



Radically Open and Profoundly Alone: Psychosis in the Peripartum

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Abstract

Pregnancy and childbirth are considered one of the major life transitions, and as such they reflect a time of massive change and even transformation. This phase poses unique challenges to self-experience and identity and can be associated with problems of selfhood for the mother, leading, in some cases, to psychological or emotional disturbances, which can manifest as psychosis. Rather than seeing this psychosis as a collection of isolated and meaningless symptoms, this paper argues that experiences associated with these diagnoses are understandable developments of human subjectivity that relates to the whole peripartum (we therefore refer to peripartum psychosis instead of the more common denomination ‘postpartum psychosis’). We develop an account of peripartum psychosis through a novel integration of three sets of literature: (1) Three accounts of pregnancy and childbirth: one covers psychotic-like experiences without hospitalization, one covers normative (nonpsychotic) experiential alterations, and one covers psychotic experiences with hospitalization; (2) Feminist phenomenological literature studying the phenomenology of pregnancy, childbirth, motherhood, and breastfeeding; and (3) Phenomenological studies of *atmosphere*—the quasi-intentional intersubjective constitution and experience of affective qualities of the lived world. We suggest that peripartum psychosis involves the appearance of common and meaningful psychological processes involved in pregnancy, childbirth, and early motherhood, and that these processes are significantly impacted by the social and cultural atmospheres in which pregnancy and childbirth occur. This has implications for treatment and prevention of peripartum psychosis, as well as for our understanding of peripartum experiences more generally.

Keywords Pregnancy · Motherhood · Peripartum psychosis · Phenomenology · Atmospheres · Feminism

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Introduction

Pregnancy and childbirth are considered one of the major life transitions, and as such they reflect a time of massive change and even transformation for both parents, but especially the mother. The peripartum is therefore a liminal phase in which the mother prepares for a new role in the world, and in which her relation to herself and others is necessarily restructured and redefined (Wojtkowiak, 2020). The significance of this transition, long recognized worldwide in many cultural traditions relating to childbirth, has generally not been addressed in medical settings, though there have been recent movements recognizing its importance for positive birthing outcomes (e.g., Crowther & Hall, 2015).

The questions raised by the notion of peripartum mental health—such as when does a mother’s experience become “pathological,” and how should it be understood and addressed—appear against this backdrop of significant reorganization, change, and vulnerability. From a biomedical perspective, significant experiential changes and associated disturbances are viewed as signs of a biological illness, which then call for more medical interventions (observation, medications, hospitalization). This may be especially true of the experiences associated with what is typically designated “postpartum psychosis”. In this introduction we will give an overview of existing research on postpartum psychosis in order to integrate it into our framework on peripartum psychosis (a shift in terminology that is discussed below).

Postpartum psychosis is typically described in psychiatric literature as a rare psychiatric condition that may appear during pregnancy or in the weeks and months following childbirth. Although not a distinct diagnosis in the current *Diagnostic and Statistical Manual of Mental Disorders*¹ (DSM5-TR; American Psychiatric Association, 2022), postpartum psychosis refers to significant alterations in mood, cognition, behavior, and general orientation that occur during pregnancy or during the year following childbirth, though these changes most frequently occur within two weeks of childbirth (Perry et al., 2021). Frequent symptoms include hallucinations (especially auditory and visual, but not uncommonly in other sensory modalities), delusions (frequently relating to oneself or the baby), significant changes in mood (especially depression, elation, irritation, and anxiety) and sleep, and the potential for confusion, disorientation, and other changes in awareness (Kamperman et al., 2017; Cohen et al., 2025). It is estimated that 1–2 out of 1000 deliveries are accompanied by changes that are classified according to conventional diagnostic practice as postpartum psychosis (Perry et al., 2021).² Estimations of historical change in prevalence

¹ Instead, it is typically classified as a form of mood disorder, i.e., bipolar I disorder with psychotic features with peripartum onset or major depressive disorder with psychotic features with peripartum onset (American Psychiatric Association, 2022). Early editions of the DSM did include postpartum psychosis as a distinct diagnosis, but this was dropped in 1980, apparently due to beliefs among influential psychiatrists that it did not constitute a distinct disorder, separate from other forms of psychosis. Recent efforts to re-establish a unique diagnosis have failed, with similar rationale given (Spinelli, 2021).

² This literature, along with the additional literature cited below on pregnancy, childbirth, and peripartum mental health, is conducted primarily or entirely within WEIRD (Western, Educated, Industrialized, Rich, and Democratic) societies (Henrich et al., 2010), and as such is significantly limited in its applicability. The conclusions and recommendations of this paper are therefore similarly limited.

are rare, with only one study (to our knowledge) directly comparing cohorts at the turn of the 20th century and the turn of the 21st century, finding a significant decrease over time in diagnosis rates (Tschinkel et al., 2007)—though this samples only one limited community in the U.K. and so faces challenges to generalization. However, reports on recent trends in perinatal mood and anxiety disorders more generally indicate significant increases over the last one to two decades (Bertram et al., 2023; Zivin et al., 2024).

Postpartum psychosis has received relatively little attention in psychiatric research and is often treated as identical to other forms of psychosis, despite clear indicators that it has distinct etiological and risk factors and is defined as only occurring within the initial days and weeks following the birth of a child (Jefferies et al., 2021; Spinelli, 2021). There are reasons to question this narrow scope. For example, women with a history of bipolar disorder *are* at higher risk for a relapse during pregnancy than during other stages of life (Bergink et al., 2012)—but these findings may lead to greater emphasis on bipolar disorder over the changes and experiences that come with pregnancy and childbirth. Gressier et al. (2020) write that currently, “no formal guidelines are available” for the treatment of postpartum psychosis (2020: 290). In the United States and other countries in which there are few or no psychiatric Mother-Baby Units (psychiatric wards that allow the mother and baby to remain together), women diagnosed with postpartum psychosis are typically hospitalized in general psychiatry wards, during which they are separated from the newborn (Griffen et al., 2021; Nonacs & Cohen, 1998). The predominant biomedical approach to treatment is pharmacological (Bergink et al., 2016; Cohen et al., 2025), though many medications for bipolar disorder and psychosis may carry risks for pregnancy and breastfeeding.

