UNTOLD MOTHERHOOD ENCOUNTERS:

AN AUTOETHNOGRAPHIC ACCOUNT OF POSTPARTUM PSYCHOSIS IN MALTA

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Abstract

This autoethnography explores my lived experience with postpartum psychosis in Malta, focusing on the intersection of personal, familial, and professional narratives. Through a qualitative lens, this research incorporates the voices of key collaborators: my mother, husband, sister, former Head of School, my perinatal psychiatrist, and midwife present during my hospital admission. The results reveal that my experience with postpartum psychosis, while profoundly personal, is also shaped by broader social dynamics, including cultural, systemic, and relational influences. For example, despite the pervasive stigma surrounding mental health in Malta, which led me to conceal my pre-psychotic depression, I received significant material support from my close network. However, no one detected the warning signs of depression until the condition escalated into a full-blown psychotic episode. This may have been partly due to my own efforts to mask my depression, influenced by the idealised narrative surrounding motherhood. Emotionally, I did not feel entirely ‘safe’ with those around me, reflecting how my attachment style contributed to the situation. My avoidant tendencies may have played a role in the progression of my condition. The findings also highlight that severe stressors served as unavoidable triggers. Additionally, the midwives lacked experience with postpartum psychosis. My treatment improved after diagnosis. My twin sister, a midwife, also helped to ensure that I received treatment at the main state hospital in a gynae ward together with my baby while other mothers with postpartum psychosis are to this day separated from their baby and referred to a psychiatric hospital. This study's strengths include the use of autoethnography to capture my lived experience with postpartum psychosis, the incorporation of the father's perspective, and the contributions of my co-storytellers. Policy recommendations include improving family-work policies, evidence-based training for healthcare professionals on maternal mental health, integrating

family therapists and peer experts into care services, and ensuring equitable treatment for all patients.

Keywords: postpartum psychosis, idealised motherhood, attachment, feminism, autoethnography, Malta, maternal mental health, systemic

For my late father, whose learned pen, brush and piano keys eloquently composed the silences I painfully longed to break.

Your stories remain forever within.

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List of Abbreviations

PP – Postpartum Psychosis

PMHC – Perinatal Mental Health Clinic

PPD – Postpartum Depression

PIMHA – Parent-Infant Mental Health Alliance

PMHIs – Perinatal Mental Health Illnesses

MBU – Mother and Baby Unit

MCH – Mount Carmel Hospital

MDH – Mater Dei Hospital

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Chapter 1: INTRODUCTION

1.1 Prologue

As the world outside lay shrouded in the stillness of a late May afternoon, a gentle voice echoed through the dimly-lit room. "Come, come, my dear", it whispered softly, "Let us go to bed together so that you get some rest".

The voice belonged to my mother - a person who cared deeply; whose only concern was the wellbeing of her distraught daughter.

The room, usually a sanctuary, now feels oppressive.

While my mother drifts into peaceful slumber beside me, I lay paralysed by a thick blanket of fear, listening to helicopters hovering above. Their incessant whirring cuts through the stillness, a menacing reminder of a world in turmoil.

As anxiety swells, I feel haunted by an intangible threat, unable to shake the sensation that forces beyond my control loom close.

With my mother asleep, I endure the darkness and noise alone, awaiting the men in black to come and capture me and settle the score.

1.2 Journeying into Motherhood

On a September evening in 2015, our son was born. In the sterile operating theatre, the medical team worked swiftly. My husband, in a green gown and white cap, stood by me as I lay on the stretcher, arms strapped, awaiting the emergency C-section.

The hours leading up had been exhausting, marked by the rhythmic beeping of monitors. Then, amid the controlled chaos, a newborn's cry filled the room, bringing tears of joy and relief.

Neil had arrived, and our journey into parenthood began.

1.3 An Unexpected Blow – PP Strikes

Eight months into motherhood, life took a harrowing turn. I found myself back in the hospital, this time involuntarily admitted with postpartum psychosis (PP), a condition that would unexpectedly change my life.

PP is a severe psychiatric condition often requiring immediate hospitalisation (Sit, Rothschild & Wisner, 2006). It is characterised by symptoms such as depression, mania, confusion, delusions, hallucinations, sleep disturbances, and obsessive or persecutory beliefs about the infant (Ramsauer & Achtergarde, 2018). PP carries a heightened risk of suicide (5%) and infanticide (4%) (Monzon, di Scalea, & Pearlstein, 2014).

The demands of motherhood, lack of sleep, and newborn care strained my mental and emotional wellbeing. What started as mood swings and anxiety soon escalated into bewildering distress and confusion.

1.4 Putting Pen to Paper – Sharing the Unsayable

The events that led up to this moment are the heart of this dissertation. They narrate a deeply personal and painful journey.

In the months after this troubling chapter, I began documenting my experiences, realising that sharing my story could both shed light on this misunderstood condition and provide personal catharsis (Fixsen, 2023).

This journey is challenging, but one I feel compelled to take. The events leading to my involuntary admission and struggles with PP form the narrative of this dissertation – a story of pain, resilience, and hope.

During my recovery, therapy guided me on a journey of rediscovery, sparking a strong urge to share my story. It felt too important to remain suppressed, as it could help others silently struggling.

The team at the Perinatal Mental Health Clinic, who had been crucial in my recovery, began discussing the creation of a new NGO, the Parent-Infant Mental Health Alliance (PIMHA). Their mission resonated deeply with my newfound purpose.

I vividly recall that summer morning, far from home on holiday, when the lead midwife who had supported me during my darkest hours called to ask if I'd join the Board of a newly formed NGO. It was an opportunity I couldn't refuse.

My involvement with PIMHA marked a new chapter in my life. As part of the organisation, I led a support group for mothers facing perinatal mental health issues, creating a safe space for them to share their struggles and triumphs.

This experience deepened my commitment to mental health, driving me to seek more than empathy. I wanted the tools and knowledge to create real change, so I decided to pursue training as a family therapist.

Becoming a trainee family therapist was a natural step in my journey to support those with mental health challenges, focusing on family dynamics, relationship complexities, and healing.

This journey was about more than my healing; it was about paying forward the compassion I had received. I aimed to help others navigate their mental health struggles, reflecting the resilience and empathy that guided me out of my own darkness.

1.5 In Search of a Method – Autoethnography

In my first meeting with my principal supervisor, I expressed my desire to share my personal story through qualitative inquiry methods. Autoethnography emerged as the best fit for my narrative.

Autoethnography allowed me to blend personal experience with academic research, enabling me to narrate my story while grounding it in analysis and exploring both personal and societal challenges for a better future (Adams, Holman Jones & Ellis, 2022).

The idea of autoethnography resonated deeply with me. It seemed like the perfect way that would allow me to write about epiphanies that transformed the trajectory of my life and use my personal experience to illustrate facets of cultural experience (Ellis, Adams & Bochner, 2011).

The excitement within me fuelled my research journey as I prepared to use autoethnography to share my narrative, guided by the research question:

What is the story of living with PP in Malta?

1.6 Epistemological Stance Regarding Psychiatric Diagnoses

Psychiatric diagnoses are shaped by the medical community and reflect socially-constructed norms of what is considered ‘normal’ (Boyle, 2002). Terms like 'madness'

influence how behaviour is observed and treated, serving to legitimise control through professional authority (Hunter, 2013).

Popular culture often portrays motherhood as idyllic, shaping the ideal of the ‘good mother’. This ideal can lead to guilt and feelings of loss among mothers who don't meet this standard, with the gap between expectations and reality intensifying emotional burdens (Choi, Henshaw, Baker and Tree, 2005).

In summary, these concepts highlight the complex relationship between societal constructs, mental health, and the pressures mothers face in meeting motherhood expectations and stigma.

1.7 A Feminist Framework

Feminism has long questioned psychiatric diagnoses within a patriarchal medical context that impacts women's identities as mothers (Swartz, 2013). Historically, madness has been linked to women's reproductive bodies, with their reproductive health seen as affecting both their psyche and wellbeing (Hunter, 2013).

Niven and Walker (1998) argue that viewing Perinatal Mental Health Illnesses (PMHIs) solely through a bio-psychological lens ignores the impact of patriarchal culture, which often portrays women's struggles as a reaction to subjugation. This leaves mothers with PP powerless within a medical system that demands they conform to the 'good mother' role (Robertson & Lyons, 2003).

1.8 A Systemic Framework

In this research, I will utilise a systemic framework to conceptualise PP in interactional terms. I will view myself as the index person, within various contexts,

considering symptoms linked to present relationships, family-of-origin, and larger socio-political factors (Jones & Asen, 2000).

Systemic thinking also emphasises understanding a family's difficulties within the context of life cycle transitions (McGoldrick, Carter & Garcia-Preto, 2015) and family structure, including roles, boundaries, and power distribution (Minuchin, 1974, as cited in Dallos & Draper, 2010). For instance, PP symptoms may arise after the transition to motherhood and can be linked to disempowerment, family dynamics, and the family's relationship with external services (Burbach & Stanbridge, 1998).

The systemic perspective avoids blaming individuals or families for problems, focusing instead on the interconnections of meanings and communication patterns (Gehart, 2018). This approach emphasises relationships and the needs of each family member, rather than following a linear path that may increase polarisation (Burbach & Stanbridge, 2006).

1.9 The Maltese Context

Malta, situated at the heart of the Mediterranean with a population exceeding 535,000 in 2023 (*Malta Population Growth Rate, 1950-2023*, (n.d.), has experienced rapid transformations.

Malta has deep religious influences embedded in its culture, with Catholicism as the official religion according to the Constitution. The Church plays a significant role in education and media, and 36% of the population attend Sunday mass (Discern, 2018). While displays of religiosity vary (Discern, 2022), Malta has evolved from a conservative society to a more diverse and liberal one, alongside a growing economy (Borg, Sammut, Grech, Lautier, Priebe & Azzopardi-Muscat, 2022).

Despite changes, traditional Mediterranean values like family support, religion, and shame still shape Maltese society's view on mental illness (Satariano & Curtis, 2018). Mental health services in Malta have often been neglected (Abela, Farrugia, Vella & DeGiovanni, 2016), with a shortage of trained professionals, one of the lowest in Europe (Camilleri, Sammut & Cachia, 2019).

While Malta is moving towards community care, discussing mental health remains rare, though growing awareness campaigns on work-life balance are increasing acceptance of mental wellbeing discussions (Scerri, Sammut & Agius, 2023).

Moving to local services, the PMHC has been operating since 2000, offering multidisciplinary support to pregnant and postpartum women (Felice, 2017). The team provides medication guidance, psychological therapies, and promotes mother-infant attachment, working closely with community mental health clinics and maternity services (C. Zerafa, personal communication, November 9, 2023).

Malta's Strategy for Positive Parenting (Abela & Grech Lanfranco, 2016) supports parents during the perinatal period. A pilot study is testing systemic psychotherapeutic interventions, including the Parents as Partners programme, for parents facing mental health challenges and post-birth relational distress (Ponzetti, 2016; Grech Lanfranco, 2021).

1.10 Layout of the Study

The upcoming section provides a review of the relevant literature related to the research question. Following this, Chapter 3 will detail the research methodology, and Chapters 4 and 5 will present the findings along with the discussion of themes. Chapter 6 will conclude the study.

Chapter 2: LITERATURE REVIEW

Sitting on my hospital bed, overwhelmed with confusion, I kept wondering - what was happening to me? My psychiatrist gently said, "Debbie, this is postpartum psychosis". In that moment, everything clicked. Finally, I had a name for what I was facing. Though the path to recovery was long, I felt comfort in knowing I wasn't alone.

2.1 Literature Search

In this chapter, I will explore the literature on PP, focusing on the firsthand experiences of affected women. To do this, I conducted a comprehensive search using keywords like *postnatal, postpartum,* and *puerperal psychosis*.

I began with a broad search to gain a comprehensive overview of the topic before narrowing my focus. In the second phase, I used phrases like *mothers' experiences, impact on mother-infant bond* and *effects on family relationships* in the HyDi database. The search engines included ProQuest Central, EBSCOhost, Springer, Wiley, and Elsevier.

Prioritising recent peer-reviewed articles, I also included older literature for its unique perspectives. The global literature search was comprehensive, avoiding focus on any specific region or country.

2.2 Unveiling the Veil: Understanding the Depths of PP

The term PP traditionally refers to intense mood disorder episodes that occur abruptly after childbirth, usually within the first two weeks (Perry, Gordon-Smith, Jones & Jones, 2021). However, VanderKruik et al. (2017) argue that the lack of a consistent time frame in the literature has led some studies to examine psychosis cases occurring beyond the typical period, raising questions about whether they should be classified as PP.

PP represents the most extreme manifestation among psychiatric disorders associated with childbirth, with an occurrence rate of approximately 0.3 to 0.6 per 1000 births (Bergink, Boyce & Munk-Olsen, 2015), while another study has found a prevalence rate of 5 in 1000 births (VanderKruik et al., 2017). These estimates of incidence seem to align quite closely with the commonly cited prevalence of 1 to 2 in 1000 births in the overall population (Kendell, Chalmers & Platz, 1987). The varied definitions and assessment methods for PP prevent data pooling for a comprehensive estimate. Additionally, PP is misdiagnosed in at least 50% of cases (Montero et al., 2017).

Women with a history of bipolar disorder, previous postpartum issues, or advanced maternal age are at higher risk (Forde, Peters & Wittkowski, 2019). However, nearly half of affected women have no identifiable risk factors (Valdimarsdóttir et al., 2009).

PP is considered a ‘psychiatric emergency’ (Jones & Smith, 2009: 411) necessitating prompt evaluation and typically leading to hospital admission to address acute symptoms (NICE, 2020). Specialised treatment and support for the mother-infant relationship are recommended, ideally through admission to a Mother and Baby Unit (MBU) (Gillham & Wittkowski, 2017). Unfortunately, inconsistent service provision means that this is not always achievable (Di Florio, Smith & Jones, 2013).

To date, there is no MBU in Malta and mothers with PP are admitted to Mount Carmel Hospital or Obstetric Wards at Mater Dei Hospital. The baby is separated from the mother at MCH (personal communication with midwife, 2023).

2.3 Unravelling the Shadows: Recognising PP Signs and Symptoms

The arrival of a baby marks a significant life transition, and for numerous mothers, it can heighten susceptibility to mental health issues (Di Florio et al., 2013). Ensuring effective mental health care during the perinatal period is vital for sustaining well-being and facilitating maternal role adjustment (Byrnes, 2018). Untreated PMHIs pose risks to mothers, their infants, and the overall family.

PP typically has a rapid onset, often within hours, with most episodes beginning between days 3 and 10 postpartum (Bergink et al., 2011a). Early warning signs may include insomnia, anxiety, irritability, and mood swings, followed by elated or depressed moods, confusion, and disorganised behaviour. Common features of PP include persecutory delusions and delusions of reference, with visual hallucinations and symptoms resembling delirium occurring more frequently than in non-postpartum psychotic disorders (Gordon-Smith et al., 2020). Delusions and hallucinations may involve the infant and can be concealed due to stigma or lack of insight (Chandra, Bhargavaraman, Raghunandan & Shaligram, 2006).

Because PP is associated with a significant risk of suicide (5%) and infanticide (4%) (Monzon, di Scalea & Pearlstein, 2014), it is crucial to identify it early. Spinelli (2009) emphasises the importance of inquiring about thoughts of self-harm or harm to the infant in any mother presenting with a PMHI.

Catatonia is also a common occurrence in PP. Mutism, withdrawal, and negativism are the most common characteristics of catatonia in PP (Nahar, Kondapuram, Desai & Chandra, 2017). PP involves fluctuating mental states and often a lack of insight. Heightened vigilance, strong social support, and close monitoring are essential, especially for women

with risk factors. Given the rapid changes and potential risks to mother and infant, admission to a MBU, where available, is recommended (Bergink, Rasgon & Wisner, 2016).

