186.3.258

Royal College of Psychiatrists. (2023, October). Infant and early childhood mental health: the case for action. Retrieved April 2, 2024, from Infant and early childhood mental health - the case for action (CR238) (rcpsych.ac.uk)

Roxburgh, E., Morant, N., Dolman, C., Johnson, S., & Lever Taylor, B. (2022). Experiences of mental health care among women treated for postpartum psychosis in England: A qualitative study. *Community Mental Health Journal, 59*(2), 243-252. https://doi.org/10.1007/s10597-022-01002-z

Schleiermacher, F. (1998). *Hermeneutics and Criticism and Other Writings,* Andrew Bowie (ed.), Cambridge: Cambridge University Press.

Schoenberger, A., Boudreaux, C., Sachdeva, J., Ruegg, H., Yadav, V., & Karol, D. E. (2022). C-L Case conference: a 33-year-old Bhutanese woman with postpartum hallucinations. *Journal of the Academy of Consultation-Liaison Psychiatry, 63,* 628-624.

Seale, C. (1999). *The quality of qualitative research.* Sage Publications.

Sit, D., Rothchild, A. J., Wisner, K. L. (2006). A review of postpartum psychosis. J Women's Health. 15(4), 352–368. https://doi.org/10.1089/jwh.2006.15.352

Sheikh, A., & Singsit-Evans, S. (2020). Mental disorders in migrants: First episode psychosis in the postpartum period. *Progress in Neurology and Psychiatry, 24*(2), 7-10. https://doi.org/10.1002/pnp.662

Sismondo, S. (2021). Epistemic corruption, the pharmaceutical industry, and the body of medical science. *Frontiers in Research Metrics and Analytics, 6*. https://doi.org/10.3389/frma.2021.614013

Smith, J. A. (1997). *Doing qualitative analysis in psychology*. (Hove: Psychology Press).

Smith, J. A. & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis.* American Psychological Association.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: theory, method and research.* (Second Edition). Sage Publishing.

Solorzano, D. (1997). Images and words that wound: Critical Race Theory, racial stereotyping, and teacher education. *Education, Sociology, 24,* 5-19.

Spinelli, M. G. (2004). Postpartum psychosis: detection of risk and management. *American Journal of Psychiatry*, *166*(4), 405–8.

Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.

Stein, A., Pearson, R. M., Goodman, S. H., et al. (2014). Effects of perinatal mental disorders on the foetus and child. *Lancet*, *394*(9956), 1800-1819. https://doi.org/10.1016/S0140-6736(14)61277-0

Stoler, A. L. (1992). *Rethinking colonial categories: European communities and the boundaries of rule*. In N. B. Dirks (Ed.), Colonialism and culture (pp. 319–352). Ann Arbor: University of Michigan Press.

The Mental Health Taskforce. The five year forward view for mental health. (2016). https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (accessed 7th of February 2021)

Thomas-Hughes, H. (2018). Ethical ‘mess’ in co-produced research: reflections from a U.K.-based case study. *International Journal of Social Research Methodology, 21*(2), https://doi.org/10.1080/13645579.2017.1364065

VanderKruik, R., Barreix, M., Chou, D., Allen, T., Say, L., Cohen, L. S., Barbour, K., Cecatti, J. G., Cottler, S., Fawole, O., Firoz, T., Gadama, L., Ghérissi, A., Gyte, G., Hindin, M., Jayathilaka, A., Kalamar, A., Kone, Y., Lange, I., Magee, L. A., Mathur, A., Binns, A. M., Morgan, M., Munjanja, S., Gichuhi, G. N., Petzold, M., Sullivan, E., Taulo, F., & TunçalpÖ, von Dadelszen, P., on behalf of the Maternal MorbidityWorking Group. (2017). The global

prevalence of postpartum psychosis: a systematic review. *BMC Psychiatry 17*(1), 272. https://doi.org/10.1186/s12888-017-1427-7

Van Manen, M. (1990). *Researching lived experience: human science for an action sensitive pedagogy*. Albany, NY: SUNY Press.

Watson, H. & Soltani, H. (2019). Perinatal mental ill health: the experiences of women from ethnic minority groups, *British Journal of Midwifery, 27*(10), https://creativecommons.org/licenses/by-nc-nd/4.0/)

Wallace, M. E., Green, C., Richardson, L., Theall, K., & Crear-Perry, J. (2017). “Look at the Whole Me”: A Mixed-Methods Examination of Black Infant Mortality in the US through Women’s Lived Experiences and Community Context. *International journal of environmental research and public health, 14*(7). https://doi/org/10.3390/ijerph14070727

Wilkinson, A., Anderson, S., & Wheeler, S. B. (2017). Screening for and treating postpartum depression and psychosis: a cost-effectiveness analysis. *Maternal Child Health Journal, 21*(4), 903–914. https://doi.org/10.1007/s10995-016-2192-9

Willig, C. (2008). *Introducing Qualitative Research in Psychology.* (Second edition). Open University Press.