Research on the etiology of the illness is inconclusive. Several studies have indicated that difficult or traumatic pregnancy and birth experiences, problematic family support, or difficulties related to breastfeeding and motherhood are viewed by women as factors contributing to the development of their postpartum psychosis (e.g., Glover et al., 2014). Women with lower socioeconomic status (Nager et al., 2006) and who face significant stress (Hazelgrove et al., 2021) are more likely to develop postpartum psychosis. Furthermore, perinatal mental health stigma has been identified as a significant barrier to seeking support and treatment among pregnant women and mothers (Daehn et al., 2022). However, most hypotheses regarding causal factors emphasize biological changes occurring during pregnancy and after childbirth (for a review, see Perry et al., 2021).

Studies focusing on the *experience* of postpartum psychosis and events surrounding it emphasize several major themes. (Here we refer to papers by Engqvist et al., 2011; Glover et al., 2014; Hunter, 2013; Jefferies et al., 2021; Robertson & Lyons, 2003; and Vanderkruijk et al., 2024.) These studies reveal a significant shift in subjective experience and consciousness, frequently away from a more mundane attitude of everyday engagement with worldly activity and one that becomes (hyper-) focused on the infant and women’s subjective processes themselves. Participants in these studies described experiencing a heightened awareness of cultural expectations of motherhood, expectations that they themselves may have internalized, but which were repeatedly reinforced through encounters with social and medical systems. They also noted that there was very little place for distress or distressing experiences

within this discourse, and they found themselves increasingly alone and isolated with their experiences. They further described a diminished ability to trust intersubjective reality, and that they felt trapped in a materialization of their most devastating fears. Participants described having difficulty knowing what to trust—the reality of their fears, or the reality of others—representing an unattainable ideal against which their own experiences were judged as incorrect and unacceptable.

In this paper, we argue that the full peripartum period, from pregnancy through childbirth and the postpartum phase, needs to be considered in its entirety in order to adequately address the experiences involved in psychosis affecting pregnant women and new mothers. For the remainder of the paper we therefore use the (somewhat less common) term “peripartum psychosis” to designate this entire transitional phase. We further argue that these processes are significantly impacted by the personal, social, and cultural atmospheres in which pregnancy and childbirth occur.

In support of this argument, we bring into dialogue three sets of literature: (1) Three accounts of pregnancy and childbirth, from women who encountered a wide range of experiences, including psychotic and more “normative” experiences. (2) Feminist phenomenological literature studying the phenomenology of pregnancy, childbirth, motherhood, and breastfeeding. (3) Phenomenological studies of *atmosphere*—the quasi-intentional intersubjective constitution and experience of affective qualities of the lived world.³ Crucially, in bringing together both lived experience and literature on the phenomenology of pregnancy/childbirth and atmospheres, we will demonstrate the ways that pregnant and maternal subjectivity arises in a world; therefore, attention to this world, including institutional expectations of and responses to pregnancy, childbirth, and maternal distress, is essential for understanding and responding to significant alterations in experience during the peripartum.

Three Narratives of Childbirth

Here we present three narratives of childbirth and the postpartum period. Two of these narratives are those of the authors—one of whom had psychotic-like experiences (PLEs), the other of whom experienced some stress and anxiety related to childbirth and the postpartum phase (but did not experience anything akin to psychosis). The third is a summary of *Inferno* (Cho, 2020), a published narrative of peripartum psychosis. These three narratives have been included to demonstrate the continuity of peripartum experiences between that which would be considered relatively “normal” or asymptomatic to changes that would be classified as psychosis.

In choosing what to include in these descriptions, we attempt to foreground the experiences that are most relevant and important to each of the women, which nec-

³ In this paper, we do not attempt to establish a comprehensive model of peripartum psychosis, as might be offered in the tradition of phenomenological psychopathology; therefore, we do not attempt to thoroughly discuss all potentially relevant forms of experience in this condition, such as temporality, intersubjectivity, and affectivity—though these are clearly relevant and embedded throughout the narratives and our discussion. Instead, we hope to highlight several features that are distinct in peripartum experiences, which, as we discuss, have some major implications for subsequent work on this topic in the field of phenomenological psychopathology.

essarily means that less personally relevant features of experience are omitted. We also include certain interpretations and statements of value or preference that relate to their pregnancies and childbirth, as they point to important meanings and values as well as the social and cultural contexts of their experiences, as we discuss later. Indeed, as Ritunnano (2022) notes, attending to meanings and values as they relate to the context in which certain phenomena appear is essential to understanding “a person’s lifeworld as she engages in acts of...self-interpretation” (2022: 253f.).

Cynthia’s Story

Since I had experienced psychosis three times before becoming pregnant, I was considered a pregnant psychiatric patient. I was informed that there was a 20% chance of psychosis after birth, and an obstetric protocol was proposed to prevent this. I had already experienced how alienating the objectifying medical gaze of psychiatry could be. Now I experienced how the objectifying obstetric gaze also affected me. I recognized its alienating effect and immediately felt a sense of resistance. It felt like there was something at stake. In cooperation with my husband and self-employed psychiatrist we managed to set up good preventative care. That was not easy.⁴ Everybody, myself included, was watching me through a magnifying glass during the postpartum.

I did not receive a psychiatric label during that period, but I did record some unusual phenomena and some psychotic-like-experiences.

As an example, the smell experience during my postpartum differed greatly from prematernal experiences. This change in olfaction already started during pregnancy; for example, I could no longer tolerate perfume. Perfume however is still clearly external and synthetic. It really got confusing right after giving birth. I strongly remember the smell after giving birth. It reminded me of the smell at the butcher, unpleasantly pungent and all-encompassing like a droning false chord. I wondered where that smell was coming from. Later, when I told the doula, she was surprised. She had not had that aversion and, as always, she had just enjoyed the smell of childbirth. Smell of childbirth? So my scent? My husband also confirmed that the smell came from my body. I had never experienced my own body odor like this before. How could nausea be caused by an odor from within? The amniotic fluid could clearly be attributed not only to myself, but also to my son. But shouldn’t I experience my son as part of myself? The smell was unmistakably emanating from my body. I found it very confusing.