Fortunately, the outlook for PP is positive, with full recovery possible through medication, though depression may persist after psychotic symptoms subside (Forde et al., 2019). The presence of bipolar disorder is a significant risk factor for PP development (Jones & Craddock, 2001). Other risk factors encompass primiparity, pregnancy and obstetric complications, c-section, lack of social support, history of mental illness, stressful life events, oestrogen reduction, past psychosis, and sleep loss, among others (Upadhyaya, Sharma & Raval, 2014).

Primiparous mothers with PP face a higher risk of recurrence and future bipolar episodes (Perry, Gordon-Smith, Jones & Jones, 2021). Due to the complexities of PP, seeking various forms of support is crucial, particularly as the child is involved. Involving the family in the treatment process is essential (Posmontier, 2010).

2.4 Echoes of the Storm: Mothers' experiences with PP

Forde, Peters, and Wittkowski (2020) conducted a meta-synthesis on mothers' experiences with PP, analysing views from 103 women and 42 family members across 15 studies. Using thematic synthesis, they found each mother's experience to be unique, with recovery being non-linear and shaped by social context. The study only included mothers from Western countries, excluding perspectives from developing regions with different family structures and healthcare systems.

In the initial phases of PP, mothers expressed feelings of shock (Heron et al., 2012) and encountered horrifying experiences (Glover, Jomeen, Urquhart & Martin, 2014). They described a rush of thoughts and harboured fears that their baby might be taken away from them (Engqvist, Ferszt, Ahlin & Nilsson, 2011). Consequently, they chose not to confide in

anyone and attempted to conceal their struggles. This reluctance to share their feelings delayed the family's decision to seek help, with fathers noting that it was only during a critical moment of extreme distress that they grasped the urgent need for the mothers' assistance (Boddy, Gordon, MacCullum & McGuinness, 2017).

The mothers described their experience as traumatic, distressing, and overwhelming, with fear heightened by involuntary hospital admission, leaving them feeling powerless (Heron et al., 2012). The sudden onset of PP, along with a lack of information, contributed to their sense of unpreparedness (Forde, Peters & Wittkowski, 2020).

The mothers also highlighted the significance of pivotal moments that contributed to a sense of hopefulness (Engqvist & Nilsson, 2013). Instances such as sharing experiences, establishing a connection with their baby (Robertson & Lyons, 2003), and the necessity of rebuilding friendships played a crucial role in helping them regain a sense of normalcy. As their close relatives began to believe in the possibility of recovery, the mothers started feeling like themselves again (Engqvist & Nilsson, 2013). Despite the challenges, the mothers felt stronger and more self-assured, using their newfound strength to support others and deepen their appreciation for those close to them.

2.5 Witnessing the Storm: Understanding PP's Impact on Family Members

Engqvist and Nilsson (2013) detailed how family members encountered comparable feelings of despair, expressing a sense of being unprepared for the sudden and severe onset of the experience. The lack of information about the disorder further contributed to their unpreparedness (Forde et al., 2020). To mitigate self-blame, family members externalised the cause of the condition, attributing it to factors such as a traumatic birth, sleep deprivation, or hormonal imbalance (Roberts et al., 2018).

Fathers found caring for both mother and baby difficult, but admission to an MBU often provided relief through better safety and care. Family members struggled to recognise the affected individual (Holford et al., 2018). The literature highlights a lasting sense of change that must be accepted (McGrath, Peters, Wieck & Wittkowski, 2013), feelings of guilt for not meeting parenting expectations (Engqvist et al., 2011), and sadness over not pursuing additional children due to the risk of relapse (Robertson & Lyons, 2003).

Similarly, family members reported developing deeper connections and increased empathy towards their relatives and individuals experiencing mental health conditions (*ibid*.).

2.6 Worn Threads: Unravelling PP's Impact on the Mother-Baby Bond

PP can negatively affect mother-infant bonding, which starts in pregnancy and shapes future attachment and maternal role fulfilment (Shrestha, Adachi, Petrini & Shrestha, 2019). The bonding process is shaped by physiological, psychological, and social changes, and adapting to an infant’s needs can be overwhelming for some mothers postpartum (Pazzagli, Buratta, Coletti & Mazzeschi, 2023). These challenges can increase vulnerability to psychological issues, hindering emotional bonding. Research suggests that negative emotions like PPD and anxiety impair bonding and increase parenting stress (*ibid*.).

Notwithstanding this, maternal psychopathology is linked to later psychopathology in children (Wan, Abel & Green, 2008a). Wan and Green (2009) further contend that maternal mental health plays a crucial role in shaping the development of a secure attachment style from infancy. The lack of social or partner support compounds the situation (Abel, Webb, Salmon, Wan & Appleby, 2005).

In a longitudinal study that investigates maternal perceived bonding from pregnancy to twelve months postpartum, and parenting stress in both women at risk of PP and those at risk who suffer a postpartum relapse, Biaggi et al. (2021) found that those at risk who later

developed PP exhibited negative affective experiences toward their pregnancies antenatally and toward their infants postnatally, in contrast to at-risk women who remained well postpartum.

A recent study found impaired mother-infant bonding in 17.6% of women with PP admitted to a MBU, with bonding improving as psychiatric symptoms decreased (Gilden et al., 2020). In a small subset (0.05%), bonding issues persisted even after symptom remission.

Though PP is a unique disorder on the bipolar spectrum affecting both mother and infant, it remains unrecognised as a separate diagnosis in psychiatric manuals (Di Florio, Smith & Jones, 2013). Research on PP's causes and treatment is limited. With generally positive outcomes when treated early, understanding PP's risk factors and origins could improve early detection and reduce its impact on mothers and infants (Jairaj, Seneviratne, Bergink, Sommer & Dazzan, 2023).

2.7 Closing the Gap: A First-Person Exploration of Unexplored PP Research

A comprehensive literature review seems to reveal a lack of first-person autoethnographic accounts on the experience of PP.

Current literature, still in its early stages, mainly focuses on a biomedical model within a medical context (Hunter, 2013).

This writing seeks to address this gap by providing an insider perspective.

2.8 Harmony in Closure: Reflections and Insights

In this literature search, I was moved by the resonances I found. What once felt isolating now brings comfort, knowing my experiences align with those of many other mothers facing similar challenges. It feels like a blessing:

In the knitted tapestry of words I find reprieve,

A literature search, a solace to believe.

For in this shared narrative, a refuge I see,

Closure and acceptance, a gift granted to me.

Chapter 3: METHODOLOGY

3.1 Embracing the Autoethnographic Journey

This dissertation was driven by my conviction that silence is unacceptable in the face of mental health stigma.

My research question aligns with autoethnography's methodology, fostering an 'epistemology of insiderness' (Adams, Holman Jones & Ellis, 2015). This approach offers an insider's perspective on culture, providing unique insights and challenging beliefs inaccessible to outsiders.

In quiet moments, I reflect on storytelling, an art my late father mastered. His voice, rich with experience, animated tales of childhood antics and vibrant local band club characters, infusing life with vivid colours through his narratives.

Unlike my father, who effortlessly told stories, I've always felt anxious about sharing mine. This anxiety peaked in the summer of 2019, during the PIMHA launch at the University in Valletta, when I was asked to share my personal experience with PP.

But standing in the shadow of the historic building, I felt connected to the past and the stories it held. I realised it was time to craft my own unique story.

A 2023 online meeting with my supervisor about incorporating my PP story into my dissertation transformed my academic journey, placing my experience at its core. Sharing it beyond my inner circle became a liberating, empowering act, turning my struggles into a compelling narrative.

Choosing autoethnography felt natural, as it blends personal narrative with cultural analysis, offering a fitting way to explore and convey the depth of my experiences (Cooper & Lilyea, 2022).

After the meeting, I felt a quiet anticipation, ready to begin a journey of self-discovery and academic inquiry.

This was more than a dissertation - it was a step toward reclaiming and sharing my story with the world, offering growth and support for others on similar paths.

3.2 Understanding Autoethnography: An Introspective Approach

Autoethnography is a qualitative method providing deep insights into personal experiences, contrasting with broader data on large groups (Adams et al., 2015). It combines ‘auto’ (self), ‘ethno’ (culture), and ‘graphy’ (writing) to use personal narratives to explore cultural beliefs and identities (Ellis, Adams & Bochner, 2011).

Autoethnography uses personal experiences and life-writing techniques, like memoirs, to reflect on key events, emotions, and aspirations (Adams & Herrmann, 2020). It involves 'memory work' (Bochner & Ellis, 2016) and 'reflexivity' to explore the connection between personal identity and cultural context (Jones, Adams & Ellis, 2016).

The 'ethno' part of autoethnography involves critiquing research, identifying patterns, conducting interviews and fieldwork, analysing discourse, highlighting 'epiphanies' and aesthetic experiences, and providing insights into areas often closed to outsiders and other research methods (Adams & Herrmann, 2020).

Lastly, the 'graphy' in autoethnography calls for creating detailed, vivid, and often emotionally impactful portrayals of experiences ('thick descriptions') and balancing 'showing' and 'telling' these stories (Geertz, 1976, in Adams & Manning, 2015).

Autoethnographers also prioritise ethics, thoughtfully presenting themselves, others, and events within their narratives (Adams, 2008; Bochner & Ellis, 2016).

3.3 Doing Autoethnography: The Process

In autoethnography, researchers blend personal narratives with research, interviews, or artifact analysis to meet social science standards (Ellis, Adams & Bochner, 2011). This approach deepens cultural insights by combining personal experiences with scholarly analysis (Denzin, 2006).

3.4 Writing Autoethnography: The Product

In autoethnographies, researchers use detailed descriptions, field notes, interviews, and artifacts to reveal cultural patterns and engage audiences, aiming to inspire personal and societal change (Bochner, 1997; Ellis, 1995).

3.5 Rationale: Why Autoethnography?

Autoethnography does not claim to produce superior findings but offers an alternative way to examine cultural experiences (Jones, Adams & Ellis, 2013). Autoethnographers create detailed ‘thick descriptions’ of cultures to deepen understanding (Geertz, 1973, as cited in Jones, Adams & Ellis, 2013).

While methods like Interpretative Phenomenological Analysis (Smith et al., 2009) and Narrative Inquiry (Flick, 2009; Reissman, 2000) were considered, autoethnography was chosen for its focus on both the personal ('auto') and cultural ('ethno').

As a PP survivor, I aim to uncover the hidden complexities of trauma that outsiders may not understand. Autoethnography allows for a deeper exploration of cultural experiences often overlooked by traditional research methods (Philaretou & Allen, 2006).

Experiencing PP has been turbulent, but writing has provided a therapeutic outlet. Autoethnography helps researchers process and express challenging experiences (Holman Jones et al., 2013), using writing as inquiry (Richardson, 2000) and a path to healing (Adams, 2012). Though cathartic for the author, it also aims to inspire and offer hope to others with similar experiences (Ellis, 2004).

Autoethnography offers relatable insights and guidance for life's challenges, aiming to provide 'equipment for living' (Burke, 1974, in Holman Jones et al., 2013) through narratives that offer more than just ideas (Bochner, 2002).

Autoethnography suits my purpose by breaking the silence around cultural experiences, emphasising subjectivity, personal narrative, and emotional depth, challenging academic norms that overlook life's complexity (DeLeon, 2010).

Conventional research values objectivity and dismisses subjectivity and emotion, often seen as feminine. Autoethnography challenges this by embracing personal experience, uncertainty, and emotion, exploring how identities shape our views and behaviours (Ellis, 1991).

Autoethnographies reveal insights into sensitive areas, exploring challenges like treatments, stigma, and resilience (Philaretou & Allen, 2006; Adams, Holman Jones & Ellis, 2022). Authors reclaim voices of marginalised experiences to 'write to right' (Bolen, 2012) and confront social norms (DeLeon, 2010) using significant 'epiphanies' to potentially alter life paths and provoke deep reflection on personal identities, relationships, and cultural contexts (Adams, Ellis & Holman Jones, 2017).

I ultimately chose autoethnography because it transcends documenting suffering, advocating for social justice and finding value in adversity. It invites readers to witness and find meaning in these narratives (Bochner & Ellis, 2016).

3.6 Co-storytellers

In autoethnography, the focus is on the self as both author and researcher (Cooper & Lilyea, 2022). Yet, it goes beyond self-study to include the author's connections, who play roles within the research and are intertwined with the author's experiences (Chang, 2008).

In my study, I was the main subject - narrator, interpreter, and researcher, with others as secondary characters. Using a ‘mediated co-constructed narrative’ approach (Ellis, 2003), I interviewed my mother, husband, twin sister, former school principal, and perinatal psychiatrist and midwife. The information letter, consent form, and interview guide are in Appendices A-E.

The self's life is central, with others' experiences enriching the narrative (Chang, 2008). Family members, as insiders, can offer deeper insights (Adams & Manning, 2015) into shared history, providing perspectives of similarity or difference (Chang, 2008).

To respect my co-storytellers' insights and reduce social desirability bias, I ensured private settings, a comfortable atmosphere, clear explanations of the research purpose, and adjusted question phrasing (Bergen & Labonté, 2020) to encourage open expression.

3.7 Collecting Autoethnographic Data

In my autoethnography, I used self-reflective journal entries, along with photographs, letters, and my medical file, to document my PP experiences and create timelines (Cooper & Lilyea, 2022). I also included personal documents, such as letters and essays written during my recovery.

Chronologically listing events helped me gather data and gain cultural self-awareness by detailing the contexts of these events and explaining their significance in my life (Chang, 2008).

I emphasised data from personal memories, considering them not as 'objective reality' but as reflections of significant aspects of experiences, thus confidently using memories to underscore important facets of those experiences (Bochner & Ellis, 2016).

Cooper and Lilyea (2022) recommend exploring culturally significant memories, including personal ones that show vulnerability. Initially, I over-included these details to later emphasise key aspects in my narrative.

Autoethnographers use interview methods ranging from introspective narratives to collaborative interviews, where researchers and participants share personal and cultural experiences within their relational context (Adams et al., 2015).

Interviews in autoethnography connect personal experiences with others, validating or challenging our own (*ibid*.). They enhance personal narratives by adding complexity, especially when revisiting trauma. This process, known as ‘collaborative witnessing’, deepens inquiry through shared experiences, requiring a close relationship among storytellers. In my interviews, I aimed for a cooperative dynamic, transforming informants and myself into ‘co-storytellers’ to construct meaning, generate knowledge, and foster empathy and care (Adams, 2016; Richardson, 2000).

3.8 Interpreting Meaning and Analysing Data

Autoethnographers interpret various data forms to create meaningful narratives. A key first step is a thorough review of all collected data, as recommended in ethnography (Miles, Huberman & Saldana, 2019). This involved reviewing texts, artifacts, and interview recordings to identify recurring themes, exceptional instances, and key insights. The data was coded into categories based on common topics, revealing connections and themes that offered sociocultural insights (Chang, 2022).

In the initial stages, I took notes on recurring topics, themes, and patterns. Following Chang's (2008) strategies, I: (1) identified recurring themes; (2) detected cultural patterns; (3) noted unusual occurrences; (4) examined inclusions/exclusions; (5) connected present data with historical context; (6) explored relationships; (7) compared my observations with others; (8) considered broader context; (9) aligned findings with social science theories; and (10) applied theoretical frameworks to analysis. An excerpt of this process is in Appendix H.

In analysing my data, I looked for cultural relevance in my experiences, focusing on specific details while considering the broader context.

Following Bochner and Ellis's guidance, I asked myself: 'What is happening here? What does it mean'? (2016, pp. 184). Some autoethnographers might prefer an intuitive and imaginative method for interpreting meanings (Bochner & Ellis, 2016) whereas others might adopt a more analytical and structured strategy to synthesise coherent interpretations from data segments (Anderson, 2006; Chang, 2008). In this study, I utilised both methods, believing that they could each offer me detailed understanding. In the meaning-making phase, I linked my findings to existing literature, reviewing emerging themes to enrich and expand the academic conversation (Chang, 2022).