Wittkowski, A., McGrath, L. K., & Peters, S. (2014). Exploring psychosis and bipolar disorder in women: a critical review of the qualitative literature. *BMC Psychiatry 14*, 281. https://doi.org/10.1186/s12888-014-0281-0

Womersley, K., Ripullone, K., & Hirst, J. E. (2021). Tackling inequality in maternal mental health: Beyond the postpartum. *Future Healthcare Journal*, *8*(1), 31-15. https://doi.org/10.7861%2Ffhj.2020-0275

World Health Organisation. (2019). WHO | Maternal mental health. Retrieved from: https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

Wyatt, C., Murray, C., Davies, J., & Jomeen, J. (2015). Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others. *Journal of Reproductive Infant Psychology*, *33*(4), 426-442. https://doi.org/10.1080/02646838.2015.1027181

Zamudio, M., Russell, C., Rios, F., & Bridgeman, J. L. (2010). *Critical Race Theory matters: Education and ideology*. Routledge: New York.

Appendices

Appendix A: Sample of Tabulated Study Details and Key Concepts

Sample of tabulated study details and key concepts

Methods and concepts	Baiden & Evans (2021)
Key study details	
Purpose	Black African newcomer women's perception of postpartum mental health services in Canada
Setting	Canada
Sample	10
Data collection	Purposive sampling and thematic analysis
Key concepts	
Patriarchal norms of Black motherhood	Internalisation of 'strong Black woman' narrative inhibits help-seeking
Racialised treatment	Racialised assumptions within healthcare perpetuate harmful narratives
	Immigration status impacts access to treatment
Racism	Frequent dismissal based on race
Community stigma	Stigma surrounding mental illness and diagnosis
Racism	Discrimination due to being Black
Cultural identity	Cultural competency must be incorporated

Explanation/theory (second-order interpretation)	Patriarchal norms of Black motherhood explicitly inhibit help-seeking and lead to assumptions of resilience and implicit racial bias within healthcare. Internalised stigmas surrounding mental illness and diagnosis actively delay treatment access. Cultural competency needs to be broadly implemented across maternal healthcare systems to reduce the potential racial marginalisation Black mothers experience in healthcare.

Appendix B: Overview of Key Concepts and Broader Categories

Key concepts found in the studies
Patriarchal norms of Black motherhood Intra-community and external stigma
Racialised treatment Racism Healthcare system neglect
Power of partners Cultural identity Posttraumatic growth

Synthesised categories
Patriarchy of Black motherhood
Multi-layered systemic racism
Social support and negotiating identity norms and inequalities

Appendix C: Interview Schedule

University of Essex

Interview Schedule

1. What was your experience of post-partum psychosis?

   Prompts: Symptoms?

   How long?

   When post-partum did your experience happen?

   How has it affected you in the long-term?

2. How was your experience of recovery?

   Prompts: Offered healthcare? How and what?

   Did healthcare feel accessible?

   If not, why not?

3. How was your experience of support?

Prompts: Partners

Family

Parents

Friends

Community

Other

4. How was your experience of barriers to support?

Prompts: Social

Cultural

Racial

Physical

Other

5. Did you experience racism and cultural discrimination at the time of post-partum psychosis?

Prompts: How did you experience this?

What made you feel this way? Why?

How has this influenced you?

6. Do you have family or friends within your community that have experienced post-partum psychosis and accessed Perinatal Mental Health Services, including an MBU? What was their experience?

Prompts: How do you feel about their experience?

Do you think others' experiences of support or barriers may have influenced you? In what way?

7. Do you have friends or family within your community that may have experienced post-partum psychosis and maybe haven't accessed services? How do you feel about this?

Prompts: Why do you think they may not have accessed this support?

How might this have influenced you?

And your beliefs about healthcare/support?

8. How do you feel your cultural background is represented in Perinatal Mental Health Services (including MBUs)?

   Prompts: In relation to service users / staff

   How do you feel about this?

   Why do you think this might be?

9. What might be helpful to think about in order to improve Perinatal Mental Health Services, including MBUs?

   Prompts: What approach could be helpful?

   Why?

   What do you think of a community approach? Why?

10. What do you think needs to be developed/improved within healthcare support for women experiencing post-partum psychosis?

    Prompts: What does recovery need to include?

    Why do you think this would be helpful?

11. What does recovery need to include to meet the cultural and social needs of Black women in the UK?

Prompts: Why do you say this?

How do you think this could be helpful?

12. What would be a helpful focus in research moving forward for women experiencing or recovering from post-partum psychosis?

Prompts: Why do you think this?

What would be helpful for Black women with experience of post-partum psychosis?

13. Do you have any other comments or relevant experiences you think would be important to share?

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Appendix D: Demographic Questions

Please complete the following questions. All questions are optional.