Conversely, my repertoire of pleasant smells also expanded. Previously, there were only a few “dirty” smells that I could appreciate, such as my husband’s body odor after a work-out. During the postpartum period I was amazed by how another objectively foul odor made its entrance as an agreeable smell; namely the smell of my baby’s poop. And to take it a step further; the smells of the baby poop and my own poop were in sync during the second postpartum period with the successful breastfeeding! Not very surprising considering the baby being fully dependent on my

⁴ For more on the difficulty of arranging good obstetric care, see *Birth Justice* by van der Waal (2024: 257ff.).

juices, but either way confusing. I experienced that something I would call ‘mine,’ namely my digestion, partly took place outside my body.

These two examples show confusion on two dimensions, namely the dimension ‘mine’ and ‘other’ and the dimension ‘knowing that I am here, and therefore not there’. The confusion about the source of a phenomenon was not limited to olfaction alone. It also appeared in the way I perceived sounds and movements in the postpartum period. Uncertainty about the source of certain sounds led to some strange situations. For example, I heard speech, but did not connect it to a mouth as the source. There seemed to be a temporary ‘ih’ cloud that penetrated expressions of people in the room in several ways. The baby made “ih”-like sounds, the maternity nurse cooed with “ih” sounds and I heard an excessive amount of “ih” sounds in the speech of others. Similarly, there was a synchronicity of movements in my maternity cocoon between me, my husband, maternity nurse, and baby that, in a psychotic state, would certainly have made me search for the choreographer of it all.

The intense contact off the beaten path was sometimes frightening. The environment, and I myself, tried to get a grip by measuring everything immediately after birth. But something as simple as a gaze, for example, could not be measured. The blank stare of my newborns evoked a sense of unease. I looked for something human in their eyes, but found nothing. During those same first days I saw distorted faces outside. Facial expressions were grotesquely distorted. These were scary hallucinations. In the second postpartum, this unease seemed to be sufficiently addressed by dreams. For example, I had nightmares about zombies, and when feeding did not go well, I dreamed that my baby had turned into a hand-sized doll. My dreams seemed to suggest to me that there was something of the inanimate or alien in this experience of a blank stare.

I was familiar with such loss of the natural attitude from previous psychoses. So when I started to have flashbacks of my psychosis, it wasn’t very surprising. I searched for something to hold on to and felt an urge for incantations. My psychiatrist comforted me. He sketched the landscape that was to come and marked a clear beginning and end of the journey. He also suggested a ritual: instead of a typical psychiatric ritual with a pill, he suggested that we end every evening in a festive way with one glass of brown beer. I needed this foothold for the next few days. One night, many buried memories from the third psychosis returned. They carried with them a promise of knowledge if I would only follow the unfinished line of thought a little further. I knew that stepping out of this train of thoughts would mean that I would not have access to the insights the next day. Fortunately, I had conditioned myself before the birth that there would be no truth-seeking, no revelation worth losing the connection to daily life and thus to my newborn. And so I stepped out and woke up the next day knowing that I had made a sacrifice. What probably also helped in the aftermath of the nightly avalanche of ideas was the focus on everyday actions and daily rituals of care. The rhythm of feeding, changing, caring broke the rhythmic cadence of the train of thoughts, like how Orpheus played a song on his lyre as to drown out the seductive songs of Sirens. The psychotic-like experiences ebbed away after a couple of days.

In retrospect, I can say that one of the most important considerations was to keep my surroundings and the people around me as constant as possible. This was especially important given how “spread out” and open I felt my self to be during this

time. During the process of giving birth and during the postpartum, I was surrounded by familiar faces. I even met the medical people beforehand. That all formed part of the psychosis prevention plan devised by my husband, my psychiatrist, and me. It appeared to be a wise decision to do most of the labor at home, with my husband and doula, in a tranquil atmosphere, and to cocoon in the attic afterwards with no visitors but my parents and parents-in-law for a couple of days.

Fortunately, I had the privilege of having the right network to tailor prevention to my situation. I didn't adhere to the protocol of preventative psychiatric hospitalization because I felt the atmosphere mattered. I didn't adhere to the protocol of preventatively chemically numbing my feelings because I felt my feelings could not selectively be numbed. Retrospectively I think I was right to sense that there was something at stake. My psychiatrist later told me that he would indeed classify my initial postpartum condition as prodromal. According to him, it was the absence of the "fear factor" that ultimately allowed the situation to normalize. That is why he considered it important to ensure that those around me did not react with fear. He knew from experience that fear was an important factor in the prodromal phase.

Liz's Story

During my pregnancy, I found the changes to my body challenging, and initially difficult to accept. I struggled to give up running, but did so after tripping and falling early on, and even gave up longer walks when my body started protesting. I also found the idea of having a separate life inside my body to be mystifying: I could imagine (and see and feel) a separate life developing, and I also immediately experienced movements and changes *from inside*, but I could not wrap my head around this growing that was both me and not me. I began writing to my unborn child, I think partially to try to do something with this experience that resisted my understanding. At the same time, I found myself uniquely sensitive to my surroundings. I could hardly bear to walk through the bath and beauty supply aisle of the drug store, because I would be attacked and invaded by all the horrible, synthetic scents. I chose to spend time outdoors as much as possible, going for long walks in the woods and swimming in the lake, as much for my own wellbeing as to somehow share these experiences, I imagined, with my not-yet-born child.

I was skeptical of the model of care in my local community, where you did not know what doctor would deliver the baby, and where I did not feel like I could build up any trust with whoever that person would be. As a result, I chose to give birth in a smaller but well-regarded hospital, where I built up a relationship with the doctors and midwife, and where I could go for long walks in the woods (and escape email) while waiting for my child to come. Although this choice was expensive and challenging (it meant long drives for check-ups through windy roads in the middle of the winter), I felt an insistent and even urgent need to be responsive to my body and my child.

This was March of 2020. As I was creating a safe and welcoming space around me, the world was collapsing. A week after my due date, I was convinced to be induced in part because of how hospitals were responding to the pandemic. I acutely remember sobbing to my midwife on one of my last prenatal visits, alone, when I thought that

my husband would not be allowed to be present during labor and delivery—at which point she removed her mask and hugged me, rejecting the new pandemic safety protocols recently put in place, in a profound gesture of human compassion and care. And eventually, my husband was allowed with me.