3.9 Self-Reflexivity

Reflexivity is key to maintaining qualitative research rigour (Berger, 2013; Guillemin & Gillam, 2004), encouraging researchers to recognise and openly discuss how their backgrounds and identities shape their research choices, from topic selection to data interpretation (Koopman, Watling & LaDonna, 2020). This introspection aims to make the influence of the researcher's perspective clear and accountable in the research and its findings (Lincoln, Lynham & Guba, 2013; Pillow, 2003).

The reflexive journey in autoethnography is complex (Adams et al., 2015), marked by ongoing self-examination and disclosure amid ambiguity (Finlay, 2002).

My values of independence, hard work, and advocacy shape my research, particularly in data gathering and analysis as an educator and trainee family therapist. Acknowledging the influence of my values, I engaged in ongoing self-reflection and dialogues with co-authors and supervisors to enhance my reflexivity.

Bochner and Ellis (2016) emphasise that autoethnography blends external conversations with internal dialogues, encouraging reflection on vulnerabilities, dilemmas, and values. It seeks authenticity, self-discovery, and ethical reflection, inviting readers into an introspective process.

Storytelling invites readers into our experiences, making reflexivity a shared responsibility. Readers become active participants, witnessing our struggles. Effective autoethnography fosters empathy, connecting our experiences with readers and encouraging action against injustices (Berry & Patti, 2015).

3.10 Evaluating Autoethnography

As autoethnography evolved, so did its evaluation criteria. Adams and Manning (2015) argue that works lacking emphasis on context aren't true autoethnographies.

Autoethnographies must blend personal recollection, reflexivity, and storytelling with ethnographic methods like fieldwork, observation, and cultural analysis. Without these elements, such pieces of work do not qualify as autoethnographies.

Evaluating autoethnography varies by type. Sparkes (2022) cautions against rigid criteria that enforce conformity, turning them into a checklist that limits diverse inquiry and

risks solidifying autoethnography genres as fixed, ignoring the dynamic and interconnected nature of research.

Autoethnography blends analytical, emotional, and poetic writing, often described as ‘braiding’ (Tedlock, 2013). This approach combines storytelling with analysis to illustrate the self's connection to the world and drive change, showcasing its fluidity and diversity (Hayler, 2013; Sparkes, 2020; Winkler, 2018; Colyar, 2013; Manning & Adams, 2015).

In this research, I used the four goals outlined by Adams, Holman Jones, and Ellis (2015) to assess autoethnography’s effectiveness. These goals focus on: (1) enhancing knowledge; (2) emphasising personal experience; (3) showcasing storytelling impact; and (4) adopting a relationally responsible approach to research and representation (pp. 102).

My goal was to share my reflections, enriched by existing research and autoethnography's insider perspectives, for the benefit of researchers, participants, and readers.

I focused on the personal and experiential, using my perspective within its culture to understand social life and embracing vulnerabilities. Emotions and physical experiences were key tools for gaining insights, highlighting the importance of personal experiences.

I used narratives to explore how meaning is constructed, focusing on reflexivity and positionality to examine my role and privilege. This approach challenged silences around power, relationships, and taboos, highlighting storytelling's power in analysing culture.

I aimed for a relationally-responsible approach, fostering cooperative relationships, protecting participant identities, and ensuring my research was accessible, with the goal of positively impacting myself, participants and readers.

Acknowledging the challenge of meeting all criteria in a single study, I aimed to ethically narrate my story, staying open to diverse meanings, interpretations, experiences, and audiences.

3.11 Navigating Ethical Considerations

In autoethnography, positioning the author as both researcher and subject (Clandinin & Connelly, 2004; Tolich, 2010), introduces ethical complexities, including the risk of exposing family members. Prior to this dissertation, I had already publicly shared my story, heightening exposure concerns in Malta's close-knit community (Piscopo, Vella & Abela, 2020). With my family's consent, acknowledging, not denying this narrative's value to our Atanasio heritage, I proceeded cautiously.

Academics must understand that these writings permanently publicise once-private emotions and thoughts, are unchangeable post-publication. Once released, they become unaltered (Adams, 2008). This research requires context-sensitive, condition-specific, and relational ethical engagement (Tullis, 2013).

Discussing personal experiences often involves others, risking unintended exposure of their identities, even with consent. The challenge is to responsibly depict relationships with honesty and complexity (Ellis, 2007).

Tolich (2010) advises beginner autoethnographers to choose topics carefully, considering all involved as vulnerable. He compares narratives to tattoos, emphasising that ‘no story should harm others’ (pp. 1608).

Autoethnographers are encouraged to write as if those mentioned could read the story, consulting with them and avoiding publishing anything they wouldn't share directly.

I obtained my family's consent to share my PP experience, considering the stigma and potential distress. I promised to show them the narrative for approval before sharing and offered University counselling if needed.

I used member-checking, peer review, and consultations to minimise risk, constantly asking myself: ‘Who might be upset by my writings?’ This heightened my awareness of potential harm and reinforced my commitment to reduce it.

Autoethnographers must balance the ethics of consequences (Etherington, 2007), weighing potential benefits and drawbacks for participants, while ensuring the overall fairness and beneficence of the project (Tullis, 2013).

I documented informed consent procedures and practiced 'process consent,' regularly checking participants' ongoing agreement to participate (Ellis, 2007). Participants were aware their involvement was voluntary and could withdraw anytime without consequences.

Approvals for interviewing professionals were obtained from the University of Malta's Ethics Committee and the CEOs of Mater Dei and Mount Carmel Hospital after the proposal was accepted by the Department (Appendix F).

3.12 Conclusion

Recently, my aunt publicly expressed pride in my conference presentation on Facebook, breaking the silence around my mental health struggles. This surprised me. Her gesture of acceptance and understanding was especially meaningful given my extended family's lack of awareness.

This story, shaped by the turmoil of psychosis, seeks clarity and resilience. It honours mothers facing similar battles, offering hope and a path to healing. More than a narrative,

it's a lifeline and declaration of survival, showing that from chaos can emerge a story of triumph and light.

This section shed light on the methodological challenges encountered in this study. The next will focus on the presentation of the findings.

Chapter 4: FINDINGS

This chapter is a personal commentary and narrative dialogue with my research collaborators. Verbatim quotes appear in italics, with the Maltese version in Appendix G. Maltese readers are encouraged to read the original to avoid additional re-construction.

Six distinct themes surfaced as I attempted to categorise them: (1) Echoes of the Unheard: The Silent Struggle; (2) Altered Reflections: The Transformation of Appearance and Demeanour; (3) Mindscapes: Navigating Hallucinations, Delusions and Paranoia; (4) Through the Storm: PP and Its Toll on my Family; (5) Whispers in the Shadows: Confronting Stigma and Gossip; (6) Healing Hands: The Journey of Treatment and Support. I will be presenting these themes in more detail.

4.1 Theme 1: Echoes of the Unheard: The Silent Struggle

One evening, I interviewed my mum for this dissertation as we sat in the cozy, warmly lit kitchen, surrounded by the comforting aroma of a home-cooked meal. She folded her hands in her lap, radiating patience and anticipation. I took a deep breath, feeling the weight of the moment, and began.

“Mum, I would like to take you back to the time when I had PP. Can you tell me a bit about the story of when I had PP?” I asked, my voice soft yet eager.

Her face grew serious as she started recounting: *"A few months after Neil was born, I started realising that your attitude and character were changing. I used to see you always irritated, and you seemed sad when I talked to you. I also noticed that the shine in your face had faded, even your smile. But I didn't want to ask you or go into detail about what was happening to you. Because with me, you didn't want that mother-daughter relationship and to open up to me. But I started realising that your character was changing”.*

I felt frustrated and hurt by the statement that I didn't want a bond with her, as it left me feeling invalidated and dismissed, despite my care for this relationship.

After Neil's birth, I took maternity leave from my teaching and management role at a local primary school, shifting from the busy rhythm of school life to the anxious, secluded pace of new motherhood.

Following paternity leave, my husband Joseph returned to work, and I isolated myself in our small apartment, finding comfort in its safety. Fear of judgement kept me inside, and anxiety about others watching me care for Neil made me withdraw further. I neglected myself to prioritise Neil, even keeping Joseph from bathing or changing him during those first months.

"Postpartum… mummy described that you were always in a bad mood and abrupt…. Fixated on the baby…. You had to do everything properly; you would remark if it wasn't done properly". My psychiatrist, Dr Susan, was recounting episodes from my medical file related to my PP hospital admission.

We sat in her office, a space designed to be welcoming and comforting.

Dr Susan sat across from me, her eyes gentle as she reviewed my file. Her calm, steady voice conveyed compassion, each word reflecting her tenderness and dedication. "***Your son was also admitted to hospital a month ago. So before we've seen you. .*** *And you were concerned … . And he was an in-patient for one week, and obviously. … You were with him. So there was this precipitant, the severe stress that would happen, that happened before you actually… You were very stressed out. Okay. So that was the precipitant that would probably find you very vulnerable and that caused you to have this onset of this psychosis. …*

With depressive symptoms". I listened as Dr Susan recounted a distant yet haunting time. Her sincere, unwavering voice showed she wasn't just sharing clinical facts but honouring my journey and the pain of that tumultuous period. *"**She opposes everything. Suspicious about the family, about your brother-in-law, about her twin sister and her husband**. So this paranoia involved also the family"*.

At three months old, Neil fell ill, resulting in three hospitalisations for breathing difficulties. Those days were filled with anxiety by his bedside, as sleep eluded me. I vividly recall holding Neil down on a stretcher while nurses struggled to find a vein, his screams echoing as tears streamed down my face, my distress unnoticed.

While studying for a postgraduate diploma in educational leadership through the University of Nottingham, I struggled with assignments and dreaded returning to work after maternity leave. Leaving Neil in someone else's care, especially while still breastfeeding, was unbearable. Though Joseph took a month off to care for Neil before childcare started, I still felt jealous, missing out on time with him.

Returning to work was overwhelming. I constantly worried about Neil's wellbeing and the childcare environment. The job that once energised me now felt like an insurmountable mountain. Evenings were spent catching up on coursework, and guilt over feeling stretched too thin led me to skip sleep, making the balancing act even harder.

Tension mounted at work as we faced an upcoming external audit. "How thin you've become, Debbie!" became a common exclamation from my colleagues. I often said, "That's because I'm breastfeeding Neil", unaware that my weight loss and paleness were due to stress, lack of sleep, and poor appetite. In hindsight, it's no wonder Mum was concerned.

Dr Susan described the writing in my file before my hospital admission: *"Mummy also said that for the past couple of days, you were not eating. So probably that was as a result of your suspicion of them, and you had loss of weight, obviously".*

Sitting across from me at the table in my twin sister's backyard, Amanda's face was partly illuminated by sunlight. She looked thoughtful, her eyes distant, before speaking with a voice tinged with pity, breaking the silence: *"You didn't, not even self-care, you didn't even do the basics. And I couldn't understand... what hit me the hardest was that I couldn't understand why this happened to you because you had all the support from the moment you had the baby. You had me at your side, if you needed anything, you could just ask me, like I already had the experience. You had Mum going up and down to your place all the time, cleaning for you and cooking and everything. You had Joseph who took paternity leave… so you had everything going perfectly [chuckles], and yet this still happened to you… that's why I couldn't understand... why this happened to you".*

I often neglected washing myself, a subtle sign of creeping depression. The effects became clear when my curly hair formed a massive knot and attempts to untangle it failed. My hairdresser spent three hours unravelling it in silence.

As sleepless nights wore on, I deteriorated. At work, I felt like I was racing against time, heart pounding, moving and speaking too quickly, my mind spinning. It was like living in fast-forward with no pause button. When colleagues asked if I was okay, I'd shrug it off, saying, "Of course! It's just a busy time!" and I genuinely believed it.

After school, I rushed home to care for Neil and handle chores before diving into work. Evenings were spent on PowerPoints, lesson planning, and coursework. Joseph hated seeing me overworked, and our chemistry faded. Conversations focused on Neil, while I rarely shared about my day.

In a desperate attempt to manage everything, I sacrificed sleep, believing it was a luxury I couldn't afford. After Neil and Joseph went to bed, I silently rose to do chores, the quiet amplifying my fears. Tasks like laundry and cleaning became a way to silence my mind, often at 2 or 3 AM. I kept these late-night routines hidden, not wanting to burden anyone with my struggles.

In the quiet of the night, I struggled with the weight of my responsibilities, unnoticed by those around me. Alone in exhaustion and anxiety, I lay awake after chores, my body aching and my mind racing with unresolved thoughts.

I hid this part of my life, not wanting to burden Joseph, who was already stressed with two jobs. I feared sharing would only add to his worries, so I carried on in silence.

In silence, my struggle was fought in the shadows, unseen by those I loved.

4.2 Theme 2: Altered Reflections: The Transformation of Appearance and Demeanour

One April evening, sitting beside my husband Joseph on the sofa, I felt apprehensive about interviewing him for my dissertation. I wasn't ready to revisit our painful experience with PP, but his gentle smile and warm hazel eyes put me at ease, making me feel comforted in his presence.

Joseph spoke calmly about the changes he noticed in me during pregnancy and postpartum.... *"It's like you were staring off into space a bit, like you were getting the 'baby blues' or whatever they call it… I started to say".*

"How was I changing? How did you see me changing?"

"Ehh... and sometimes it was like you were spaced out. Not... not nervous, just spaced out... I have to tell you the same word twice, so what's it called... But then suddenly, vrufff... just like that after you had Neil, after how long? I mean, maybe 5 months, 6 months

passed? But it was all of a sudden, I mean really sudden. Maybe from a week before you started, it seemed like you got a certain fear, if I remember correctly. But that weekend was awful, really... it was the worst weekend for me. The worst weekend, and... seeing you in that state... mentally and physically, because even physically. You... it's like you aged. From the worry you had. Yes, you seemed like you aged... depressed. You looked depressed and... that's how you changed... you changed in every way. And I was stunned because I never, never experienced, never expected that a person could change like that overnight, just all of a sudden".

Silvio, my former Head of School, also noted the changes he observed before my PP experience: *"But I was noticing, for example, that you would stare off for a long time, that you weren't focused, that I would ask you something and you would respond briefly".* As I stared at the garden Silvio lovingly tended, he took a sip of his coffee to jog his memory and continued… *"At that time, you had also changed physically. I remember, you became really just skin and bones... I can't imagine you were eating".*

In May 2016, I was admitted to an obstetric ward. Alison, the perinatal midwife, was shocked by my appearance. I don't remember all the details, but I felt physically weak. Mum had made me shower before taking me to the clinic. Too exhausted to walk, I was paralysed by hallucinations and unable to answer the midwife's questions. My mind had shut down, and the paranoia made me feel helpless, consumed by confusion and fear.

"And when I saw you... Your facial expression and the way you were holding yourself... at that moment, I thought, gosh! How much this woman is suffering! The questionnaire was the PNRQ, the postnatal risk assessment questionnaire. We used to give it alongside the EPDS. At that time, those were the two we used. And at that moment, it struck me... I thought, gosh, she's really suffering!' And in truth, it was the first time I encountered

someone with PP. We had other patients before who weren't well and might have needed admission, but they always had other mental health issues before pregnancy. It wasn't, so to speak, a pure postnatal psychotic episode, PP, actually. And at that moment, I thought, gosh! She's suffering.' The thought process. How can I explain it to you?... For you, that's the reality, what your mind is telling you at that moment. That's the reality you're living. It's not the reality of the people around you".

When I finally glanced at my naked reflection in the hospital mirror, it hit me: I was seriously ill. What had I done to myself? The skeletal figure staring back, with tired eyes and a gaunt face, was the same body that had nurtured Neil. Ironically, as I gained this insight, the medication slowly began to work.

4.3 Theme 3: Mindscapes: Navigating Hallucinations, Delusions and Paranoia

"I've got so much to say on this, I can't keep it secret. It's like selling my soul to the devil, to reveal this dark and shameful secret, to say something so big such as suicidal thoughts… What the hell was my brain thinking at that moment? I was planning the perfect suicide… with my dead family members present to witness it… they weren't dead after all. They were laughing at me. It was all a show – their funerals, the flowers, the crying… it's just mad and mental…".