1. What Gender do you identify with?

   Male

   Female

   Other (please specify)

   Prefer not to say

2. What is your age range?

   18-25

   25-34

   35-44

   45-54

   55-64

Over 65

Prefer not to say

3. What ethnicity do you identify with?

Black British Caribbean

Black British African

Mixed race

Other (please specify)

Prefer not to say

4. What is your first language?

English

Other (please specify)

5. Do you have a spiritual or religious practice? (E.g. Buddhism, Christianity, Muslim…)

Yes (please specify)

No

Prefer not to say

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

Primary school

GCSE’s or equivalent

A-levels or equivalent

College course/Diploma

University undergraduate programme

University post-graduate programme

Doctorate degree

Prefer not to say

7. Are you employed?

Yes (please specify)

No

Prefer not to say

8. How old is you baby or child?

6-months

6-months-1 year

1-2 years

2-4 years

4-6 years

Prefer not to say

9. What is your sexual orientation?

Heterosexual

Bisexual

Homosexual

Asexual

Pansexual

Other (please specify

Prefer not to say

10. What is your living situation?

Single

Co-habiting

Civil partnership

Married

Divorced

Other (please specify)

Prefer not to say

Appendix E. Participant Information Sheet

Participant Information Sheet

Exploring Black women's Experiences of Post-partum Psychosis and the Role of Racism

Invitation to Participate

My name is Emily Monger, and I am a Trainee Clinical Psychologist in the Department of Health and Social Care at the University of Essex. I would like to invite you to take part in a qualitative research study. Before you decide whether to take part, it is important for you to understand why this study is being done and what it will involve.

I am passionate about improving the experiences of recovery from post-partum psychosis for women. Working in a Perinatal Community Mental Health Service in the East of England was an interesting and rewarding experience. Working with Black mothers, who attended the therapeutic groups at this service, led me to wonder about the challenges and cultural barriers these women faced, and how this may have impacted their recovery. I am specifically interested in how racism may play a role in experiences of recovery from post-partum psychosis for Black women.

I am working with a UK-based charity, to be better able to recruit participants for this study. All participants will be part of this charity, as members, volunteers, or associates. The charity will promote the study and provide my contact details as part of the recruitment process. Everyone that participates will receive a £20 Amazon voucher as a reward for their time and efforts. This will be arranged and provided over email by myself, the researcher. If you choose to withdraw from the study, you do not need to give a reason, but if you have already taken part in an interview, this data will be kept, and you will still receive the voucher. If you have not taken part in an interview, unfortunately you will not be eligible for a voucher.

I feel it is important to acknowledge that I am a White woman from the UK, in my early 30s, and I am not a mother. I realise that my cultural and social experiences may likely not reflect those of the participants of this study, and that this could possibly influence certain aspects to the study. I will be adopting a reflexive approach throughout the whole process, which means I will reflect on my own assumptions, beliefs and experiences throughout all stages of the data collection, analysis and writing up of the study. I hope to be as transparent, empathetic and compassionate as possible throughout this study.

I am hoping this study will help in providing a voice for Black mothers with experience of post-partum psychosis, that may have felt discriminated against, or felt barriers related to race or culture, and potentially help improve experiences of recovery in the future. Please take time to read the following information carefully before deciding to take part.

What is the purpose of this research study?

The purpose of this research study is to better understand the experiences of Black women that have experienced post-partum psychosis. I am interested in both the experiences of women that may not have accessed support from services, as well as women that have received either NHS or alternative support. I am interested in how these mothers may view the potential racial, cultural, and social barriers that may have impacted their recovery and access to services.

I hope to recruit 15 women, that are at least 1-year post-partum, that self-identify as from a Black ethnic background, that currently reside in the UK, and that self-report as having experience of post-partum psychosis. Women do not need to have received a diagnosis of post-partum psychosis or have accessed mental health services for perinatal mental health difficulties, including for post-partum psychosis, but must be able to self-identify experience of symptoms of psychosis in the post-partum period. Participants may still be under the care of a perinatal mental health service, but for ethical reasons I am requesting that all women must consider themselves no longer symptomatic of psychosis. This is so women would feel well enough to participate and also be in a position to reflect on their experiences. Women do not need to speak English, and those that may have difficulties with speaking English will be offered support from an interpreter from a credited company. This support would include translation of the study advert, consent form and participant information form, as well as with the interview, as needed.

I am the main person involved in this study, over the course of three years (October 2021-October-2024), and I will be submitting the study as my doctoral thesis to the University of Essex.

What will participating involve? What information will be collected?

Participation will involve taking part in a semi-structured interview with myself, a Trainee Clinical Psychologist at the University of Essex. We would agree on a date and time together, and I am happy to be flexible to suit you. The duration of interviews would approximately be around 60 minutes, but this can also be flexible to suit you. All interviews will be carried out over the online platform of Microsoft Teams or Zoom.

The interview structure will involve me asking about your experience of post-partum psychosis, your experience of support and recovery in relation to services, and what support may or may not have been offered, your experience of support in relation to significant relationships with relatives/friends/partners. I will also ask you about the barriers and facilitators to your recovery that you may or may not have experienced, and then more specifically, about how race, culture and social contexts may have influenced your recovery, as well as your views about services.