After my daughter was born, she was with me all the time. I carried her in a sling on my body, nursed constantly, and tried to sleep from time to time. On those rare waking occasions when she was not with me, my body felt the absence, almost like a phantom limb: it wanted to have the weight, the bulk, and felt lesser because my daughter was absent. I also experienced waking nightmares, as did my husband, when we woke up searching the sheets in a panic, sure we had somehow lost our daughter in the moment when we lowered our vigilance. Intrusive thoughts were fairly common, and ranged from images of dropping my daughter, to thoughts and dreams of home invasion, to worries about electrical fires. As for many mothers, sleep was difficult, and I woke at the slightest stirring from my daughter (not to mention the frequent nighttime feedings), often with difficulty falling asleep again.

I was lucky that she had relatively little difficulty nursing, as there was no one able to come to our house and support this process during the pandemic. Nursing felt like her answer to our separation, her sense that we were connected again in the way that felt familiar and right to her. And feeling her relax allowed me to relax. But still this was not always easy: she seemed to feel whole and connected during this time, but nursing asked so much of me. It was both a relief and a loss when I eventually made the decision to fully wean her.

As a new mother, I initially found solace in seeing my changed and sometimes distressing experiences as continuous with “normal” maternal distress and difficulty. I feel lucky to have had relationships with women who could share with me their own stories of distress, disappointment, surprise, and transformation during pregnancy and postpartum, and who could listen to mine without judgment or dismissal. During the pandemic, we were already cut off from the typical trappings and routines of the outside world; what would it have meant for me to feel cut off from love and understanding as well?

Catherine’s Story

Catherine begins her narrative in her memoir *Inferno* (Cho, 2020) by describing the Korean traditions following childbirth: mother and child are not supposed to leave the house for 21 days, the mother is not supposed to have water on her body for one week, her first meal is supposed to be a traditional seaweed soup. Catherine, a Korean American born and raised in the United States and living in London, describes how she broke these traditions “or superstitions, as I thought of them” (2020: 1), culminating with a “fateful thing” (2020: 1), a trip across the U.S. to introduce her extended family to her son, two months after his birth. Although arguably it is the stress of this trip that precipitates her psychotic symptoms, Catherine describes many impactful experiences, starting with her pregnancy.

During the prenatal period, Catherine finds herself reflecting on her past, and her family’s past: the fact that she is having a son reminds her of an earlier, physically abusive relationship with a man, and on his mother: “How would it feel, to have

something of my own creation, a beautiful thing, become twisted and dirty and abusive?” (2020: 103) she writes. Similarly, she thinks about her grandmother’s wish for a son, and of the three generations of women that ended now with her. She remarks on her unborn son’s movement in her womb, she attempts to grapple with his semi-independent existence: “I held my hands close to my stomach and tried to feel the tiny beats of his legs, the pulse of his body, the reminder that he was alive, a living thing” (2020: 102), while at the same time feeling a strange distance from her own body: “Pregnancy felt like a separation from the body. My body was doing something on its own, a pre-programmed path it already knew, and I no longer had any control over it...It was also an erasure of self...My body was no longer my own...” (2020: 103).

During the birthing process itself, Catherine is induced two days early because of her gestational diabetes and the large size of her baby. Her labor progresses slowly, she develops sepsis after the breaking of her waters, and she ultimately ends up having a C-section. When her son is delivered, she remembers thinking “are you sure? He didn’t look like either of us” (2020: 107). And later: “I didn’t feel a rush of love or an overwhelming weight of responsibility, emotions that I’d been expecting. Instead, I felt curious, like I’d just been introduced to a stranger” (2020: 109).

She is surprised by the sheer physicality of caring for her son, how her body still is not really hers even though her son is no longer inside her. She is grateful for the brief times she has to herself, when she can “remember that I had a self, that I was something more than a mother,” (2020: 125); though she struggles with this notion of identity—of fully embracing her new role as a mother, and of her feeling that that role had changed everything for her: “My identity, my existence had shifted without me realizing it. The axis of my world had changed. Everything was now in relation to this other life” (2020: 126).

As Catherine recovers and rests, she is scolded by her mother for not following Korean tradition more closely, and by her parents-in-law for wanting to travel with her son before the 100-day celebration, an important marker in Korean culture of the child and mother’s entrance into the social world. Catherine’s family visits friends in San Diego, then Catherine’s brother-in-law in Los Angeles. Catherine first starts to become aware of difficulties after she realizes that her brother-in-law’s house has numerous Nest Cams, which she initially laughs off, but starts to become more preoccupied with.

Visiting her parents-in-law in New Jersey, she faces what feels like a barrage of criticism related to her decisions as a parent and her son’s health. Feeling trapped and stifled, Catherine starts to experience more and more stress. Later she discovers that her parents-in-law have Nest Cams also, which are accessible to James’ brothers as well. When she expresses her feeling to her husband that no one is listening to her or seems to care about her experience, he states “‘You’re doing great ...Don’t worry about them...They don’t mean what they say’” (2020: 157).

Soon, Catherine starts to have the sense that her mother-in-law is sending secret signals to her via gestures and eye movements. Her father-in-law, though trying to express empathy and awareness of her struggles, ends up frightening her with horror stories of other women with postpartum illness. Catherine feels it is necessary to leave their house, at least temporarily, and so she goes with her husband and son

to a hotel in town, but while there she becomes even more convinced she is being watched and filmed. It is at this point she looks at her son and sees his eyes as “devils’ eyes” (2020: 172), and others’ faces start looking distorted. Catherine hears the voice of God telling her that her son must be sacrificed. She is immensely distressed by this prospect but feels there is no option to disobey the will of God. She comes to think of herself as Beatrice, and her husband as Dante, and that they are both fated to move through Hell. She has repeated visions of her son, dead, in her husband’s arms, feeling like time is looping and splitting off into different possible futures and bringing the past into the present.