- An excerpt from my speech at the PIMHA Conference on Perinatal and Infant Mental Health, 25th November 2022.

Writing helped me process the overwhelming thoughts and memories after psychosis. I soon realised PP disrupted my cognitive processing, and creating a timeline brought clarity. My mind was so chaotic it felt like an uncontrollable rollercoaster ride. I fear I may not do my story justice, but I ask for your patience as we navigate this complex journey together. To the outside world, I seemed nonsensical, but for me, the reality was as clear as day.

At times, I feel guilty about what I put my family through. When I asked Mum about her perspective, this is what she shared:

"It started exactly when at night, you called out to me... I was asleep in my own apartment on the ground floor and you called out to me, 'Mummy, can you come up?' I asked you, 'Now?' and you said, 'Yes.' So I went upstairs, and you took me into the study, and you started telling me that the police were coming for you. They were behind the door and were going to take you away. You asked me to take down the framed certificates that were hanging on the wall and to hide them because they were coming for you. You mentioned something about the CIA. And I started asking you, 'Debbie, what are you saying? What are you talking about, Debbie?' But you remained serious, I remember. And you repeated it, continuing to tell me these things that to me sounded like nonsense, but then I started to take them seriously because I know these things happen in movies, not in person with you, my daughter!"

Earlier at home, I started eyeing Joseph suspiciously. I didn't speak, but my mind was a whirlwind of dark thoughts. Why are there CCTV cameras installed in our house? Who came and fixed them on the chandeliers? Why is everyone watching me? I thought of the technicians at school - maybe Joseph let them in, or they broke into our home while we were out. I felt the urge to escape, to leave the house and go far away. But then a terrifying thought struck me: what if there's a bomb implanted in my car? These people are capable of anything, and they want me dead.

I checked on Neil, and to my horror, I found him covered from head to toe in bedsheets. What the hell? I wanted to scream. I quickly removed them and checked his breathing. Just as Joseph came back in from the balcony where he'd been smoking, I started yelling at him. I was convinced this was a conspiracy against me, that he was plotting to have me taken away; that social services would come and put Neil up for adoption.

- Journal entry, 6th March 2019

In my psychotic state of mind, I was terrified of trusting anyone. I felt my security was jeopardised, terrorised by the thought that I was being constantly watched and followed.

After a sleepless night on Saturday, I decided to talk to my brother-in-law about work issues. I went downstairs to my sister's apartment and, in a frantic state, rambled about redundancies, audits, and the government taking away my warrant.

Amanda: …and you came knocking on our door - mine and Mario's (Amanda's husband) - and you told us you needed to talk about important things. So, we let you in, and you started telling us that you felt people at work were conspiring against you…

Debbie: And what was your reaction?

Amanda: At first, when you started telling us, we almost believed it because you were very convincing. You were really convincing…

Debbie: And what did I start telling you?

Amanda: You started telling us that there was a conspiracy against you - the students and the teachers were turning against you. Let me try to remember what else you said… you started telling us things that didn't make sense, like they were recording you, and that they were going to plant a bomb under your car… things like that…

Debbie: And was I saying who, who was it?

Amanda: I think you were talking about your teachers, your colleagues, and even the students - you said they were all in on it together, like part of a conspiracy. But your story was very convincing, I remember, because even Mario started to agree with you and told you that if needed, we should go to… what's it called, there in Floriana? The Depot… he told you, if necessary, we'll go to the Depot right away."

That night, after the house fell quiet, I left our bed and wrote a 5-page letter to my sister, a desperate plea for understanding. I acknowledged our bond, telling her, “Though we were born together, we won't enjoy each other's company until the end”. I confessed my sense of betrayal, writing, “Things are all against me”. I wrote in the letter that the world had conspired against me, feeling trapped in a web of deceit and accusation. “I was framed”, I wrote, trembling, hoping it would absolve me of the guilt and terror I felt. I detailed Neil's hospitalisations, claiming they were a plot to frame me for neglect, and described conspirators trying to annul our marriage, falsely accuse me of infidelity, and deny Joseph as Neil's father. At work, I was targeted by a political agenda, my every move being recorded. I begged for a lawyer, a fair trial, and urged my sister to contact the EU courts. I described hacked accounts and accusations of stealing from Neil’s savings. The letter ended with: “I'm going to drown”.

I wanted to die. I believed I didn't deserve life, that my son didn't deserve me as his mother. I felt completely useless, convinced that everyone would be better off without me. I was consumed by shame and guilt, certain that if I died, all this would be over, and everyone would be glad. The best place to be was Dead. How I longed for it! I looked at it in the face and smiled. For those around me, it would look like I was surrendering. But, no, I was conquering it. Death was welcoming me, embracing me, and setting me free.

On Mother’s Day, Joseph took Neil to grandma’s, leaving me too weak to speak. My body feels drained, and Mum, noticing my frailty, climbs into bed beside me. But sleep eludes me as my mind races with fear.

The sound of helicopters overhead sends a jolt of panic through me. I know they're coming for me. Trembling, I peer through the window and see three armed figures in black

across the road, approaching our block. Terror grips me, freezing my thoughts. They're here. There's no escape now. The walls close in, and all I can do is wait for the inevitable.

Mum took me for a walk to distract me, but I couldn't shake the feeling of being watched. When I glanced behind, I saw them in a black Mercedes, their faces twisted in mocking smiles. Anxiety surged, and I quickened my pace, leaving Mum behind.

We bumped into the parish priest, and Mum stopped to chat. Seizing the moment, I typed a desperate message on my phone, trembling as I silently showed it to him: "Please help me. Tell them I'm innocent and that I'm going to the EU law courts. They'll believe you, but not me".

He glanced at Mum, and she shook her head, her face flushed with embarrassment.

As we walk, I ramble about the film 'The Life of David Gale', convinced my life will end like Constance Harraway's. I'm desperate to be heard, but no one listens. Mum keeps shushing me, dismissing my fears and reassuring me that Neil is mine and Joseph's, not of the official from the Education Department. But I know something's wrong, and I'm running out of time to tell my story before I'm locked up forever.

Mum took me to the local health centre, but I felt trapped, convinced the nurses were part of a plot against me. I secretly photographed their badges, determined to gather evidence. I felt everyone's eyes on me, like they were all talking about me. When they handed me sleeping pills, I feared they were meant to kill me. Terrified, I refused to take them. The following Monday, they referred me to the PMHC.

On the way to the hospital with Mum and Neil, every billboard seemed to shout at me. While waiting in the outpatients' corridor, every conversation felt like accusing whispers about me as a mother, filling me with terror and shame. On admittance, Alison, the midwife,

recalled: *"The look was a bit dishevelled. But the thing that struck me the most was how much you were trying to hold yourself together... Even your shoulders were hunched. And the look in your eyes... It was like you were constantly on the lookout... like something was about to happen.*

Debbie: Vigilant...

Alison: Yes... very vigilant... like you were suspicious of everything... of everyone... At one point, I remember while we were waiting for the ward, you wanted to go out and smoke a cigarette, and I came with you... [yes] and we went outside, Mater Dei, outside... And you started asking me certain questions, as if... like why I was with you, what they were going to do to you, if there was going to be a camera...? And I started saying... at that moment, I said, "Poor thing!" You know how it is? It's mentally very taxing. Because if it were true, see how... how it's something that triggers a certain fear and certain... what can I say, feelings, that are difficult to deal with. And I knew that at that moment, that was your reality. I remember when we went back in, Dr Susan was there, and I told her, "Let's go check on her because she's really not well…" Then I went with you to Obs 3, they had given you the single room...

Debbie: Bed 18. That's the same bed I had before I went into labour. They had prepared the cot for the baby. So that he could stay with me, and I started imagining things, because they started padding the sides. Because there aren't cots for 8-month-olds, as Neil was 8 months old, the cots were for newborns, so to prevent him from getting hurt, they started covering the sides of the cot, and I started imagining they were going to put me in a strait jacket [oh my]. When they kept covering and covering the sides... I started thinking they were going to cover me up, in a strait jacket now.... Like in the movies. Like those with mental issues. I started imagining, and when they put me in the bed and started attaching the wires to check me, the same thing... I started saying, "I've come here to the final phase now... they're covering me

with wires... there are cameras above my head." The TV in the waiting area was on, about adoptions, and I started imagining they were going to put the baby up for adoption. [oh my...]

Alison: See how there are things that we don't even notice, in reality...

Debbie: And when they brought me the menu to choose the food, I said, "They're mocking me...", "In a hospital, you choose food from a menu?" I kept thinking to myself… "They're mocking me..." I kept thinking. That they were going to poison me… That this was poison… and then one time they brought me some sweets, poor things... chocolates because I knew the midwives and nurses there, as they were colleagues of my sister. And the same thing... I started saying, "They're mocking me... they're going to poison me..." [paranoia...] The paranoia...

I spent two weeks inpatient, starting treatment for psychosis and being closely monitored. Gradually, the hallucinations and paranoia faded, but I remained withdrawn and dissociated. This marked the beginning of a long recovery.

4.4 Theme 4: Through the Storm: PP and Its Toll on Those Around Me

Navigating PP, the storm affected not just me but everyone around me. My family, especially, felt the strain, confused and helpless as they watched me struggle with a frightening, unfamiliar reality. Our bonds were tested, and the emotional toll was heavy.

I asked Joseph about his emotions during those turbulent times. He paused, searching for the right words: *"No I was broken... I was a wreck. I was stunned. There were times when you would be in hospital, and I'll be here alone. Even though only two hours would have passed, I wouldn't know what happened during those two hours, and I wouldn't even know if I had slept. Just, with the TV on, and that's it, two hours would have passed. Even if the TV or my eyes were closed, I wouldn't know... Help, I didn't know what to do, I didn't know what to*

do, nothing at all. [You didn't know how to help me...] No, no, I was literally lost, alone. Now you tell me, you could have found... help, who do I ask? That I needed help, or… I just kept trying to cope on my own during that time".

Silvio echoed Joseph's powerlessness, noting the toll it was taking on him: *"I remember Joseph telling me once, 'I don't know what more I can do… I'm going crazy, I'm feeling it.' He said, 'Because I don't know.' He said, 'I'm going crazy because I'm trying to talk to her with the right words and slowly, but I don't exactly understand what's happening".*

Silvio was deeply troubled by the situation, seeing my struggle and growing anxious about my wellbeing: *"I started saying, 'Oh my, Debbie! Debbie! ...', you know how? 'We're going to lose her, we're going to lose her'. At first, I said, 'My God...', the first thing I said, 'She's going to lose her mind', understand? I said, 'This is a problem,' I said, 'Poor family, poor thing...', I said. It's scary".*

Amanda, already overwhelmed with her own life, struggled to support me while caring for her newborn and older son. The added stress of my condition strained her immensely: *"I had to keep up with my newborn baby and a toddler. I already had my own concerns, plus my worries about you. I was afraid you would go write something on Facebook or whatever, and you had some saved work on the laptop - I don't know what you did with it. Because someone with mental problems, you wouldn't trust them with social media, especially. By the time you recovered, you were like a patient to me, and...someone needed to take care of you...because you weren't capable of taking care of yourself or your baby. At the same time, I really pitied you, the way you ended up... Then I remember telling Mum, 'Don't leave her alone for a second!'... That's what I remember... On Sunday... I told her, 'Because she's not doing well.' I told her, 'Don't leave her alone for a second!' That's what I told her".*

4.5 Theme 5: Whispers in the Shadows: Confronting Stigma and Gossip

During those turbulent times, those aware of my situation made efforts to keep it discreet, especially from relatives and colleagues. Mum was especially adamant, asking Silvio to ensure my condition stayed confidential. Later, during my recovery, I learned Silvio had emailed the staff, stating I was ill without sharing further details. Their actions, hidden from me at the time, showed their concern and respect for my privacy.

Some family members, like my aunt and cousins, were unaware of my illness. It wasn't until after my recovery, when I shared my story on social media, that my aunt expressed surprise, revealing she hadn’t known until much later. Their distance, whether by choice or circumstance, added to the secrecy surrounding that difficult time.

I once sent a nonsensical message to all staff while still in the hospital, my mind unclear. Silvio quickly noticed, called me urgently, and advised me to delete it. He was trying to protect me, managing the situation carefully to prevent gossip among my colleagues.

Silvio: Because you had even started saying things openly to the staff, and those who didn't know could have either...

Debbie: What was I telling them?

S: Let me try to remember... I recall that, for instance, one time we had some event, and you sent a message that had nothing to do with the event... and I remember someone came up to me and said, "Listen, what is Debbie talking about? What did she mean?" And I told them, "Don't worry about it, just ignore it..."

D: Oh yes, I remember, you called me while I was in hospital and told me, "It's better if you delete that message," the one on Messenger...

S: Yes, I forgot what the exact message was... but I remember I told you that.

My sister, a midwife, deeply felt the taboo surrounding my condition. When I was admitted to her ward, she was determined to avoid transferring me to MCH, a place stigmatised for mental illness. *“No, she’s definitely not going to Mount Carmel...," I insisted. Then, I remember I called the ward, and the ward staff called the consultant... something like that, more or less. No, I told Dr. Susan, "Mr. Friggieri looks after us. Our consultant is Mr. Friggieri, and he definitely won't let her go to Mount Carmel. And if we explain the situation to him," I told her, "he'll agree to admit her to our department, sort of”.*

Debbie: And how did you live these times? With me being your sister and admitted to your ward… and your colleagues?

Amanda: I was… I was really not well… Besides, I was still on maternity leave and all, and I had a toddler and a one-and-a-half-month-old baby, so I wasn’t in a good place at all. I’d stay up all night researching psychosis and everything. I wasn’t doing well at all. And I really felt guilty, like I wasn’t aware of your situation. Plus, having to admit you to the ward where I work, I thought, "Who knows how the gossip will spread everywhere… throughout the entire department. People will know that Amanda’s sister was admitted, and who knows how people will talk about it, the colleagues… it would be a big thing and spread throughout the department, and they’d say, 'How didn’t she notice,' or something like that, being a midwife”.

As a survivor, hearing my family and friends express their concerns left me feeling ambivalent. I appreciated their efforts to protect my dignity out of love and concern, for which I’m grateful. Yet, I felt sadness knowing they too had to bear the weight of societal stigma, shielding me from a world that still struggles with mental health. This mix of gratitude and sorrow stays with me as I reflect on those difficult times.

4.6 Theme 6: Healing Hands: The Journey of Treatment and Support

I believe my recovery truly began when Mum sought help at the health centre. That simple act marked the turning point, the first step on a long road to healing. *"And when you told me 'Yes', to taking you to a doctor, at those hours, I couldn't find a doctor, so I called the Floriana polyclinic. A female doctor spoke to me, and when I started telling her what you had told me, she said, 'Bring her now!' She emphasised, 'Bring her now!' she told me, 'Immediately!'"*

At the PMHC, Dr Susan expressed deep concern for my condition, emphasising its severity and her urgent desire to help me heal. Her words, filled with empathy, reflected her strong wish to ease my suffering as quickly as possible. *"I know it was an assessment that I had to do on an urgent basis where you were brought to the clinic. My initial response was that of intense focus and I found myself deeply intrigued by the complexity of your experiences and the events occurring around at that time. It always … when you hear these stories, they're always complex and different. And the way you were navigating your experiences, your reality or your world compared to the world that really existed was quite complex. So, it was for me, very, very moving because obviously I could feel that you were going through extreme stress and extreme suffering, that I wanted, obviously, as every professional probably would want to do, is alleviate your suffering and get you better as fast as I could because of your own suffering, that of the family and of the baby. So, it was quite, it was very intense"*.

Dr Susan explained that being admitted to a gynaecology ward was a positive aspect, as it allowed me to stay close to my baby, bringing a sense of normalcy amid the uncertainty. "*The fact that you were admitted (in an Obs ward) was, I think, a big plus, a big bonus to all"*.