I will ask you some demographic information, such as ethnicity, gender, and age, which is just so I can understand more about who you as participants are. All your information, including demographic information, will remain confidential and non-identifiable to you.

How will my information remain confidential?

All information you give will remain confidential and anonymous. All interviews will be carried out over the online platform of Microsoft Teams/Zoom, where they will be recorded and stored safely and securely on my personal University of Essex Box account, which is an online platform for storing data securely. It will only be myself facilitating the interviews, which I will carry out in a private confidential space. Once I have transcribed all interviews they will be deleted. Transcriptions will also be stored in the same way and given a unique identification number to protect anonymity. Transcriptions will be deleted once the data has been analysed. It is only the research team that will have access to the data, this includes me, the researcher, and my two University of Essex supervisors.

All data will be analysed by myself, and I will also write up the study. I will also write up a summary of the study, which will be available to you and all participants, should you wish to request a copy. I am hoping to disseminate the study more widely, such as to an online peer-reviewed journal, to help inform the work of others. This is part of a wider aim to promote empowerment and more culturally appropriate and helpful support for Black mothers with experience of post-partum psychosis.

Is participating mandatory? Are there any benefits or disadvantages/risks?

Participation is entirely voluntary, and all participants have the right to withdraw at any time without giving a reason. Withdrawal will have no impact on your current or future support from mental health services, such as with the NHS or any other provision of support, including with any charities. If you decide to take part, you will be provided with a consent form to sign beforehand.

Whilst there are no direct benefits to participating apart from receiving an Amazon voucher, the benefits of your views, experiences and insights will be invaluable to this study and potentially future research. I hope that there could be further benefit for Black mothers that may or may be likely to share similar experiences of post-partum psychosis. I hope that the findings could potentially help promote more specific and appropriate support that addresses culture and race for Black mothers, within services for post-partum psychosis. I hope the result of this could help facilitate access and a better experience of support for Black women.

I understand that there are potential risks with taking part in this study. I completely understand that participating in interviews is time consuming and that you will have to take time out of your day to do this. I realise that you could likely be caring for your baby, as well as potentially other children. I would like to offer all participants the choice of whether their infants are present at the time of interviews. I would like to advise that children over the age of 1 year-old are not present, due to the sensitive information that could be talked about. I also understand that you may have employment commitments, therefore I am happy to arrange an interview at any date or time that works for you best.

I realise that some questions or topics may feel personal and possibly harmful to reflect on, particularly if you have had negative or traumatic experiences. I also realise these experiences may be particularly difficult to talk about with a person you have just met, and that may not share the same cultural and social experiences as you. I want to let you know that you only are required to share what you are happy to in the interview. If you were to share anything that indicated need for concern about your safety or wellbeing, or that of someone else's, you may be signposted to the relevant charities for further support and confidentiality broken in this instance. This is something I would reflect on with my supervisor, and you would always be informed if this were necessary. This process is important just to enable safety for everyone. Information about necessary relevant resources around support would be provided and you would be updated throughout this process. I would also like to let you know that you have the right to take breaks or stop the interview whenever you feel you want or need to.

I acknowledge that, as a White woman that is not a mother, I do not have personal direct experience that may relate to your own experiences, or necessarily to this research. I want to let you know that I will be consistently reflecting on how my own cultural, racial and social experiences, and background, may influence the study. My reflections will be an essential part of the analysis I undertake, and to this study generally. If you have any questions about this, I am happy to talk things through with you.

What is the legal basis for using the data and who is the Data Controller?

As this is a research study undertaken by a Trainee Clinical Psychologist, all University guidance has been followed in relation to obtaining consent, in compliance with the EU General Data Protection Regulation (GDPR). The GDPR states that consent must be freely given, specific, informed and unambiguous. It is also to show that you are willing to participate, understand the purpose and process of the evaluation, and are not committing to providing any data or information you do not consent to. This will occur by your signing of the consent form provided, should you wish to take part.

The Data Controller for this evaluation will be the University of Essex, and should you require further information about any legal information, or have concerns, please contact the University Information Assurance Manager (dpo@essex.ac.uk).

Who is funding and reviewing the evaluation?

I will be providing regular updates on the progress of the study to the University of Essex, and more specifically, my thesis supervisors. Dr John Day, Clinical Psychologist and Research Tutor, is my primary thesis supervisor, and Dr Richard Pratt, Clinical Psychologist, is my secondary thesis supervisor. Both supervisors will be overseeing the project, supervising the process, and reviewing my academic work.

The research study will be funded by the Health and Social Care Department, at the University of Essex.

Concerns and Complaints

If you have any concerns about any aspect of this research study, or you have a complaint, in the first instance please contact Emily Monger, on em21633@essex.ac.uk. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the facilitator, please contact [name], Departmental Director of Research for Health and Social Care, at the University of Essex on [name] or [name], the Research Governance and Planning Manager at the University of Essex on [name]. Please include the ERAMS reference which can be found at the foot of this page.