Ultimately, her husband takes her to an emergency room, where she is put in restraints, given antipsychotics, and eventually committed to an involuntary psychiatric ward for over a week. During this time she is separated from her son and has brief phone contact and infrequent visits with her husband and parents, as she gradually understands where she is and why. When she was discharged and reunited with her son, who by then is bottle feeding, she has difficulty recognizing him or experiencing an emotional response: “We were separate beings, truly separated,” she writes. “It was like he had been cut from me, again” (2020: 243). When she returned to her home in London, she fell into a deep depression that lasted for several months, during which she continues to struggle to feel a sense of connection or capacity to care for her son. Gradually, though, this returned, until “one day, an ordinary day, as I was holding him, I remembered him. His smile, the feel of his breath against my arm, the warmth of sun against our cheeks, the weight of his body against my own. And I was a mother again” (2020: 256).

Feminist Phenomenology of Pregnancy, Childbirth, and Motherhood

Although it has not explicitly discussed peripartum psychosis, the field of feminist phenomenology provides a context for the subjective changes that occur in this condition by situating them within the transformation of awareness and subjectivity that generally takes place during pregnancy, childbirth, and the postpartum period.

Pregnancy is discussed as a condition in which the illusions of separateness and unity are laid bare—where the woman’s body is both herself and not herself, its movements are hers and yet they also belong to something that exceeds her. Here we can see the placenta as what LaChance Adams and Lundquist (2013) call (following Irigaray) “a vital mediating space,” the organ that “preserves differentiation within the relationship. There is neither fusion nor conflict, but a negotiation...” (2013: 16). Similarly, Verhage (2013) sees pregnant embodiment as suggestive of Merleau-Ponty’s vision of the “contact surface”: a relation between body and world that is porous, pliable, and allowing for exchange between “two separate but connected entities” (2013: 314).

This porosity and fluidity is evident in Liz’s and Cynthia’s experience of the too-closeness of particular scents and images, as well as, for Cynthia, the strange otherness of her own scent, the strange familiarity of her baby’s scents, and the lack of boundaries around sounds and movements. For Cynthia, this disintegration of the ‘thingness’ of perceptions made her doubt what belonged to her and what did not.

For Liz, we see this transformation in her shifted body boundaries after childbirth and her sense of relaxation and relief during childbirth, but she also describes the ways these expanded boundaries too must shift with her daughter's development and her own needs. Catherine similarly describes a shift in identity and boundaries that she attempts to adapt to after childbirth, both taking actions to remind herself "that I was something more than a mother" while also seeing that her "identity, my existence had shifted without me realizing it".

Confronting the newborn as a separate entity, then, can be shocking after this sense of merging and stretching of one's own boundaries of the self. Simone de Beauvoir (2011) suggests that the new mother faces surprise, sadness, and estrangement at first meeting her child face-to-face: "The being would not exist without her, and yet he escapes her... The woman would like to feel him *hers* as surely as her own hand: but everything he feels is closed up inside him, he is opaque, impenetrable, apart... she is stupefied by the indifference with which she receives him" (2011: 549f). Catherine's sensation of meeting a stranger, her attempts to grapple with the identity of her child and related confusion, her lingering feeling of disconnection all seem to refer, at least partially, to this new phase of the continued process of renegotiating the boundaries of self and the relation to the new being created within one's body. Cynthia's dreams about zombies and a baby-like doll also reflect such shock.

The pregnant woman also becomes aware of the anonymous physicality of her experience, the ways that her subjectivity (perhaps most obviously her body) heeds its own call, outside of the dictates or desires of the conscious ego. This physicality may present a particular dilemma or risk for women in misogynist or patriarchal cultures, since it points to the animal quality of living inherent to all humans and risks de-humanizing or debasing women who may be more explicitly confronted with it (de Beauvoir, 2011); addressing this difficulty itself may be a kind of taboo. Trigg (2021) notes how this physical "anonymity" is especially present during childbirth itself, finding that this transformational moment shows how "the body can appear for us irreducibly as one's own while also never being entirely possessable by the subject" (2021: 631), something that he also links to the disconnection and *disbelief* the mother can feel with her newborn as well as to the range of affective reactions women can have toward the act of childbirth. Nausea and insatiable hunger, fatigue and surges of energy, body aches, heartburn, sleeplessness, heightened sensorial and emotional sensitivity, the phases and movements of labor and childbirth—all of these come upon a woman, requiring her constant adaptation and adjustment.

Feminist philosopher Bigwood (1991) calls this the "physical," a Greek term reflecting an upsurge of life force from within: "In pregnancy, a woman actively and continually responds to the fresh 'physical' [nature] upsurge that independently runs through her body with a life of its own". The pregnant woman is passively swept into a flow that exists beyond and before her, but one that she can take an active stance toward—something called "pactivity" by the philosopher Bornemark (2023). This is also apparent in breastfeeding, where, as Verhage (2013) notes, "rather than quietly settling into a purely natural process, I am again creatively engaged in and struggling with an action over which I do not have full control" (2013: 319).

In Liz's story, we see some difficulty initially coming to terms with these processes, involving the changes in her body. Catherine similarly describes the sense of

strangeness she feels from this new relationship to her body: “My body was doing something on its own...[it] was no longer my own”. For Liz, Cynthia, and Catherine, this receptivity extended beyond the childbirth process to their cognitive processes (unusual perceptual experiences, intrusive or confusing thoughts, unbidden memories, automatic associations to personal and family past, heightened alertness). As Cynthia describes, although she could not control what she became aware of and how, she did experience herself as being able to organize her cocoon/surroundings in a way that helped her feel grounded and safe; for Liz, contextualizing these experiences in the range of “normative” maternal responses allowed her to respond to them with greater (if not total) flexibility and ease. Along these lines, it might be said that Catherine’s altered perceptions and interpretations of her situation (such as believing she is being watched continuously, seeing others’ faces as distorted, thinking her son needs to be sacrificed) reflected her attempts at making meaning out of and wresting a sense of control over interactions and encounters that were distressing and uncontrollable (such as being recorded without her consent, receiving critical feedback on her parenting, or dismissive responses to her concerns).