"So you are, confused. So in that state, it is difficult for you to do it (accept treatment). So we needed to find an environment which is calm, which is not home, but which is as well, not a psychiatric hospital. Obviously, the fact that your sister was a midwife, I think that really, really helped, because she could be there with you. Obviously, there are other midwives who would support her, but we had to make sure that you were in a safe environment where you are watched all the time and obviously compliant to treatment. So that was also something that was possible. And obviously the fact that you were admitted because you could have your baby, if not additionally, probably until".

Dr Susan's tone shifted with disappointment when she mentioned that admission to a gynae ward was no longer possible in 2024. I felt grateful for my past admission but sorrowful for mothers now facing admission to a MCH ward during such a vulnerable time. It was a bittersweet realisation. "*But it is also, it was for me, something positive that you could be admitted there with your baby, which unfortunately, now it has been stopped, and it is, I mean, this, we're talking in 2016. So we are now in 2024, and what we had in 2016, now in this age, in this day and age, we are not able to admit because the protocol for admission has changed, which is a loss, which is a loss".*

"Probably you are the only one who can say and talk about the importance of being in an environment which is safe for the mother, safe for the child, and supported". Hearing my psychiatrist's words reignited my motivation. Despite the responsibility, I saw clearly that writing this dissertation was a meaningful endeavour. Her encouragement deepened my determination to finish it.

The staff at *Obs 3* showed great commitment to my recovery, allowing Silvio, an outsider, to visit me. I often asked for him, as my hallucinations involving colleagues didn't feature him. His presence brought me much-needed reassurance and validation. With my

family's consent, the midwives permitted him to visit at night, and his updates from work, along with my employer's eventual visit, played a crucial role in my recovery. *"You were scared that you would be fired. You started worrying that you would end up without a job. And I remember that I even spoke to Mr. Savona, who was our employer at the time, and I remember he told me, 'Reassure her that if she needs to take even months off, we love her, we respect her, we know her always with us and that she always loved us...', and I told you, 'Listen, Mr. Savona is telling you that you can take as much time as you need for sick leave,' so to speak. And I remember he even came to the hospital, in fact. Once, I think he came more than once. On one occasion, I know I went up with him myself and he told me, 'Listen, let's go visit Debbie at the hospital'".*

My sister helped my recovery by regularly taking me out during my hospital stay, with the ward staff's permission. These outings, though small, were an important part of my healing.

Amanda: Then, during those 15 days, I would come to see you almost every day. Mum was with you all the time, plus the constant watch… and they were planning and deciding what to do, with the treatment, and they wanted to give you shock therapy…

Debbie: It probably didn't start working in the first week, since they wanted to give me ECT…

A: I'm not sure, but they said they'd start with the treatment first… Then, after the first week, they told you that you could start going out for a few hours and then come back. I would come for you, and we'd go out in the car.

D: Where did we go?

A: I remember once we went to Mistra; we went for a walk there, and once we went to Għajn Tuffieħa…

D: With the baby…

A: With my baby for sure… I'm not sure if Neil was with us…

D: Oh, I have a photo of Neil in the pushchair…

A: He was with us. And I would take you out almost every day. During your stay.

Recovery was a long, challenging journey with moments of progress and setbacks that tested my resolve.

After my psychosis subsided and I was discharged, I entered a period of depression, struggling with low self-esteem, memory, and attention issues. Flashbacks haunted me, but I regained my appetite, slept better, and became more coherent. I was no longer suicidal.

I began therapy, including EMDR, to process the trauma, and was prescribed anti-depressants alongside anti-psychotics. The PMHC team closely monitored me for months, advising against another pregnancy due to relapse risks. However, my husband and I decided to try for a sibling for Neil, stopping the medication during pregnancy. After our baby's birth in 2017, I resumed medication under supervision. The clinic staff closely monitored me, reintroducing anti-depressants as a precaution, and thankfully, everything went well.

My PMHC appointments ended in 2020, but in February 2023, I relapsed due to work, study stress, and treatment non-compliance. I was diagnosed with bipolar disorder and started on lithium, with an increase in my anti-psychotic medication. Since then, I've been seeing my psychiatrists regularly, staying committed to my treatment and managing the condition.

During my recovery, my family was very cautious around me, tiptoeing with their words and actions. Their constant vigilance, though born from love, sometimes made me feel as if I were under a microscope.

Through every twist and turn, I am surrounded by those who wish me well, their support a steady source of strength.

I will be discussing these findings in the next chapter.

Chapter 5 Discussion

In this chapter, I will discuss the findings which I narrated in the previous chapter. Several important points will be highlighted which mainly have to do with motherhood, stigma, healing and support and the importance of communication with family members.

5.1 "Am I Mum Enough?"

In the interview, my sister Amanda suggested my mental illness was triggered by the drastic shift to parenthood. Regardless of the support I had, she felt I wasn't equipped for the change, and the leap from freedom to parenting overwhelmed me. This is because Joseph and I chose to wait before transitioning into parenthood, enjoying four carefree years of camping and motorbike trips across Europe. Though we knew we'd start a family, I didn't expect to question whether I was truly ready or 'mum enough'.

However, Dr Susan's explanation resonated more with me: Neil's hospitalisations, my workload, and returning to work likely triggered my earlier depression, which, untreated, spiralled into psychosis - a buildup of pressures my mind couldn't handle.

As I delved into the literature, I realised my mental struggles were more complex than I'd thought - rooted not only in biology and genetics but also in structural and systemic factors.

A feminist view sees motherhood as socially constructed and tied to social and political agendas (Ferree, 2010), with recent research increasingly focusing on women's experiences of motherhood (Choi, Henshaw, Baker & Tree, 2005). By prioritising women's voices, these findings challenge idealised cultural views of motherhood, which assume women are naturally fulfilled as selfless caregivers (Woollett & Marshall, 2000). Good

mothers are expected to prioritise their children's needs, protect them, and foster their independence, often putting aside their own interests (Elliott, Powell & Brenton, 2015).

However, ‘intensive mothering’ (a term coined by Sharon Hays in 1996) is especially challenging for full-time employed mothers of young children, often leading to anxiety, depression, and self-blame (Walls, Helms & Grzywacz, 2016). Was I trying to be ‘supermom’ by balancing a demanding job, part-time studies, and a newborn? I often wonder if I was chasing an impossible standard, feeling pressured to prove I could handle it all, even as it overwhelmed me. I took 18 weeks of maternity leave, and Joseph a month of unpaid leave, but it felt like time flew by. As the breadwinner, I felt pressured to return to work while handling the intense demands of raising a baby. Beneath it all, the ‘supermom’ myth loomed - the idea that women could ‘have it all’ (Leupp, 2019). However, the reality was far from that, as the rise in women's employment wasn’t matched by changes in household labour or workplace policies (Van Gorp, 2013), leaving me both physically exhausted and mentally strained.

Depression is reported to be notably higher among wives working long hours and husbands working over 45 hours a week, showing the impact of husbands’ work on wives’ mental health. Shared breadwinning only became harmful for mothers facing high childcare demands (Leupp, 2020). This suggests that balancing motherhood and work is easier when husbands share household duties or social policies ease child-rearing burdens.

In 2016, Malta offered just one day of paternity leave, which was extended to 10 paid days in 2022, still the EU minimum (Kern & Lecerf, 2023). Joseph took unpaid leave to care for 5-month-old Neil, strengthening their father-son bond but adding financial strain, which only worsened our challenges.

5.2 No One Knows, No One Asks – Invisibility and Stigma

For me, new motherhood revealed unspoken truths, unseen sacrifices, and silent doubts. While society in general, views childbirth as a joyful event (Kuipers, van Beeck, Cijsouw & van Gils, 2021), I struggled with emotions that didn't fit the narrative. Like many mothers, I felt ashamed for being depressed during a time meant to bring happiness, and the pressure to feel joyful made it hard to seek help (Senator, 2015).

Thurgood, Avery, and Williamson (2009) argue that undiagnosed PPD often results from the stigma of being labelled an 'unhappy mother'. While women may accept their depression after screening, they often reject the term 'PPD' as it suggests their feelings are caused by their babies. The authors emphasise how society's idealised view of motherhood can lead to shame, guilt, and embarrassment when mothers' experiences do not align with this ideal. Indeed, in Maltese culture, having children is highly valued, and the birth of a first child is typically a celebrated event (Borg Xuereb, Abela & Spiteri, 2012). Rather than seeking treatment, depressed mothers often hide or downplay their symptoms, continuing their silent suffering in fear that their child will be removed (O'Hara & McCabe, 2013).

Previous research has emphasised that experiencing PP, along with an inability to meet societal expectations, can intensify feelings of guilt and loss. These emotions often persist even after recovery, as women reflect on their experiences (Heron et al., 2012; Engqvist, Ferszt & Ahlin, 2011; Robertson & Lyons, 2003). For women hospitalised due to PP, the view that mothers should prioritise baby's needs, isn't always feasible, which can heighten their feelings of loss and failure (Robertson & Lyons, 2003).

Edwards and Timmons (2005) found that stigma around postpartum mental health issues leads to isolation and withdrawal. Robertson and Lyons (2003) noted that mothers with psychotic symptoms and their families often feel isolated, with recovery involving a period of

‘grieving’ to accept the impact on both the mother and her family. This shows that the burden of mental illness extends beyond the caregiver. After my psychosis, I felt guilty for what I had put my family through and ashamed of how PP might have affected Neil. The fear of impacting him deepened my guilt, which lingered as I tried to heal.

My experience with PP was marked by secrecy, inferring that the illness is a taboo. The deliberate omissions and whispered conversations reflected discomfort with acknowledging my condition. I wondered if my mother hid it to save face, driven by the "What would the neighbours think?" mentality, where shame overshadowed everything - even trust in the parish priest. Admitting my struggles seemed to threaten the family's image, so she kept it hidden, no matter the cost. In Malta's close-knit community, this pressure to maintain appearances is even stronger (Abela, 2016).

Research shows a 'hierarchy of stigma' among psychiatric conditions, with disorders like schizophrenia more feared than others like depression (Huggett et al., 2018). Severe or misunderstood diagnoses carry greater stigma (Mann & Himelein, 2004), but this doesn't lessen the guilt and stigma people feel during their darkest moments (Fixsen, 2023). In Malta, offensive remarks about mental illness are still common, affecting self-perception and willingness to seek help (Scerri, Sammut & Agius, 2023). The term ‘miġnun’ ('crazy') reinforces stigma (Cachia, 2018), and inappropriate behaviour often leads to gossip in Malta (Abela, 2016).

It is no wonder Mum was embarrassed meeting the parish priest or didn’t tell other relatives about my psychosis, and why my sister was so opposed to my transfer to MCH. Amanda’s resistance reflected her own struggle with society’s perceptions of my condition, wanting to shield me from harsh judgments and preserve my dignity - and perhaps her own - amid a reality still seen as taboo and likely to fuel gossip among her colleagues.

Resonating with all this, Agius, Falzon Aquilina, Pace and Grech (2016) argue that although Maltese society is becoming more accepting of mental illness, individuals often struggle with how to address it within their friendships and families because there is a general tendency among Maltese people to avoid discussing or acknowledging the presence of mental health issues in their families.

5.3 Healing and Support: A Journey Through Visibility and Vulnerability

I have a box file in my study, a kind of personal archive. In it, I keep handouts from mental health seminars I attend with PIMHA and others, as well as presentations I sometimes give about my lived experience.

Among these documents are two handwritten pieces that capture the extremes of my journey: the first, a farewell letter I had written to my sister during my most hopeless moments, folded neatly on blank printer paper as if ready for an envelope. It signifies a painful ending, a point when I could see no way forward. The second document is from a few months after my psychosis, an attempt to map out a new beginning - a rebirth, a path forward.

These letters, opposites yet intertwined, stay together as a reminder. They reflect the irony of my journey: that even in the chaos, I found a path to visibility, resilience, and ultimately healing. Madness gave me the visibility I needed; writing gave me the voice long silenced. This file stands as a testament to survival - from silence to self-expression, and from personal healing to helping others. This through the power of the written word.

Sharing an illness narrative can be cathartic, helping to move beyond the passive role of a patient (Fixsen, 2023). For me, autoethnography was a key part of this process. Writing

has been a powerful tool for reflection, release, and self-understanding. As Johnston (2020, pp. 140) states in his autoethnography on psychosis:

> *'There is no easy way of confronting the darkest period of one's life and turning it into an article or dissertation. Making sense of my greatest tragedy and victory started the day I became psychotic, and will live on in the words and memories I choose to surrender*'.

Writing this autoethnography felt like releasing parts of myself, like sunflower seeds carried by the wind. As Smith (1999) notes, it takes courage to share one's darkest moments with an unknown audience. Exposing my most painful and vulnerable parts required deep 'surrender', but it was also a step toward healing.

The hospital and healthcare professionals were crucial to my recovery. Being in an Obs ward with Neil made the process feel more attainable. Research shows a baby's presence can both comfort and challenge during PP recovery, with these roles shifting over time (Plunkett, 2015). For me, Neil's presence was grounding yet demanding, and it was my family who took on his daily care. I couldn't fully be his mother at that time.

Hospital admission is often needed, with MBUs internationally recognised as the preferred service for PP (Green, Hofberg, Carr, Fanneran & Sumathipala, 2016). MBUs allow mothers and babies to stay together, providing specialised care while promoting safety, stronger bonding, increased confidence, and higher patient satisfaction (Christl, Reilly, Yin & Austin, 2014).

Yet, there is patchy specialist perinatal services between countries (Glangeaud-Freudenthal, Howard & Sutter-Dallay, 2014), with Malta having no specialist MBU for families to benefit from. Despite available specialist PMH services, admitting women to MCH remains highly unfavourable, as Malta still lacks this service, leading to mothers being separated from their babies at MCH.

I was fortunate enough to be admitted to MDH with my baby. This treatment was offered to me because it was felt to be the treatment of choice by the consultants but also as a privilege, thanks to my sister's professional role there and both consultants consenting to my transfer. In Malta's small, densely populated society, where people frequently interact across social roles, favouritism is a common issue (Sultana & Baldacchino, 1994). Studies suggest clientelism is more likely to thrive in smaller societies (Veenendaal, 2019).

The principle of justice requires us to treat similar situations equally and to approach different situations differently (Black, 2022). Equality in healthcare encompasses three key aspects: equal access to care for similar needs, equal use of services for those needs, and equal quality of care for everyone seeking it (Whitehead, 1992). I often wonder if perinatal mental health patients in our country are treated justly, especially without a dedicated MBU and its benefits for both mothers and families.

5.4 Lost in Translation: Navigating Family Communication and Emotional Withdrawal

Joseph was shocked by how quickly I seemed to change, commenting that he'd never seen anything like it before, though this had been building for a long time. I had unknowingly hidden my depression so well, staying high functioning, that only when I spiralled into full-blown psychosis did he grasp the severity of it.

Looking back, I think our relationship dynamics played a role. I didn't feel emotionally safe enough to share how overwhelmed I was by balancing work, studies, and motherhood, or how deep my depression had become. Perhaps I feared dismissal or misunderstanding. Focused solely on caring for Neil, I neglected my own wellbeing and our relationship, with little insight into my struggles or Joseph's feelings. I was running on autopilot, disconnected and avoidant.

Mikulincer and Shaver (2010) suggest that individuals with high levels of avoidant attachment often use deactivating strategies - such as avoiding closeness, denying their attachment needs, and refraining from seeking proximity or interdependence in relationships. These strategies typically emerge in relationships with attachment figures who inhibit expressions of closeness, need, or vulnerability (Ainsworth, Blehar, Waters & Wall, 2015).

Attachment styles may also explain this (Hazan & Shaver, 1987). Bowlby (1982) proposed that humans have an innate attachment system, seeking closeness in times of need. When attachment figures are consistently supportive, they foster secure attachment and a positive self-image. However, unreliable support can lead to insecurity, negative self-views, and higher risks of emotional issues (*ibid*.).