What happens next?

If you are happy to participate, I will provide you with and ask you to sign the Participant Consent Form. This is just to confirm that you are willing to participate and understand the purpose and process of the study, and what information is being asked of you. This is also to make sure you are not committing to providing any data or information without providing consent.

Once you have signed the Participant Consent Form, I will be in touch with you via email to arrange a mutually agreed date and time to carry out the interview. If you have any questions, please feel free to get in touch with me, Emily Monger, on em21633@essex.ac.uk.

Appendix F: Consent Form

University of Essex

Participant Identification Number for this study:

PARTICIPANT CONSENT FORM

Title of Project: Exploring Black women's experiences of post-partum psychosis and the role of racism.

Please initial box

1. I confirm that I have read the information sheet dated 7th March 2023 (version 7) for this research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to change my mind at any time without giving any reason. Upon requesting to withdraw from the study, all raw data provided will be destroyed; although aspects of data that have been already been analysed at the point of withdrawal will remain part of the study. ☐
3. I understand that my interview data will be recorded on Microsoft Teams/Zoom, but that this will remain confidential and only be available to the researcher and will be destroyed once analysed. ☐

4. I understand that anonymised data, that ensures I will be non-identifiable, will be shared with the University of Essex and disseminated for publication. ☐

5. I consent voluntarily to participate as a participant in this study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Person seeking consent	Date	Signature

Appendix G: Interpreter Consent Form

University of Essex

Participant Identification Number for this study:

INTERPRETER CONSENT FORM

Title of Project: Exploring Black women's experiences of post-partum psychosis and the role of racism.

Please initial box

1. I confirm that I have read the information sheet dated 7th February 2023 (version 6) for this research study and understand the purpose of the study, but that I am not a participant. I have had the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that I am free to withdraw my support at any time without giving any reason, but that any data obtained on my behalf will be kept by the researcher. ☐

3. I understand that the interview data will be recorded on Microsoft Teams/Zoom, but that this will remain confidential and only be available to the researcher and will be destroyed once analysed. ☐

4. I understand that anonymised data, that ensures I will be non-identifiable, will be shared with the University of Essex and disseminated for publication. ☐

6. I consent to provide translation of the language requested for the allocated participant for the purpose of this study, potentially requiring translation of the: study advert; participant information sheet; consent form; participant’s verbal contributions within the interview in their own words. ☐

____________________	____________________	____________________
Name of Interpreter	Date	Signature
____________________	____________________	____________________
Name of Person seeking consent	Date	Signature

Appendix H: Example Transcript

Interviewer:

Hi there, nice to see. I found that some people, there's, there can be a bit of a loss, less, loss of connection. So do let me know if you can't hear me at any point. Okay?

Nemy:

Yes.

Interviewer:

Alright. So, I'll begin. My first question is what was your experience of postpartum psychosis?

Nemy:

Okay, for... do you want some detail, or...?

Interviewer:

Yeah, as much as you're, what you're happy to share, in your own words.

Nemy:

Okay, I experienced this when I was twenty two years old, when I gave birth to my [name]. I'm a first time mom. So, and I also was not mentally prepared to be a mother at that age. So, that's, that's another thing that's triggered. There was thought, um, and curses... And yes. When I had it, I, I I'm gonna lose it by myself, because certain things started changing like, whereby I'd start hallucinating. I felt like sometimes I was hearing some sounds.... but sometimes I was hearing like my baby's crying. When I look, the baby's not crying.

Interviewer:

Mmm.

Nemy:

And... also, another note that I had during that time is insomnia, whereby my sleeping patterns, while they were the normal, my normal sleeping routine was altered. And most of the time, I was having sleepless nights. And, during the morning, that's when I was sleeping a lot, much during the night I was having sleepless nights. And also... sometimes I was feeling irritated. I was easily irritated. And, I could, just um.. just out, out of nowhere, and I get very angry. I had maybe, a feeling guilty, for giving birth at such a young age. Also, delusions, I would have some thoughts,... I could think things what were not even making sense. Then, I also got disconnected from the reality... the way things are going. And just the normal things.

Interviewer:

Yeah.

Nemy:

Yeah.

Interviewer:

Well, it sounds a really scary and quite confusing time. Yeah.

Nemy:

Yeah.

Interviewer:

How long did that last for you, those kinds of symptoms that you're describing?

Nemy:

Okay, at first, it was serious, before, like, the first ten days it was so serious, then, after I started seeking treatment... So... therapy sessions since...

Interviewer::

Yes.

Nemy:

Yes. It's lasted for... the same times went down and subside. Like, they were reducing slowly by slowly, but I was good, completely good, after like, eight months, when my kid was eight, yes, that's when I saw like, complete changes to the situation.

Interviewer:

Okay, so it sounds like it was quite severe at the beginning and then you sought help. And then it took eight months for it to really sort of change things for you. Um, did you did you go to hospital in the end? Or did you what, happened?