Feminist phenomenology also exposes the discrepancy between the lived experience of this expanded subjectivity, its intimacy and familiarity, and the objectification of medical institutions, which emphasize control and measurement. Young (1984) and Levesque-Lopman (1983) both note that the pregnant woman is primarily addressed within the medical setting, with the consequence that her state is assumed to be abnormal, indeed even “sick” or “diseased” and needing management and treatment. Here, the doctor is the one with specialized knowledge, and the woman is the patient, the passive recipient of this knowledge. Her welfare, according to this model, depends on the degree to which she conforms with the advice and strictures of the physician. We see Cynthia and Liz attempt to avoid this pressure, at least in part, by choosing birthing settings in which they developed trusting relationships with medical providers,

Simultaneously, others have pointed to the effects of popular discourse and conceptions of motherhood. This includes Hays’ (1998) identification of the cultural shift of the 1990s toward “intensive mothering,” which involves wide-ranging expectations that mothers be highly devoted to their children above all else, a devotion which includes frequent turning to experts for guidance (see also Ennis, 2014, for discussions of more recent manifestations of intensive mothering). Consistent with these arguments, a study of several authoritative perinatal mental health texts identified key themes in these texts, including: emphasis on the mother’s wellbeing primarily in service of the family, medicalization and individualization of distress, and belief that expert clinicians were necessary to treat mothers with perinatal distress (Pape, 2014).

These forms of objectification and circumscription of experience serve to deny the ambiguous qualities of subjectivity the pregnant woman may be faced with—a denial that may feel much more comfortable to woman and medical provider alike, but one which may come at a cost—including, but not limited to—decreased awareness of and ability to respond actively to the body during the pregnancy, labor, and early

mothering.⁵ Catherine becomes hyper-aware of the expectations and worried watchfulness of family and friends through their constant questioning and critiques, which is made even more concrete when she realizes that she is literally being watched by security cameras in her relatives' homes.

One way that we might think about peripartum psychosis is as a failure to navigate this expanding awareness of selfhood. Mothers might easily get swept up, confused, disoriented by these changing boundaries, the paradoxes of separate-and-together, subject-and-object, actor-and-acted upon that are present but so little addressed in literature, particularly medical and popular literature—both of which act as normative forces for pregnant women. However, feminist phenomenology does not stop with a focus solely on the individual: it also recognizes the crucial role of the *institution*—part of the situation in and through which a mother experiences herself.

The institutions associated with motherhood, we find, frequently leave very little room for understandable confusion, tension, distress, and discomfort that result from such a transformative experience. It is easy to see how experiences, thoughts, feelings that do not conform to this discourse, and that instead attempt to express these impossible splits—within subjectivity, and between subjective experience and institutionalized expectation—can get taken up as *a problem*, one that may be alternately treated as a medical illness, dismissed as a momentary weakness, or hidden away as a shameful secret. The woman then finds herself caught between two worlds—the one of her own experiences that are undeniable but that cannot find any home or harbor, and the one reflected back to her as the “correct” or “healthy” way to experience pregnancy and motherhood. That she should be unable to reconcile these is therefore unsurprising; as we see in Catherine’s story, it is both facing this conflict between her experience and the expectations of others, coupled by others’ dismissal of her distress and concern, that eventually pulls her into an isolated hell, one that gets labeled as psychiatric symptoms that result in her hospitalization.

Debordering Maternity: Contributions of New Phenomenology

This feminist approach, however, still tends to take the woman as more-or-less “separate” from her surrounding social and cultural world, and it emphasizes more active intentional processes involved in making meaning out of her lived experiences. Of course, a major driving ethos in phenomenology is the attempt to avoid such divisions and objectification, as Merleau-Ponty (2008) writes evocatively: “Man is before himself in the world, and it is in the world that he knows himself” (2008: 62). But this recognition is vulnerable to getting lost when attention is focused on the acts of *intentionality*, in which readers might mistakenly conceive of a separate subject engaging in uni-directional acts that constitute a world. An approach to phenomenology called *New Phenomenology*, originally developed by Schmitz (2023), offers an important entry into the more fluid, affective, and embodied qualities of experience, one that has

⁵ Schuetze and von Maur (2022) have suggested that such tendencies and practices in medical childbirth settings are more general products of a society with a predominantly *rationalistic* orientation (see, 712f.).

been taken up by a number of writers in phenomenological psychopathology, among other fields (see, e.g., Costa et al., 2014; Esposito & Stanghellini, 2024; Fuchs, 2019).

Here we do not deny the relevance of original ideas from foundational writers in phenomenology. This includes Husserl (1970), whose later work on the *lifeworld* sees transcendental subjectivity as embedded in the taken-for-granted and pre-given world of our daily lives, Merleau-Ponty (2008) on the *intertwining* of subject/body and world, and Heidegger (1962) on *moods* and *attunement* to the world. Also clearly relevant is more recent work by Roald et al. (2021) that centers the affective and atmospheric nature of subjectivity. But we suggest that New Phenomenology offers important conceptual tools that more precisely target the affective and atmospheric qualities of motherhood and peripartum psychosis (see also Otero, 2022 for a discussion of New Phenomenology's unique emphasis on the "embodied and affective resonance" of subjectivity (2022: 140), and Moldzio (2004) for a discussion of certain key differences between classical and "new" phenomenology related to psychopathology).

The starting point for New Phenomenology is affectivity. We are affectively involved in our surroundings; affect is the first hint of what matters to us and how. For Schmitz, "affective involvement is 'the most important thing in life' precisely because it clearly points out 'what humans take seriously and for or against what they choose to take action with a great heart'" (Schmitz, 2003: iii; in Gugutzer, 2020: 187). Affect is our capacity to *be moved* by this world, by what are called "social actors": other people (including infants), non-human animals, also spaces, and "atmospheres". The concept of "atmosphere" refers to feelings that are felt subjectively but that can also permeate and be picked up from a particular environment or situation (e.g., the solemn spirituality of a cathedral, or the madness of a rioting crowd).