Research shows that attachment styles can be assessed along two independent dimensions: attachment-related anxiety and avoidance (Brennan, Clark & Shaver, 1998). The anxiety dimension reflects a person's fear that their partner will be unavailable in times of need, while the avoidance dimension reflects distrust and a preference for emotional distance and self-reliance (Mikulincer & Shaver, 2012). Attachment theory suggests that inconsistent or insensitive attachment figures hinder secure mental foundations, weakening resilience in

stressful situations and raising the risk of psychological breakdowns in crises (Bowlby, 1988). Therefore, attachment insecurity is seen as a trigger for mental health disorders (Stanton & Campbell, 2014).

In my research, I found that marital communication is shaped by both attachment styles and family-of-origin. Childhood patterns subtly influence how we relate in marriage (Knapp, 2013), with parents shaping their children's attachment styles and impacting future relationships. The quality of their marriages affects their adult children's perceptions of romance (Busby, Gardner & Taniguchi, 2005). Additionally, positive parent-child relationships and effective parenting during adolescence foster secure attachments (Dinero, Conger, Shaver, Widaman & Larsen-Rife, 2008) and enhance relational competence, leading to greater warmth and support between partners later in life (Conger, Ming, Bryant & Elder, 2001).

Pursuing a Master's in Systemic Family Therapy opened my eyes to deeper family dynamics. I began to see our tendency for emotional avoidance. I remember Mum, often frustrated, mentioning how Dad never spoke up, leaving her unsure of their emotional standing. This pattern of silence and avoidance had quietly shaped how we connected, or didn't, becoming part of our family narrative.

Sibling interactions also reflect attachment behaviours that shape future romantic relationships by building interpersonal skills (Conger, Cui, Bryant & Elder, 2000). With hindsight, it's curious that my sister, despite our closeness, never voiced concerns about my situation. Was it fear of embarrassment, discomfort with the topic, or simply the demands of her own young children? Perhaps I hid it too well - or was our family's pattern of emotional

avoidance at play? Mental health stigma too did not help, and it further reinforced my tendency to hide my emotions.

Adopting a systemic perspective, particularly the attachment approach, allowed me to conceptualise PP in a way not present in current literature. Incorporating this lens, besides stigma, and a feminist perspective adds a valuable layer of understanding.

Studies show that strong social support from key figures, like romantic partners, aids mental disorder recovery (George, Blazer, Hughes, & Fowler, 1989) and lowers the risk of conditions like schizophrenia (Cannon et al., 2008). For example, individuals with anxious attachment who receive support during stressful events, like transitioning to parenthood, often report greater relationship satisfaction over time (Rholes et al., 2001). Those with avoidant attachment who feel supported and more dependent on relationships tend to handle conflict better (Campbell et al., 2001). Thus, strong social support can significantly boost wellbeing for individuals with insecure attachment styles.

As Amanda had put it, I had “all the support from the moment you had the baby”. But my perception was entirely different. I was overwhelmed and exhausted, unable to fully grasp what was happening around me. Like other mothers as previously cited in the literature, I was reluctant to share my feelings because I was afraid they would take away my baby. Instead of feeling grateful, I found myself feeling jealous of Joseph, who got to take leave and bond with Neil. Rather, my sense of support felt inadequate, overshadowed by my emotional turmoil, despite the presence of others willing to help.

What I truly needed then was visibility, validation, and emotional intimacy. I realised that emotional support often matters more than material help. During pregnancy, I was pampered, but once I became a mother, expectations shifted - I was suddenly expected to fulfil my duties without question. This abrupt change was unsettling.

I was unseen by others, and I struggled to see myself. I realise I am emotionally avoidant and often reluctant to ask for help, perhaps finding it hard to accept love. While colleagues checked in, there were times, like during Neil's hospitalisations, when I needed someone to ask how I was truly doing. This left me feeling dismissed, as my struggles went unnoticed.

Ironically, PP granted me the visibility I craved. I suddenly found myself at the centre of attention, the ‘prima donna’ at school, in the *Obs* wards, and among my close family and friends. Where I had once felt invisible, I was now under constant observation - from healthcare professionals who watched me cautiously to security personnel who monitored my every move. Reflecting on this paradox brings a smile to my face now; the very condition that consumed me also transformed me into a central masterpiece, revealing the complexities of my experience. I often wonder if this is what my mind and body really needed at the time.

5.5 Conclusion

The next chapter concludes this research with recommendations for policy and practice and suggestions for future research.

Chapter 6: CONCLUSION

Guided by the research question *What is the story of living with PP in Malta?*, I here highlight the strengths of the study, summarise key findings, put forward practice and policy recommendations and suggestions for future research.

6.1 Study Strengths

This study's use of autoethnography is a contribution to knowledge given the lack of literature on PP using this qualitative methodology. The key strength of this study is the blending of my experiences as both researcher and survivor together with the ' perspectives from collaborators that helped to provide a fuller picture of PP in Malta. It addresses a specific research question and sheds light on a complex journey, giving me a voice after a time of upheaval. This method captures the unique yet relatable aspects of my experience, which I now view as a blessing that revealed an inner voice. Autoethnography may also empower other Maltese women who have endured PP in silence.

This autoethnography also includes the father's narrative – an important and particular voice gaining attention in postpartum literature but still in need of greater recognition (Hunter, 2013).

Last but not least, including research collaborators in this autoethnography enhanced the trustworthiness and credibility of my narrative.

6.2 Summary of Salient Findings

i. This study includes a feminist lens to examine motherhood and mental health, suggesting that the challenges that some mothers face are often overlooked. Mothers may also avoid disclosing issues due to stigma, prevailing idealised social constructionist beliefs around motherhood and fear of treatment.

ii. An attachment-focused perspective has uniquely helped me understand PP, by offering insights into its onset and supporting my recovery. It allowed me to reclaim my identity and answer the question, "Why did this happen to me?" The attachment approach provided a ‘breakthrough’ after my ‘breakdown’, helping me process guilt, shame, and unresolved questions. It clarified my key relationships, and with ongoing therapy, I aim to build a healthier family narrative.

Practice Recommendations:

Providers can better assess mental health, including serious conditions like PP. This can be carried out by having frequent checkups with healthcare providers during the child’s first year supported by empathetic questioning and proper screening tools. Thus, training in effective questioning and screening is essential for early detection.

Policy recommendations:

My recovery was aided by preferential support, but this level of care should be available to all mothers with severe PMHIs. Currently, affected mothers are sent to MCH, where they are separated from their babies, lack specialist midwife support, and face stigma - an unacceptable situation today. MBUs are the gold standard for severe conditions like PP, as they preserve the mother-baby bond. An MBU in Malta, staffed with PMHI-trained professionals, including family therapists and offering peer support, would significantly benefit Maltese families.

Professionals' responses to PP, such as my sister’s guilt for missing my symptoms, may stem from limited training on evidence-based knowledge on severe PMHIs. Involving mothers with lived experience in media, training, and as peer experts in the national health service could also educate both professionals and the public, empowering mothers to view themselves as survivors, fostering a sense of agency.

6.3 Future Research Suggestions

This study highlights a number of issues that merit further research.

Future research needs to address the benefit of including fathers whose partners were treated in general psychiatric settings, as well as address the support needs of carers for mothers with PP.

In light of my story and the lack of research on longitudinal outcomes following PP, it would be interesting to explore what contributes to post-traumatic growth in mothers who go through PP and who succeed in bouncing back from this adversity.

Future research could also explore the impact of systemic family therapy with a focus on the attachment approach when treating a mother with PP, addressing a gap in current PP literature.

6.4 Conclusion

Writing this autoethnography forced me to confront the haunting memories I knew were within me. There were nights, alone in our kitchen, when writing certain sections of the ‘Findings’ brought back memories of hallucinations and paranoia I had once endured. It felt eerily scary. Nevertheless, during this dissertation journey, I never felt alone and felt supported throughout.

Autoethnography is not for the faint-hearted. Yet, despite the challenges, the writing process has empowered me - giving me a voice, helping to heal my wounds, and illuminating the darkest moments of my life, casting shadows over my past.

I am deeply grateful to the collaborators who shared their time and experiences during such a painful period. I hope this study offers valuable insights for professionals, inspires further research, and brings hope to mothers and their families facing PP.

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Appendix A

Letter of information for relative/friend

INFORMATION LETTER FOR RELATIVE/FRIEND

Dear ********,

I am writing this letter to explain to you what my research is about and what your participation involves, should you accept to take part.

As you know, I am a student at the University of Malta, presently reading for a Master's in Family Therapy and Systemic Practice. I am currently conducting a research study for my dissertation titled 'Untold Motherhood Encounters: An Autoethnographic Account of Postpartum Psychosis in Malta'. This is being supervised by Prof. Angela Abela and Prof. Jeannie Wright.

The aim of my study is to bring to light the experience of living with postpartum psychosis within the Maltese context. Autoethnography describes and analyses the personal to understand the cultural experience. It highlights the author's ability to offer understanding into processes that do not feel right or make sense in life. It is an invitation to intimately enter the most challenging, confusing events, relationships and experiences encountered throughout life, such as seeking treatment, handling stigma, and becoming resilient. This study seeks to move beyond the suffering towards social justice, by inviting the reader to see the meaning and value in suffering. Your participation in this study would help contribute to a better understanding of mothers who experience postpartum psychosis in Malta. Any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, I will ask you to narrate your side of your story of having to witness and care for me while I was experiencing postpartum psychosis. This will help me discover the psychosis experience from your own point of view. Our meetings will take the form of a narration and you will be able to construct a story to depict your experience. You may choose to write your story, audiotape it or narrate it to me during an interview. I will audio -record the interview and then have the conversations transcribed. Your story can include details such as your reactions, decisions taken, collective conversations with others, and coping strategies used. Your story would reflect what it felt like to live through these events in as much detail as possible. Only my supervisor and I will be able to listen to the recordings, and after I finish my study, I will have the recordings destroyed.

Data collected will be given back to you for review before dissemination, and if you want to add, delete or change anything, you may do so. Your name will be given a pseudonym throughout the research project, however, there may be a chance that someone reads my study and recognise you.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

If you choose to participate, please note that there are no direct benefits to you. Your participation entails the following risks: reliving a traumatic experience may trigger painful emotions. For this reason, you have access to a list of free services, which list is being given to you.

Please also note that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased. All data collected will be stored in an anonymised form on completion of the study.

A copy of this information sheet is being provided for you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to let me know on ********; you can also contact my supervisor over the phone: ******** or via email: angela.abela@um.edu.mt

Sincerely,

Deborah Atanasio Prof. Angela Abela

Appendix B

Letter of information for professional

INFORMATION LETTER FOR PROFESSIONAL

Dear ********,

I am writing this letter to explain to you what my research is about and what your participation involves, should you accept to take part.

My name is Deborah Atanasio and I am a student at the University of Malta, presently reading for a Master's in Family Therapy and Systemic Practice. I am currently conducting a research study for my dissertation titled 'Untold Motherhood Encounters: An Autoethnographic Account of Postpartum Psychosis in Malta'. This is being supervised by Prof. Angela Abela and Prof. Jeannie Wright.

The aim of my study is to bring to light the experience of living with postpartum psychosis within the Maltese context. Autoethnography describes and analyses the personal to understand the cultural experience. It highlights the author's ability to offer understanding into processes that do not feel right or make sense in life. It is an invitation to intimately enter the most challenging, confusing events, relationships and experiences encountered throughout life, such as seeking treatment, handling stigma, and becoming resilient. This study seeks to move beyond the suffering towards social justice, by inviting the reader to see the meaning and value in suffering. Your participation in this study would help contribute to a better understanding of mothers who experience postpartum psychosis in Malta. Any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, I will ask you to narrate your side of your story of having to witness and care for me while I was experiencing postpartum psychosis. This will help me discover the psychosis experience from your own point of view. Our meetings will take the form of a narration and you will be able to construct a story to depict your experience. You may narrate your story to me during an interview. I will audio-record the interview and then have the conversations transcribed. Your story can include details such as your reactions, decisions taken, collective conversations with others, and the care plan involved. Your story would reflect what it felt like to live through these events in as much detail as possible. Only my supervisor and I will be able to listen to the recordings, and after I finish my study, I will have the recordings destroyed.

Data collected will be given back to you for review before dissemination, and if you want to add, delete or change anything, you may do so. Your name will be given a pseudonym throughout the research project, however, there may be a chance that someone reads my study and recognise you.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

If you choose to participate, please note that there are no direct benefits to you. You will be the only midwife interviewed for this research project.

Please also note that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased. All data collected will be stored in an anonymised form on completion of the study.

A copy of this information sheet is being provided for you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me on ******** or via email: deborah.atanasio.04@um.edu.mt; you can also contact my supervisor over the phone: ******** or via email: angela.abela@um.edu.mt

Sincerely,

Deborah Atanasio Prof. Angela Abela

Appendix C

Consent form for participants

CONSENT FORM FOR PARTICIPANTS

My name is **Deborah Atanasio** and I am currently reading for a Master's in Family Therapy and Systemic Practice at the **University of Malta**.

I am currently conducting research that aims to give an autoethnographic account of my experience of postpartum psychosis within a Maltese context. The interview that you have been invited to participate in forms part of this study. This will take you approximately one hour. Any data collected from this survey will be used solely for the purposes of this study. There are no direct benefits in taking part. Participation is entirely voluntary, i.e., you are free to accept or refuse to participate.

At no point will you be asked to provide your name or any other personal data that may lead to you being identified, though it is important to be aware that you may still be identifiable. Furthermore, you may skip over any questions that you do not wish to answer.

If you wish to participate in this study, please underline the statement that says, "I agree to participate". If not, please underline "I do not wish to participate".

Should you have any questions or concerns, you may contact myself or my supervisor on the details provided below.

Yours Sincerely,

_____

Deborah Atanasio

deborah.atanasio.04@um.edu.mt

_____

Prof. Angela Abela

angela.abela@um.edu.mt

Research Supervisor

DECLARATION BY RESPONDENT:

I hereby confirm that I am 18 years of age or older. I am aware that taking part in this interview implies that I am participating voluntarily and with full informed consent on the conditions listed above.

- I agree to participate

- I do not wish to participate

Signature: _____ Date: _____

Appendix D

Interview Guide for Relative/Friend (English and Maltese)

INTERVIEW GUIDE (relative/friend)

I would like to take you back to the time when I was suffering from postpartum psychosis.

1. Can you narrate the story of when I was suffering from postpartum psychosis?
2. Can you tell me how you experienced this episode in your life?
3. What was your role in all that was happening?
4. What were the thoughts you were experiencing at that time?
    - What emotions did you feel?
5. Did your perception of your relationship with me change after you found out what was happening to me?
6. Was there ever a time when you came face to face with a person suffering from mental health difficulties?
    - Has your experience in my regard made a difference?
7. What are your attitudes regarding persons suffering from mental health difficulties?
    - Have your thoughts always been like this?
8. Were you aware of the fact that the period before a baby's birth and afterwards carries with it certain challenges with mental health?
9. If you could turn back the clock, what would you have done the same and/or differently?

GWIDA GĦALL-INTERVISTA (qraba/ħabib)

Nixtieq nieħdok lura għaż-żmien fejn kont qed inbgħati mill-postpartum psychosis….

1. Tista’ tirrakkontali ftit l-istorja ta’ meta jien kelli l-postpartum psychosis?
2. Tista’ tgħidli kif esperjenzajt dan l-episodju f’ħajtek?
3. X’kien l-irwol tiegħek f’dak kollu li kien qed jiġri?
4. X’kienu l-ħsibijiet li għaddew minn moħħok dak iż-żmien?
    - X’emozzjonijiet ġarrabt?
5. Inbidel xi ħaġa fil-perċezzjoni tar-relazzjoni tiegħek miegħi wara li sirt taf b’dak li ġrali?
6. Qatt kont ġejt wiċċ’imbwiċċ ma’ persuni b’diffikultajiet mentali?
    - L-esperjenza li kellek fil-konfront tiegħi, għamillek differenza?
7. X’ihuma l-attitudnijiet tiegħek dwar persuni li jaffaċċjaw diffikultajiet ta’ saħħa mentali?
    - Minn dejjem kont taħseb hekk?
8. Kont konxju tal-fatt li l-perjodu ta’ qabel it-twelid ta’ tarbija u wara jġib miegħu ċertu sfidi fejn tidħol is-saħħa mentali?
9. Kieku kellek tibdel xi ħaġa minn dak li ġara, x’kont tagħmel l-istess u/jew differenti?