Nemy:

Okay, at first when I started experiencing those things, um, um... my husband, so I told him and he also had noted it, so we discussed it. He paid for my bed, for me to go the treatment. So I went to the hospital for two weeks with my tiny baby then after that, I was, I went back home. But I was monitored by therapists. So I was just going to sessions and coming back home.

Interviewer:

Okay, okay. So did you feel supported in that time, when you were sort of in your recovery?

Nemy:

Yes, I felt the support from my partner, because, like, he, personally he had seen the challenge that I was having, then he, he offered to pay the bills, so that we treated and he was also there mentally.

Interviewer:

Hmm. Yeah.

Nemy:

Yes. And he could involved himself in taking care of the kid most of the time. So that I take a nap for a long time.

Interviewer:

Yes. So you got some rest and recovery from it. Yeah. Um, and were you in the UK at that time, because I noticed if you went private, basically, rather than through the NHS.

Nemy:

Pardon?

Interviewer:

So were you in the UK at this time? Because you said that, uh, he paid for it. So you obviously went private with the healthcare. I wondered if you?

Nemy:

Yeah. Yes.

Interviewer:

Yeah. Okay. And do you feel like, do you feel like healthcare is accessible? Was, or was accessible for you at that time?

Nemy:

Yes.

Interviewer:

Yeah. Okay. Yeah, that you made the decision to sort of go private, rather than the NHS kind of thing. Yeah.

Nemy:

Yes.

Interviewer:

Okay.

Interviewer:

And it sounds like your partner was really supportive, which was great. What about family, friends or community? How was that experience for you?

Nemy:

Okay, personally, I can say that my friends did not take it positively, and they totally missed me. And I am facing up with most of them. For instance, my friends, we used to work together, she came over to visit me. Then, when she came and I explained to her the issue that I'm having, then she also saw that. Then afterwards, when she went back to where we were working, she went and changed the story. Like, she did not have the full concept. She was just saying some stereotypes and misconceptions. And that's not what I actually told her I'm suffering from. So, my friends, and workmates, they ended up distancing themselves from me. So, from friends, I can't say that I was supported. But, family-wise my mum was there to help, with also watching the baby. Yeah.

Interviewer:

Yeah, I'm sorry that your friends weren't supportive. That must have been really hard. Yeah. But it's nice that your mum was. Yeah. Um. And which, what were the kind of long term impacts of going through the postpartum psychosis, would you say?

Nemy:

I don't, have not gotten...

Interviewer:

What were the long term impacts of the postpartum psychosis on you would you say?

Nemy:

So like one which I had is, I had, I did not have good bonding with my kid.

Nemy:

Some ways, I did not bond with my kid that much. So there was no connection, like the deep connection with a mother and her kid. Yes.

Interviewer:

Yeah. Yeah. And I think that's something lots of mums said about and it's really hard, isn't it? Yeah. Okay. And did you experience any barriers to support, so any barriers like, it could be anything social, financial, cultural, racial, any kind of discrimination?

Nemy:

Er... maybe, I, the only thing that I experienced was... personally, I had that... I was reluctant to the treatments, like I will still... That's this is happened to me. That was... the other thing, which was the way my friends went to the job place whereby we are working and she, she know... She spread those things that soon came, may come mentally “she's having challenges”. So, when I, after I finished my maternity leave, when I went back to check for the job, the manager was a bit reluctant to believe that I'm well, and he kept on asking some questions: “Are you sure that you will work like before?” “Are you sure you are well?”. So, that was the discrimination that I faced there. And also, say people not being supportive.

Interviewer:

Okay, okay. Yeah. Okay. And, how do you think that might have influenced you, that experience of that kind of being questioned about whether you're fit to work and that kind of thing?

Nemy:

At first, I never looked, um, depression. And, then I was feeling guilty. Maybe I'm the one that I have the problem? So I should accept what people are doing to me. Yes.

Interviewer:

Okay. So yeah, it sounds like it really impacted you and sort of internalising what other people were saying. Yeah. Okay, okay. Um. And do you know anyone else, whether it's family or friends, or anyone really, that's also gone through postpartum psychosis?

Nemy:

Yes, a friend. But she recovered also.

Interviewer:

Okay.

Interviewer:

And do you know if your friend found that, she accessed support okay, or how was that for her?

Nemy:

Okay, personally, she did not share much. And after that it became so difficult to follow up about somebody, and I was also at amiss.

Interviewer:

Okay, that's fair enough. Yeah. Okay. Okay. Um, and, yeah, if you've got any friends or family, um, that have found it difficult to access mental health services in general, or... what's their experience been like?

Nemy:

Okay, personally, I can say maybe I experienced this. I, I got the services that is, because my partner was there. But let's say for people who have nobody to back them up, it's more difficult to access the services, the mental health services. Yeah.

Interviewer:

Yeah. So something around having the part, a partner, or someone close to you that can back you up, as you say.

Nemy:

Yeah.