For this reason, human beings are characterized as *patheurs*—individuals that are motivated and driven by "vital and intuitive impulses rather than...rationally and methodically acting individual[s]" (Gugutzer, 2020: 188). There is an important quality of being acted-upon at the heart of the notion of the *patheur* that, when extended further, suggests a subjectivity that is constituted through its intertwining with the so-called external world. This is also related to the way Schmitz describes emotions. He considers "emotions as atmospheres [that] are spatial in a surfaceless space" (Schmitz, 2019: 94). This way of describing emotions moves a large part of the story of Cynthia into a normative context. While Schmitz and others in this tradition have developed this theory and its implications quite a bit further (describing, e.g., different types of social actors and "quasi-things," different forms and levels of "vital drives," etc.), these initial concepts still offer much to the conceptualization of peripartum experiences.

Fear, understood here as an atmosphere poured out into space, plays a role in the story of Liz. Liz's terror at the possibility of being alone during childbirth—itsself a reflection of a world atmosphere of uncertainty and fear at the dawn of the pandemic—could have easily derailed her birthing process, but for the soothing responsiveness and genuine care of her midwife in that moment. Cho also had to deal with anxiety. Unfortunately, Cho was unable to overcome her anxiety, as she had to deal with anxiety-inducing conditions; she had to endure a lot of comments from her overprotective mother-in-law, while her father-in-law shared frightening stories of

postpartum depression. We might say that in her case, many people brought anxiety into the perinatal space.

With Cho's narrative in mind, it's quite revolutionary how the psychiatrist from Cynthia talks about "the fear factor". By emphasizing that *bystanders* should not be frightened, he actually approaches the feeling more as an atmosphere than as an internal condition. This approach is consistent with feelings that are like atmospheres poured into space. If fear were to enter Cynthia's cocoon, it would inevitably flow through Cynthia as well, with all the consequences that entails.

Although it is each woman who expresses their affective experience, this affect is not simply *within* these women: each woman expresses an affective atmosphere that invades them—is them at the same time that it is quasi-independent of them. Here we see that the choices women make, or cannot make, bring them into contact with affective atmospheres that either facilitate their successful maternal transformation or else impede it: ending the day with a celebratory glass of beer; spending the lay-in period in a cozy, familiar attic; spending the prenatal period surrounded by wilderness; feeling the urgency of the impending pandemic; becoming more and more aware and impinged on by the gaze and judgment of others; finding minimal response to one's concerns or wishes. All of these are encountered and taken up by the women as part of their experiences of childbirth and early motherhood, and as such, they are inextricable from their sense of wellbeing, comfort, and stability; or conversely, their distress, mistrust, and destabilization.

New Phenomenology offers the opportunity, then, to look beyond the mother, and even the mother-child dyad in experiences of pregnancy, and of peripartum psychosis. This reflects what Schmitz calls a *debordering* of experience—the individual may be the locus of the experience, but that experience is not only within her. So it can no longer simply be about, e.g., whether the woman actively takes up or rejects sociocultural messages of idealized motherhood in relation to her own lived experience, or whether she has faced certain experiences that make her more vulnerable to distress or psychosis. Instead, New Phenomenology forces us to reckon with the inescapability of social actors—places, atmospheres, other people *will* act on us; more accurately, *we are* them.

That doesn't mean they inevitably move all people in the same way: although Cho's psychosis may have been inevitable *for her* given where she found herself at this vulnerable stage of her development, her narrative points to the unique way she was moved by her surroundings and how this arose from her long personal (and family-cultural) history of being moved in the world. However, if we take this notion of situationally-embedded *pathours* as the zero point of subjectivity, then it shifts the locus of peripartum experiences, including peripartum psychosis, to a shared social space. Along these lines, Dörpinghaus (2016), a midwife and phenomenologically-informed professor of midwifery, advocates for caregivers to take into account the impact of atmospheric elements and bodily resonance when assisting in the birthing process, and to act accordingly; Otero (2022) similarly suggests that affective atmospheres are foundational to the psychotherapeutic encounter; and Roald et al. (2021) find that the process of affective attunement between mother and infant reflects not only mother and child as engaged individuals, but also involves the shared space they both find themselves in.

Subjectivity may feel especially fluid and open during pregnancy and the postpartum because of the unavoidable challenges this state presents to previously unquestioned assumptions of agentic, individual subjectivity. The nature of engagement with this process is that of *becoming*: an affective transformation that must now account for *something new*—something that calls up all the old affective commitments that the woman embodies and requires their reworking to respond to this completely unprecedented situation. As Cho writes, “My identity, my existence had shifted without me realizing it. The axis of my world had changed”.

Schmitz (2023) identifies how subjective engagement with one’s situation requires the qualities of receptiveness, flow, oscillation, and attunement—qualities that are equally needed of the pregnant woman and new mother as she faces the challenges posed by this affective transformation. However, these qualities may be easily blocked or derailed, including through the anxiety and terror about the mother’s transformation and what is required of her, as well as through traumatic or difficult childbirth or postpartum period, problematic social environments, physical exhaustion, and certain medical interventions—each of these creating its own affective atmosphere that may interrupt or intrude on the possibility for flow and receptiveness. (Similarly, Otero (2022) argues for a primary role of affectivity in psychopathology, finding specifically that alterations in one’s capacity for flexible resonance with the world can characterize a range of conditions.)

A successful matrescence—the transition to a new personality—requires such a flow or receptivity during the peripartum period. If the transformation stalls, a paralysis of the personality can occur, one of the roots of schizophrenia according to Schmitz (in Moldzio, 2004: 64). In fact, the extraordinary receptivity to atmospheres as described by Cynthia shows similarities to what Conrad would describe as the *Trema*—a phase of heightened awareness to imperceptible and unstateable global or atmospheric changes thought to precede the more specific and obvious changes of acute psychosis (Conrad, 2012)—although Conrad does appear to suggest that these atmospheric changes arise within the individual rather than, as New Phenomenology suggests, as something between the individual and their world. A second crucial difference between the *Trema* and Cynthia’s experience seems to be the relationship to ‘that which is to come’: with the *Trema*, there is an anticipatory sense of excitement or fear, which manifests in later acute psychosis symptoms, whereas with Cynthia, the atmospheric changes could be addressed and modified to support healthy integration into maternal identity. In addition to not allowing fear to enter the cocoon, the way in which the psychiatrist helped by marking the beginning and end of the journey may well have made the difference.