Appendix E

Interview Guide for Professional

INTERVIEW GUIDE (professional)

I would like to take you back to the time when I was suffering from postpartum psychosis.

1. Can you tell me what you remember at the time when I was admitted under your care?
2. Can you tell me what was your experience of looking after me at the time?
3. What were your thoughts and feelings?
4. Were you satisfied as a professional with the service I was provided with?

Appendix F

Ethics Research Approval

FACULTY RESEARCH ETHICS COMMITTEE APPROVAL

L-Università ta' Malta

Deborah Atanasio <deborah.atanasio.04@um.edu.mt>

Research Ethics Application - Approved by FREC, no UREC decision needed

SWB FREC <research-ethics.fsw@um.edu.mt> 2 October 2023 at 14:44
To: deborah.atanasio.04@um.edu.mt
Cc: Angela Abela <angela.abela@um.edu.mt>, "Ms Ingrid M. Grech Lanfranco" <ingrid.grech-lanfranco@um.edu.mt>

REDP Application ID: SWB-2023-00378

Dear Deborah Atanasio,

Your ethics application regarding your research titled *Untold motherhood encounters: An autoethnographic account of postpartum psychosis in Malta* has been **approved**.

Faculty Research Ethics Committees are authorised to review and approve research ethics applications on behalf of the University of Malta, except in the case of sensitive personal data. In this regard, your ethics proposal **does not need to be sent to UREC-DP**. Hence, **you may now start your research**.

Disclaimer: *The research team should note that only the English versions of the documents submitted have been reviewed by FREC. It is the duty of the research team to ensure that all documents in Maltese (or any other language) are faithful translations of the English version.*

Regards,

L-Università ta' Malta

Faculty Research Ethics Committee

Faculty for Social Wellbeing
Room 113, Humanities A Building
+356 2340 2237 / 3956 / 3220
um.edu.mt/socialwellbeing/students/researchethics

Appendix G

Findings with Direct Quotes in Maltese

Chapter 4: FINDINGS (Maltese quotes)

This chapter is a personal commentary and narrative dialogue with my research collaborators. Verbatim quotes appear in italics, with the Maltese version in Appendix G. Maltese readers are encouraged to read the original to avoid additional re-construction.

Six distinct themes surfaced as I attempted to categorise them: (1) Echoes of the Unheard: The Silent Struggle; (2) Altered Reflections: The Transformation of Appearance and Demeanour; (3) Mindscapes: Navigating Hallucinations, Delusions and Paranoia; (4) Through the Storm: PP and Its Toll on my Family; (5) Whispers in the Shadows: Confronting Stigma and Gossip; (6) Healing Hands: The Journey of Treatment and Support. I will be presenting these themes in more detail.

4.1 Theme 1: Echoes of the Unheard: The Silent Struggle

One evening, I interviewed my mum for this dissertation as we sat in the cozy, warmly lit kitchen, surrounded by the comforting aroma of a home-cooked meal. She folded her hands in her lap, radiating patience and anticipation. I took a deep breath, feeling the weight of the moment, and began.

“Mà, nixtieq nieħdok lura għaż-żmien li kelli l-PP. Tista’ tgħidli ftit l-istorja ta’ meta kelli l-PP?” I asked, my voice soft yet eager.

Her face grew serious as she started recounting: *“Wara t-twelid ta’ Neil, wara ftit xhur bdejt ninnota li l-attitudni li ħassejt li bħala karattru kont qiegħda tinbidel, kont narak qisek dejjem bin-nervi u dejjem qisek imdejjqa meta kont inkellmek. Naf illi kien spiċċa dak ix -‘shine’ li kellek ġo wiċċek u dik is-‘smile’ li niftakar li kellek. Però, qisni qatt ma ridt insaqsik jew nidħol fid-dettal x'qed jiġrilek. Peress illi inti miegħi ma kontx narak illi trid dik*

ir-relazzjoni bejn l-omm u l-bint li tiftaħ qalbek miegħi. Però, kont ninduna li l-karattru tiegħek kien qiegħed jinbidel”.

I felt frustrated and hurt by the statement that I didn’t want a bond with her, as it left me feeling invalidated and dismissed, despite my care for this relationship.

After Neil's birth, I took maternity leave from my teaching and management role at a local primary school, shifting from the busy rhythm of school life to the anxious, secluded pace of new motherhood.

Following paternity leave, my husband Joseph returned to work, and I isolated myself in our small apartment, finding comfort in its safety. Fear of judgement kept me inside, and anxiety about others watching me care for Neil made me withdraw further. I neglected myself to prioritise Neil, even keeping Joseph from bathing or changing him during those first months.

“Postpartum… mummy described that you were always in a bad mood and abrupt…. Fixated on the baby…. You had to do everything properly; you would remark if it wasn't done properly”. My psychiatrist, Dr Susan, was recounting episodes from my medical file related to my PP hospital admission.

We sat in her office, a space designed to be welcoming and comforting.

Dr Susan sat across from me, her eyes gentle as she reviewed my file. Her calm, steady voice conveyed compassion, each word reflecting her tenderness and dedication. “***Your son was also admitted to hospital a month ago. So before we've seen you. .*** *And you were concerned … . And he was an in-patient for one week, and obviously. … You were with him. So there was this precipitant, the severe stress that would happen, that happened before*

you actually… You were very stressed out. Okay. So that was the precipitant that would probably find you very vulnerable and that caused you to have this onset of this psychosis. … With depressive symptoms". I listened as Dr Susan recounted a distant yet haunting time. Her sincere, unwavering voice showed she wasn't just sharing clinical facts but honouring my journey and the pain of that tumultuous period. *"**She opposes everything. Suspicious about the family, about your brother-in-law, about her twin sister and her husband**. So this paranoia involved also the family"*.

At three months old, Neil fell ill, resulting in three hospitalisations for breathing difficulties. Those days were filled with anxiety by his bedside, as sleep eluded me. I vividly recall holding Neil down on a stretcher while nurses struggled to find a vein, his screams echoing as tears streamed down my face, my distress unnoticed.

While studying for a postgraduate diploma in educational leadership through the University of Nottingham, I struggled with assignments and dreaded returning to work after maternity leave. Leaving Neil in someone else's care, especially while still breastfeeding, was unbearable. Though Joseph took a month off to care for Neil before childcare started, I still felt jealous, missing out on time with him.

Returning to work was overwhelming. I constantly worried about Neil's wellbeing and the childcare environment. The job that once energised me now felt like an insurmountable mountain. Evenings were spent catching up on coursework, and guilt over feeling stretched too thin led me to skip sleep, making the balancing act even harder.

Tension mounted at work as we faced an upcoming external audit. "How thin you've become, Debbie!" became a common exclamation from my colleagues. I often said, "That's because I'm breastfeeding Neil", unaware that my weight loss and paleness were due to stress, lack of sleep, and poor appetite. In hindsight, it's no wonder Mum was concerned.

Dr Susan described the writing in my file before my hospital admission: *"Mummy also said that for the past couple of days, you were not eating. So probably that was as a result of your suspicion of them, and you had loss of weight, obviously"*.

Sitting across from me at the table in my twin sister's backyard, Amanda's face was partly illuminated by sunlight. She looked thoughtful, her eyes distant, before speaking with a voice tinged with pity, breaking the silence: *"Ma kontx, lanqas 'self-care', ma kontx tagħmel 'basic' lanqas. U jien ma stajtx nifhem… l-iktar li ħadtha bi kbira jien għax ma stajtx nifhem il-għala ġralek hekk, għax inti kellek is-sapport kollu minn mindu kellek it-tifel, u. Kellek lili taħtek, jekk kellek bzonn xi ħaġa, taqbad u ssaqsini, tipò diga' kelli l-esperjenza jiena. Kellek il-mummy ħin kollu tiela' w niezla' għandek tnaddaflek u ssajjarlek u kollox, kellek il-Joseph ħa l-paternity leave… ġifieri kellek kollox miexi fuq ir-rubini suppost [chuckles], u xorta ġralek hekk… ġifieri għalhekk ma stajtx nifhem jiena…għalxiex ġralek hekk"*.

I often neglected washing myself, a subtle sign of creeping depression. The effects became clear when my curly hair formed a massive knot and attempts to untangle it failed. My hairdresser spent three hours unravelling it in silence.

As sleepless nights wore on, I deteriorated. At work, I felt like I was racing against time, heart pounding, moving and speaking too quickly, my mind spinning. It was like living in fast-forward with no pause button. When colleagues asked if I was okay, I'd shrug it off, saying, "Of course! It's just a busy time!" and I genuinely believed it.

After school, I rushed home to care for Neil and handle chores before diving into work. Evenings were spent on PowerPoints, lesson planning, and coursework. Joseph hated seeing me overworked, and our chemistry faded. Conversations focused on Neil, while I rarely shared about my day.

In a desperate attempt to manage everything, I sacrificed sleep, believing it was a luxury I couldn't afford. After Neil and Joseph went to bed, I silently rose to do chores, the quiet amplifying my fears. Tasks like laundry and cleaning became a way to silence my mind, often at 2 or 3 AM. I kept these late-night routines hidden, not wanting to burden anyone with my struggles.

In the quiet of the night, I struggled with the weight of my responsibilities, unnoticed by those around me. Alone in exhaustion and anxiety, I lay awake after chores, my body aching and my mind racing with unresolved thoughts.

I hid this part of my life, not wanting to burden Joseph, who was already stressed with two jobs. I feared sharing would only add to his worries, so I carried on in silence.

In silence, my struggle was fought in the shadows, unseen by those I loved.

4.2 Theme 2: Altered Reflections: The Transformation of Appearance and Demeanour

One April evening, sitting beside my husband Joseph on the sofa, I felt apprehensive about interviewing him for my dissertation. I wasn't ready to revisit our painful experience with PP, but his gentle smile and warm hazel eyes put me at ease, making me feel comforted in his presence.

Joseph spoke calmly about the changes he noticed in me during pregnancy and postpartum.... *"… qisek xi kultant tiċċassa xi naqra, qisu jaqbdek il-'baby blues' jew x'jgħidulhom 'aw, bdejt ngħid…*

D: Kif kont qed ninbidel? Kif rajtni qed ninbidel?

J: Eee.. u xi kultant qisek tkun aljenata. Mhux ħa… mhux nervuża, tkun qisek aljenata… kelma rrid ngħidhielek darbtejn, biex x'jismu…. Imma imbagħad f'daqqa wahda istra hekk, vrufff… qisek hekk wara li kellek lil Neil, wara kemm? Insomma għaddew kemm kienu

għaddew 5 xhur, 6 xhur? Imma qisek f'salt din, imma ġifieri f'salt. Forsi minn ġimgħa qabel qisek bdejt, qisek qabbdek ċertu biżà hekk, jekk għadni niftakar sew. Imma kien weekend ikrah e, vera…. l-agħar weekend għalija kien dak. L-agħar weekend u… narak dik is-sura… mentalment u fiżikament għax anke fiżikament. Qas… bqajt… qisek xjaħt. Bl-inkwiet qisu li kellek. Iva kont qisek xjaħt.. imdejjqa. Kont tidher li mdejjqa u. Hekk, hekk kont inbdilt… f'kollox inbdilt. U bqajt imbellaħ għax qatt ma', qatt m'esperjenzajt, m'appretendejt li l-bniedem mil-lejl għan-nhar jiġi hekk, jinbidel f'salt".

Silvio, my former Head of School, also noted the changes he observed before my PP experience: *"Però, kont qed ninnota li pereżempju kont tiċċassa fit-tul, illi ma tiffukax, illi kont nistaqsik xi ħaġa u tirrispondi fil-qasir".* As I stared at the garden Silvio lovingly tended, he took a sip of his coffee to jog his memory and continued… *"Dak iż-żmien, kont inbdilt anki fil-'physique' tiegħek. Ġifieri niftakrek, kont ġejt vera għadma w ġilda… ma nimmaġinax kont tiekol".*

In May 2016, I was admitted to an obstetric ward. Alison, the perinatal midwife, was shocked by my appearance. I don't remember all the details, but I felt physically weak. Mum had made me shower before taking me to the clinic. Too exhausted to walk, I was paralysed by hallucinations and unable to answer the midwife's questions. My mind had shut down, and the paranoia made me feel helpless, consumed by confusion and fear.

"U kif rajtek…. Il-ħarsa ta' wiċċek u l-mod kif kont qed iżzomm ġismek…. dak il-ħin għedt: "Il-aħwa kemm mhix tajba din il-mara! Il-questionnaire kien il-PNRQ, il-postnatal risk assessment questionnaire. Konnha tajnik lilu u l-EPDS. Dak iż-żmien dawk it-tnejn konnha nagħtu. U dak il-ħin, hekk, 'it struck me'… illi għedt: "Il-aħwa din kemm qed tbati!" U fil-verità qisu, kien l-ewwel darba li ltqajt ma' xi ħadd b'postpartum psychosis… tipò ġieli kellna pazjenti oħra li ma kinux tajbin u li forsi kellhom bżonn 'admission'. Imma dejjem kien

hemm 'other mental health issues' minn qabel il-'pregnancy'. 'It wasn't…' qisu, 'a pure postnatal, psychotic episode, postnatal psychosis', fil-verità. U dak il-ħin għedt: "Il-aħwa! Din qed tbati". It-'thought process'. Kif ħa naqbad nispjegalek?... Inti għalik dik hi r-realtà, dak li qed jgħidlek moħħok dak il-ħin. Dik ir-realtà tkun qed tgħix. Mhux ir-realtà tan-nies ta' madwarek".

When I finally glanced at my naked reflection in the hospital mirror, it hit me: I was seriously ill. What had I done to myself? The skeletal figure staring back, with tired eyes and a gaunt face, was the same body that had nurtured Neil. Ironically, as I gained this insight, the medication slowly began to work.

4.3 Theme 3: Mindscapes: Navigating Hallucinations, Delusions and Paranoia

"I've got so much to say on this, I can't keep it secret. It's like selling my soul to the devil, to reveal this dark and shameful secret, to say something so big such as suicidal thoughts… What the hell was my brain thinking at that moment? I was planning the perfect suicide… with my dead family members present to witness it… they weren't dead after all. They were laughing at me. It was all a show – their funerals, the flowers, the crying… it's just mad and mental…".

- An excerpt from my speech at the PIMHA Conference on Perinatal and Infant Mental Health, 25th November 2022.

Writing helped me process the overwhelming thoughts and memories after psychosis. I soon realised PP disrupted my cognitive processing, and creating a timeline brought clarity. My mind was so chaotic it felt like an uncontrollable rollercoaster ride. I fear I may not do my story justice, but I ask for your patience as we navigate this complex journey together. To the outside world, I seemed nonsensical, but for me, the reality was as clear as day.

At times, I feel guilty about what I put my family through. When I asked Mum about her perspective, this is what she shared:

“Bdiet, eżatt meta billejl għajjatli…. jiena kont qiegħda isfel u għajjatli, “Mummy, tista’ titla’?” Għedtlek: “Issa?” Għedtli: “Iva”. U tlajt fuq, daħħaltni fl-‘istudy’ u bdejt tirrakkontali illi gejjin il-pulizija għalija. Qegħdin wara l-bieb. Se joħduni. Għandi dawn l-inkwatri taċ-ċertifikati li qegħdin imdendlin, aqlagħhomli, erfagħhomli għax se jiġu għalija. Semmejtli xi CIA. U jien bdejt ngħidlek: “Debbie, x’inti tgħid? X' inti tgħid, Debbie?” U inti bqajt serja, niftakar. U erġajt irrepetejt, u inti komplejt tirrakkontali dawn l-affarijiet, li għalija kienu qishom ħmerijiet imma mbagħad ħadthom bis-serjetà jien, għax naf illi dawn l-affarijiet tarahom ġo films, mhux narahom in-person miegħek, ma’ binti!”