Interviewer:

Okay. Um, and how do you feel that your cultural background is represented in services? Like within the NHS or mental health services?

Nemy:

Okay, say average? Not that good.

Interviewer:

Not that…Yeah. How do you feel about that?

Nemy:

Okay, maybe when, let's say maybe there could be policies to also list that voice for the Black for equal treatment. So before we went postpartum psychosis, or whatever the cause is to be, given also a chance, a better chance to access the services. Because most of the people they are suffering, and they, they are not aware of their rights. Yeah.

Nemy:

Yeah, yeah. So maybe something around how, um, help is offered, like how people let people know that what's out there, you know? Make people aware as well.

Interviewer:

Okay. And what might, other than what you've mentioned, what might be helpful to think about in order to improve perinatal mental health services? For women like you that have gone through this?

Nemy:

I think people choose... should avoid misconception and stereotypes... they shouldn't have... seek to understand hallucination. And somebody should not say, they should avoid being judgmental. And now, sort of maybe, their health care providers, they should guarantee confidentiality. They shouldn't let me discuss a person's condition with another person, without the consent of the person.

Interviewer:

Okay. Yeah. Yeah. So is it, did that kind of, did you go through that experience? Or is that something you, maybe you've heard about?

Nemy:

Okay, that's one something I heard about. Cuz... You like, somebody should let somebody tell it, on how only she's comfortable about sharing her story.

Interviewer:

Hmm. Yeah. No, yeah, you should always be made aware, shouldn't you of what's going to be shared, and how, and that kind of thing. I can understand that. You mentioned about stereotypes as well. Could you tell me a bit more about that? You don't have to go into personal detail, but maybe what that kind of means to you, the stereotypes that maybe people had and things like that.

Nemy:

Okay. Like, I told my friend, I, like her, she, she's, not, she, she has not had a kid and she has not experienced this. So when I was explaining to her about the condition, like I told her my symptoms, and er, what she went and told people then and so they guess… Nemy is running mad, like, then they're like, somebody who has experienced this cannot fully recover - those misconception now. They're like somebody who has experienced that cannot be a good parent, like, people are just judgement on, and they really don't know the condition. Yes.

Interviewer:

Yeah, totally. Yeah, that sounds really hard, hard to sort of, have someone say those things, but yeah, it is. I think you're right. It's when people don't necessarily know. But yeah, okay. Um, and what, apart from what is there anything else? Because you've mentioned quite a lot around what could be improved and things. Is there anything else that needs to be improved, you think within healthcare systems to support women, particularly Black women that go through postpartum psychosis?

Nemy:

Yes. Hmm. Let's say their posts, let's say post, post-training... Maybe after somebody has had the condition, then after that person has recovered, there should be, maybe, the post services, whereby somebody who had experienced that, that condition still goes, is monitored. Yes. Okay.

Interviewer:

As there is actually a charity called [name]. Have you heard of that?

Nemy:

No, no.

Interviewer:

It's a UK wide charity. And they offer things like peer support groups. So they offer a space for women with lived experience to connect with each other. But I guess they don't offer medical check-ups or anything like that. So, it's not the same as maybe, what exactly what you're saying. But that's, there's a couple of things out there. I am working with them to recruit people for this study. But I'm actually having more luck recruiting people from, like, Twitter and stuff. So I wonder, I wonder how much people know about these charities? Because maybe it's the same thing people don't know, because they're not. Unless you know, someone that's part of it, it's hard to find it, isn't it?

Nemy:

Yeah.

Interviewer:

So would you like me to share the link with you in an email over about that charity? Yes, it's they might, they might have something that you could benefit from, whether it's like a group or... so just information really. So I'm happy to do that. But yeah. But yeah, basically, you're saying basically longer sort of support around recovery... would be helpful. Yeah. Okay. And, and what do you think support might need to include to meet the cultural and social needs of Black women in the UK?

Nemy:

They should maybe be, be given a fair, fair representation. And they should... Yes, a platform maybe whereby they can voice out their issues and challenges and somebody listens to them. And they should be treated...

Interviewer:

Treated... equally did you say?

Nemy:

Yes, yeah.

Interviewer:

Yeah. No, those are really good, good points. Yeah. Thank you. Yeah, I think we've nearly, nearly covered everything. It's been really, really helpful. My last question, um, was... what would be helpful to focus on in research moving forward for women that are going through postpartum psychosis? In your view?

Nemy:

What would be... pardon?

Interviewer:

What would be helpful to focus on in research? So like, similar to my study? Any, any other research that would be helpful to focus on for women that have gone through postpartum psychosis?

Nemy:

Yes, I guess. I'm not guessing. I presume it's helpful because people that are straggling, people are going alone. They call that, er, just depressed, and they... when somebody does research, maybe he or she can discover better ways, better to create and, a new thing that can suit to fit the situation.

Interviewer:

Yeah, yeah. Okay. All right. Thank you so much Nemy. Did you have anything else you wanted to add to, or speak about?