Considered in this light, the devastating and intrusive experiences of peripartum psychosis might be understood as an atmospheric interference with the newly predominant structures of subjectivity that arise in the peripartum. Whether a woman develops psychosis during the peripartum, or not, is no longer the sole result of internal processes, but must include the result of an estrangement/alienation caused by the

inability to allow for and integrate certain kinds of experiences that challenge more comfortable norms and assumptions.⁶

Conclusions

As we have detailed above, phenomenology allows us to attend to the subjectivity that is expressed through peripartum psychosis, while also helping to see the ways that this is continuous with the range of experiences that occur during the peripartum phases. In particular, we see that women are faced with a newly expanded awareness of the boundaries of their subjectivity, finding these to be more fluid and open than they had been aware of in the past. They are also aware of the uncontrollable acts of the body, to which they are more (though not entirely) passive observers. And they are faced with a range of internalized and externally expressed institutional expectations related to motherhood, which may be drastically at odds with their experiences. Such openness, fluidity, and vulnerability may trigger a radical transformation of identity and self-awareness, one that starts with pregnancy but continues long past childbirth.

Feminist attention to the role of the institution and New Phenomenology's awareness of affective atmospheres in the shaping of subjective experience show us that such difficulties are *not* the provenance of the woman as some separate individual (indeed, that none of us can be conceived as wholly separate individuals), but surface through her as an expression of her participation in the world—a world that too frequently prioritizes control of the physical, knowledge of the self, and the idealization of motherhood, while fearing ambiguity, uncertainty, and risk. This atmosphere may impede a woman's natural process of facing and coming to terms with the challenges and even distress that maternal subjectivity seems to require. Though not the only aspect of psychosis worth attending to (and here we do not deny the intertwining of experience with bodily-physical processes—indeed, this would be contrary to phenomenology's vision of the embodied subject), the attention in peripartum psychosis shifts from a sole focus on the mother and various individual processes to a deeply embedded subject whose experiences are meaningful and expressive of her unique situation.

This perspective on pregnancy and motherhood requires us to critically evaluate the ways peripartum psychosis is presented in scientific and psychiatric literature. Consider, for example, the decision to classify peripartum psychosis as simply a specifier (“with postpartum onset”) for other forms of psychosis in the *Diagnostic and Statistical Manual of Mental Disorder* (DSM; APA, 2022), which arguably contributes to a dearth of research on the distinct nature of these experiences (Brown, 2019). But establishing a distinct psychiatric diagnosis raises the very real risk of further pathologizing a wide range of maternal experiences and erasing their potential meaning and significance for the mother (for some discussion of this topic as it relates to schizophrenia, see van Os, 2010).

⁶ Also see, e.g., Dörpinghaus (2016: 75) on the choice of a c-section as a reflection of fears related to being in contact with the body and loss of autonomy.

The insights suggested by this paper are relevant to work in the field of phenomenological psychopathology, a discipline that applies the concepts and methods of phenomenology to systemically investigate the experiences of mental illness. Much of the work on psychosis in this field centers on discussions of schizophrenia, proposing that the experiential alterations in this condition, and their manifestation in acute psychosis, are the result of disturbances of minimal selfhood or *ipseity*—that is, disruptions of the basic sense of being present to and the origin of one’s subjective experience (Sass & Parnas, 2003). However, our findings suggest caution in developing models that overly emphasize an isolated self, one in which basic subjective processes, and any alterations or disturbances, are viewed as primarily residing *within* an individual. Instead, models of psychosis need to more fully recognize a self and experience that occur and appear within a pre-existing social, cultural, and historical world (see Pienkos, 2020) and to emphasize the role of affect and atmospheres in psychopathology (see Francesetti & Griffero, 2019). Models of peripartum psychosis in particular would benefit from a phenomenology with a more *sociological* lens, offering greater attention to the “social...construction of social reality” (Gugutzer, 2020: 2) and the ways this is taken up by individuals. Some conceptual footholds for this direction already within phenomenological psychopathology include Pienkos et al.’s (2023) “situated phenomenology” and Ratcliffe’s (2017) discussion of *loss of basic trust* in the development of psychosis, as well as Sass and Feyaerts’ (2024) contextually-responsive revision of the ipseity disturbance hypothesis.

Ignoring perinatal subjectivity almost ensures pathologization of otherwise normative experiential transformations; this, as we have seen, can drive those experiences underground, creating an atmosphere of fear and shame. Similarly, a focus on individual pathology, whether in conventional biomedical psychiatry or in phenomenological psychopathology, ignores what appears to be distinct about the differences in subjective experiences between women with peripartum psychosis and those without: those with psychosis find themselves in inescapable situations or atmospheres where their experiences and concerns find no harbor but are viewed as increasing evidence of the woman’s instability and unfitness for motherhood. Put differently, a culture that maintains an objectifying and individualizing medical attitude toward peripartum psychosis, whether viewed as simply one manifestation of broader category of illness, or viewed as a distinct diagnosis, risks propelling women into psychotic alienation.

If, instead, we view peripartum psychosis as partially expressing a sociocultural incapacity to face and contextualize the unique subjectivity of early motherhood, it requires a very different stance toward prevention and treatment. Medical professionals would be counseled to take time with women to hear their concerns and establish relationships of trust and support that permit true shared decision-making around pregnancy, the birthing process, and beyond. Similarly, treatment would recognize the delicate state of the new mother’s subjectivity, one that is naturally finding new contours that must take into consideration the newborn as well. Keeping the mother with the newborn and supporting her as she works to understand and integrate the more distressing or intrusive aspects of her experience seems crucial, particularly to the ongoing development of her identity, and to the porous interface between subject and world, which starts with childbirth. Moving away from the dominant biomed-

cal perspective requires society to redistribute responsibilities. Here, prevention and care becomes a social and community concern, in which both formal and informal discussions of pregnancy and motherhood include all the messiness, uncertainty, and challenges that occur in these situations. The goal is to establish a new maternal atmosphere, which is not intended to prevent psychosis, but to create a space that recognizes and respects the radical experiences of subjectivity that must be borne by new mothers.

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