Nemy:

Not really.

Interviewer:

You’ve given me so much information, I really, really appreciate it. Thank you for being so open with me. Um. Yeah, I think I've asked you more or less everything. Yeah. So I think that's it from me. Yeah, shall I, is there anything else, or I can stop recording if not?

Nemy:

You can stop recording.

Interviewer:

Thank you. So I guess with the next steps, what I'll do is send you an Email.

Appendix I: Group Experiential Themes, Subthemes, and Experiential Statements

**PP is postpartum psychosis*

Group Experiential Theme	**Subtheme**	**Experiential Statements**
1. ‘The Debilitating Impact Of PP* On Emotions’	1.1 Extreme ‘sadness’	Processes in the interview of sorrow, guilt and shame visceral narrative, makes you feel how emotionally debilitating (sad, shameful) the experience of PP was
	1.2 ‘Terrifying beyond belief’	Terrifying, emotionally scary Emotionally painful Birth trauma role and connection with PP
	1.3 ‘Intense anger’	Anger expressed as a symptom Anger at those closest Anger at discrimination experiences
2. ‘Disconnect With The External World’	2.1 ‘Disparity between the internal and external’	Hallucinations, delusions, paranoia, confusion, intense insomnia Belief in own reality, disconnected with external world and others’ perceptions Struggling to differentiate between reality

		and imagination Lack of knowledge about difference response to treatments, culture, historical oppression
	2.2 ‘Withdrawal is a means of protection’	Isolated in illness, withdrawing only protection Standing alone Visceral narrative Not wanting to be around people, leave the house
	2.3 ‘Black women are outcasts’	Feel like an outcast, don’t belong – lack of representation Barriers disproportionate to Black women The only Black pregnant one apparently Black and heavily medicated Doctors prefer whites, better treatment for white mothers Perfect mother is white and middle class
3. ‘Acceptance Is The Hardest Process’	3.1 ‘Accepting need help ‘	Accepting have mental health problem that’s so severe and you’re seeing things differently to everyone else Accepting need help (long time before reaching out just didn’t know) Strong narrative – I should be able to

		manage
		Immense pressure of cultural norms inhibit help-seeking
		Weakness, taboo in seeking psychiatric help
	3.2 ‘Accepting this diagnosis’	Accepting the diagnosis is hardest thing (and wrong diagnosis)
		Overly medicated because Black, treated differently
		Embarrassment and shame around stigma of PP – seen as crazy
		Taboo in seeking help within Black community (sign of weakness)
		She’s a mad Black lady and it just happens to them – being accepted in white society even harder now?
		Misconception of madness
		Not listened to, dismissed
		Not believed, made to feel a liar
		It’s because I’m Black – expectations/stereotypes/assumptions – i.e., not seen as vulnerable, feared by white doctors
4. ‘Power In The Advocate’	4.1 ‘Significant others are the ‘force of	Significant others crucial to recovery, noticing changes, supporting, being force of

	hope’’	hope Making healthcare accessible Power in advocate specifically more important than information – what about single mothers? Persistence in support from sig other makes all the difference: a lifeline, so helpful, inspired to integrate again
	4.2 ‘Power in self-advocacy’	Self as an advocate in LSA Own knowledge helped get through, own resilience and insight Contrast with most who did not have insight Not listened to for having insight
	4.3 ‘Rejection from significant others leads to internalised shame’	Rejected by family (abortion one SQ) – standing alone and sorrow Judgement from sig others leads to internalised shame and impact on recovery long-term Abandonment from friends, family, partner where abusive – sense of loss Desperate for connection, for saving, for help but nowhere to turn Power in making things far better or far

		worse
5. 'Black Motherhood As A Collective: Empowerment Vs Mythologies'	5.1 'Power in black motherhood community'	Shared identity feels at home, secure, safe, understood – use having other women helpful Shared experience validates trauma and helps acceptance and reduces burden of pain Cohesion, safety, appreciation, security, understood – community groups Cohesion is key, goes beyond this, it's feeling wanted in white dominated system Posttraumatic growth essential
	5.2 ''Mythologies' of Black Communities'	Not helpful if feel discriminated against – misconception of madness Mythology of Black women and having communities around them Felt broadly oppressed by school, hospital, family Rejected by all Lost in the system Overarching oppression/intersectional impact: class, money, motherhood, race, age (for youngest participant) Segregation perpetuated (see ones which

		didn't access treatment) Being ostracised comes from black communities and white communities Classist system – waiting longer for medication Depression is for rich white people Therapy is a luxury – financial or for people who don't work hard
	5.3 ''Mythologies' of Black motherhood'	Explicit racism is isolating and reduces help-seeking, impacts self-worth Internalising guilt, shame, feeling worthless – self-blame Shame in connection with motherhood I'm a bad mother You shouldn't have had a baby Workplace discrimination She won't recover, she's not a good parent Something in motherhood and stigma itself Role of Black mothers is fixed and selfless: must prioritise family not personal wellbeing