Earlier at home, I started eyeing Joseph suspiciously. I didn't speak, but my mind was a whirlwind of dark thoughts. Why are there CCTV cameras installed in our house? Who came and fixed them on the chandeliers? Why is everyone watching me? I thought of the technicians at school - maybe Joseph let them in, or they broke into our home while we were out. I felt the urge to escape, to leave the house and go far away. But then a terrifying thought struck me: what if there's a bomb implanted in my car? These people are capable of anything, and they want me dead.

I checked on Neil, and to my horror, I found him covered from head to toe in bedsheets. What the hell? I wanted to scream. I quickly removed them and checked his breathing. Just as Joseph came back in from the balcony where he'd been smoking, I started yelling at him. I was convinced this was a conspiracy against me, that he was plotting to have me taken away; that social services would come and put Neil up for adoption.

- Journal entry, 6th March 2019

In my psychotic state of mind, I was terrified of trusting anyone. I felt my security was jeopardised, terrorised by the thought that I was being constantly watched and followed.

After a sleepless night on Saturday, I decided to talk to my brother-in-law about work issues. I went downstairs to my sister's apartment and, in a frantic state, rambled about redundancies, audits, and the government taking away my warrant.

Amanda: … "u ġejt tħabbtilna l-bieb lili u lil Mario, u għedtilna li trid tkellimna fuq affarijiet importanti. U nsomma, u dħalt ġewwa u bdejt tgħidilna, li qed tħossok li tax-xogħol qed jagħmlu komplott kontrik…

Debbie: U x'kienet ir-reaction tagħkom?

A: Li bdejt tirrakkonta inti, bdejna dak il-ħin qisna nemmnuh għax kont vera 'convincing'. Kont vera konvinċenti…

D: U x'bdejt nirrakkonta?

A: Bdejt tgħidilna li qed jagħmlu komplott kontrik – l-istudenti u t-'teachers', qed iduru kontrik. Ħa nipprova niftakar x'bdejt tgħidilna… u bdejt tgħidilna qishom affarijiet li ma jagħmlux sens… li qed jirrekordjawk, li ħa jagħmlulek bomba taħt il-karozza… affarijiet hekk…

D: U kont qed ngħid min, min huma?

A: Mingħalija l-għalliema tiegħek, ta' miegħek, il-kollegi tiegħek u anki l-istudenti bdejt tgħid li qegħdin magħhom, speċi, komplott magħhom. Imma kienet konvinċenti ħafna l-istorja tiegħek, niftakar, għax anki Mario beda jaqbel miegħek u jgħidlek issa jekk hemm bżonn immorru 'aw, x'jgħidulu hemm il-Furjana? Id-Depot… qallek jekk filkas immorru issa d-Depot"…

That night, after the house fell quiet, I left our bed and wrote a 5-page letter to my sister, a desperate plea for understanding. I acknowledged our bond, telling her, “Though we were born together, we won't enjoy each other's company until the end”. I confessed my sense of betrayal, writing, “Things are all against me”. I wrote in the letter that the world had conspired against me, feeling trapped in a web of deceit and accusation. “I was framed”, I wrote, trembling, hoping it would absolve me of the guilt and terror I felt. I detailed Neil's hospitalisations, claiming they were a plot to frame me for neglect, and described conspirators trying to annul our marriage, falsely accuse me of infidelity, and deny Joseph as Neil's father. At work, I was targeted by a political agenda, my every move being recorded. I begged for a lawyer, a fair trial, and urged my sister to contact the EU courts. I described hacked accounts and accusations of stealing from Neil’s savings. The letter ended with: “I'm going to drown”.

I wanted to die. I believed I didn't deserve life, that my son didn't deserve me as his mother. I felt completely useless, convinced that everyone would be better off without me. I was consumed by shame and guilt, certain that if I died, all this would be over, and everyone would be glad. The best place to be was Dead. How I longed for it! I looked at it in the face and smiled. For those around me, it would look like I was surrendering. But, no, I was conquering it. Death was welcoming me, embracing me, and setting me free.

On Mother’s Day, Joseph takes Neil to grandma’s, leaving me too weak to speak. My body feels drained, and Mum, noticing my frailty, climbs into bed beside me. But sleep eludes me as my mind races with fear.

The sound of helicopters overhead sends a jolt of panic through me. I know they're coming for me. Trembling, I peer through the window and see three armed figures in black

across the road, approaching our block. Terror grips me, freezing my thoughts. They're here. There's no escape now. The walls close in, and all I can do is wait for the inevitable.

Mum took me for a walk to distract me, but I couldn't shake the feeling of being watched. When I glanced behind, I saw them in a black Mercedes, their faces twisted in mocking smiles. Anxiety surged, and I quickened my pace, leaving Mum behind.

We bumped into the parish priest, and Mum stopped to chat. Seizing the moment, I typed a desperate message on my phone, trembling as I silently showed it to him: "Please help me. Tell them I'm innocent if I'm going to the EU law courts. They'll believe you, but not me".

He glanced at Mum, and she shook her head, her face flushed with embarrassment.

As we walk, I ramble about the film 'The Life of David Gale', convinced my life will end like Constance Harraway's. I'm desperate to be heard, but no one listens. Mum keeps shushing me, dismissing my fears and reassuring me that Neil is mine and Joseph's, not of the official from the Education Department. But I know something's wrong, and I'm running out of time to tell my story before I'm locked up forever.

Mum took me to the local health centre, but I felt trapped, convinced the nurses were part of a plot against me. I secretly photographed their badges, determined to gather evidence. I felt everyone's eyes on me, like they were all talking about me. When they handed me sleeping pills, I feared they were meant to kill me. Terrified, I refused to take them. The following Monday, they referred me to the PMHC.

On the way to the hospital with Mum and Neil, every billboard seemed to shout at me. While waiting in the outpatients' corridor, every conversation felt like accusing whispers about me as a mother, filling me with terror and shame. On admittance, Alison, the midwife,

recalled: *“The look was a bit dishevelled’. Imma l-iktar ħaġa illi ‘it struck’, hekk…. kemm kont qed iżżomm ruħek iebsa…. Anki spallejk, hekk, kienu qishom ‘hunched’. U l-ħarsa ta' għajnejk…. Qisu l-ħin kollu ‘on the lookout’… qisu ħa jiġri xi ħaġa.*

D: ‘Vigilant’…

A: Eħe… ‘vigilant’ ħafna… ‘very vigilant’… u qisu tissusspetta f’kollox… f’kulħadd… F’ħin minnhom, niftakar sakemm konnha qegħdin nistennew il-ward, inti xtaqt toħroġ tpejjep sigarett u ġejt miegħek jiena… [eħe] u ħriġna barra, Mater Dei, barra… U inti qisek bdejt tistaqsini ċertu mistoqsijiet, illi bħal speċi… għalfejn qiegħda miegħi, x'se tagħmluli, jekk hux se jkun hemm xi kamera…? U bdejt ngħid.. dak il-ħin, hekk, għedt, “Miskina!” Taf kif? ‘It’s mentally very taxing’. Għax li kieku kien vera, ara kemm….. kemm hi xi ħaġa li tqanqal ċertu biżà u ċertu…. x'taqbad tgħid, ‘feelings’, li huma diffiċli tiddilja magħhom. U kont naf li dak il-ħin inti dik kienet ir-realtà tiegħek. Niftakar kif dħalt lura, kien hemm Dr Susan, għedtilha: “Ejja ħa narawha għax din xejn mhi tajba e…” Imbagħad kont ġejt miegħek sal-Obs 3, kienu tawk is-single room…

D: L-18. Dik kont fiha qabel dħalt inwelled. Kumbinazzjoni, u kienu lestewli l-‘cot’ għat-tifel. Biex joqgħod miegħi, u bdejt nimmaġina, għax bdew idawwru l-lożor. Għax cots m'hemmx għal 8-month-old, għax Neil 8 xhur kellu, il-‘cots’ ta’ ‘newborns’ kienu, allura biex ma jweġġax, jaħasra, bdew jiksuha bil-lożor id-dawra tal-‘cot’ u jien bdejt nimmaġina li ħa jagħmluni fi ‘straight jacket’ [illami]. Meta bdew iduru ħafna bil-lożor u jdawwru jdawwru bil-lożor… bdejt ngħid ħa jiksuni jiena, bl-‘istraight jacket’, issa…. Bħal tal-‘films’. Dawn tal -‘mental issues’. Bdejt nimmaġina, u x’ħin daħħluni fis-sodda u bdew iwaħħluli l-‘wires’ biex jiċċekkjawni, l-istess… bdejt ngħid: “Ġejt hawnhekk l-aħħar fażi issa… qed idawwruni bil-‘wires’… hemm il-kameras fuq rasi”. Kien hemm it-televixin mixgħul tal-‘waiting area’ fuq l-‘adoptions’ bdejt nimmaġina li t-tifel ħa jitfugħ għall-‘adoption’. [illami…]

A: Ara kemm ikun hemm affarijiet li 'we don't even notice', fil-verità…

D: U meta ġabuli l-'menu' biex nagħżel l-ikel, għedt: "Dawn qed jitmejlu bija…", "mela ġo sptar tagħżel l-ikel fuq il-'menu'?" Bdejt sejra ġo qalbi…dawn qed jitmejlu bija…" bdejt sejra. Hekk bdejt ngħid, li ħa jivvelenawni…. Li dan velenu… imbagħad darba minnhom ġabuli l-ħelu, jaħasra… ċikkulajjet għax kont nafhom l-'midwives' u n-'nurses' t'hemmhekk, peress li kollegi t'oħti. U l-istess… bdejt ngħid: "Dawn qed jitmejjlu bija… dawn ħa jivvelenawni…." [paranoja..] Il-paranoja…"

I spent two weeks inpatient, starting treatment for psychosis and being closely monitored. Gradually, the hallucinations and paranoia faded, but I remained withdrawn and dissociated. This marked the beginning of a long recovery.

4.4 Theme 4: Through the Storm: PP and Its Toll on Those Around Me

Navigating PP, the storm affected not just me but everyone around me. My family, especially, felt the strain, confused and helpless as they watched me struggle with a frightening, unfamiliar reality. Our bonds were tested, and the emotional toll was heavy.

I asked Joseph about his emotions during those turbulent times. He paused, searching for the right words: *"Le kont imkisser… Kont żibel, u. Imbellaħ kont. Kienet ħinijiet minnhom, tkun l-isptar u haw waħdi. Li anqas ikunu għaddew sagħtejn, ma nkunx naf dawk is-sagħtejn x' ġara, u qas kont inkun naf jekk irqadtx. Għax 'just', televixin mixgħul u tagħmel hekk, u jkunu għaddew sagħtejn. Jiġifieri, għalkemm it-televixin… jew tkun marret għajni bijja, ma nafx…. Għajnuna, ma kontx naf x'se nagħmel, ma kontx naf x'se nagħmel, xejn xejn xejn. [Ma kontx taf kif se tgħinni…] Le, le, kont kont letteralment mitluf waħdi. Issa tgħidli li kieku ma tistax issib…? Għajnuna lil min ħa nsaqsi? Li għandi bżonn l-għajnuna jew, bqajt qisni nikkkowpja waħdi dak iż-żmien"*.

Silvio echoed Joseph's powerlessness, noting the toll it was taking on him: *"Niftakar anki Joseph, darba minnhom kien qalli, "Ma nafx x'ħa nagħmel iktar… qed niġġennen, qed inħossni". Qalli: "Għax ma nafx, u". Qalli: "Ħa niġġennen, għax qed nipprova nkellimha bil -kelma t-tajba u bil-mod, imma mhux nifhem eżatt x'inhu jiġri".*

Silvio was deeply troubled by the situation, seeing my struggle and growing anxious about my wellbeing: *"Bdejt ngħid: "Ilallu Debbie! Debbie!...", speċi, taf kif? "Se nitilfuha, se nitilfuha". Għall-ewwel għedt: "Madonna..!", speċi, l-ewwel kelma għaliha, għedt: "Din se jmurilha moħħha", fhimt? Għedt: "Di problema", għedt: "Imsieken il-familjari, miskina hi…" għedt. "Tal-biżà'".*

Amanda, already overwhelmed with her own life, struggled to support me while caring for her newborn and older son. The added stress of my condition strained her immensely: *"Jiena ridt inlaħħaq ma' 'newborn baby' u t-tifel. Kelli diġà l-ħsibijiet tiegħi, u l-inkwiet fuqek. U bdejt ngħid, ara tmur tikteb xi ħaġa fuq Facebook, jew hekk, u kellek xi xogħol issejvjat, ma nafx x'għamilt bih inti, fuq il-'laptop'. Għax persuna b''mental problems', mhux ħa tafdaha fuq 'social media', speċi u. Sakemm fiqt kont għalija qisek pazjenta u…xi ħadd irid jieħu ħsiebek… għax ma kontx kapaċi, għal xejn, tipò la biex tieħu ħsieb lilek innifsek u qas it-tifel, imma fl-istess ħin kont vera nitħassrek u hekk u, biex spiċċajt hekk… Imbagħad il-'mummy' niftakar għedtilha: 'Tħallihiex waħedha għal sekonda!'… dik li niftakar.. Il-Ħadd… u għedtilha: 'Għax mhix qegħda sew'. Għedtilha: 'Ara ma tħallihiex waħedha sekonda!' jien. Bdejt nagħmillha hekk".*

4.5 Theme 5: Whispers in the Shadows: Confronting Stigma and Gossip

During those turbulent times, those aware of my situation made efforts to keep it discreet, especially from relatives and colleagues. Mum was especially adamant, asking Silvio to ensure my condition stayed confidential. Later, during my recovery, I learned Silvio

had emailed the staff, stating I was ill without sharing further details. Their actions, hidden from me at the time, showed their concern and respect for my privacy.

Some family members, like my aunt and cousins, were unaware of my illness. It wasn't until after my recovery, when I shared my story on social media, that my aunt expressed surprise, revealing she hadn't known until much later. Their distance, whether by choice or circumstance, added to the secrecy surrounding that difficult time.

I once sent a nonsensical message to all staff while still in the hospital, my mind unclear. Silvio quickly noticed, called me urgently, and advised me to delete it. He was trying to protect me, managing the situation carefully to prevent gossip among my colleagues.

Silvio: Għax inti anki bdejt tgħid affarijiet, anki 'open' lill-istaff, u min ma jkunx jaf, jistà jew…

Debbie: X'kont ngħidilhom?

S: Ħa nipprova niftakar… niftakar li pereżempju darba minnhom kellna xi ikla u kont bgħatt messaġġ li m'għandu xejn x'jaqsam mal-kontenut tal-ikla… u niftakar kien hemm min ġie u qalli: "Isma', x'inhi tgħid Debbie?… X'riedet tgħid Debbie?" U jiena għedtilhom: "Tatux kas, speċi…"

D: E jien niftakar, kont ċempiltli, kont l-isptar u għedtli, "Aħjar tħassru dak il-messaġġ", tal-'Messenger'…

S: Ehe, insejt x'kien il-messaġġ eżatt… ehe, imma niftakar kont għedtlek hekk.

My sister, a midwife, deeply felt the taboo surrounding my condition. When I was admitted to her ward, she was determined to avoid transferring me to MCH, a place stigmatised for mental illness. *"Le, Mount Carmel żgur ma tmurx…", jiena nsomma. Imbagħad, la naf ċempilt is-sala u tas-sala ċemplu lill-konsulent… xi ħaġa hekk, insomma.*

Le, lil Dr Susan għedtilha: "Aħna jieħu ħsiebna Mr Friġġieri. Il-'consultant' tagħna huwa Mr Friġġieri u dak żgur mhux ħa jħalliha tmur Mount Carmel. U jekk nispjegawlu s-sitwazzjoni, għedtilha, jaċċetta li tidħol fid-dipartiment tagħna, speċi".

Debbie: U kif għexthom dawn iż-żminijiet? Peressli oħtok, u dieħla fis-sala tiegħek… u l-kollegi….

Amanda: E jiena kont…. kont vera ħażin… apparti kont għadni bil-'maternity leave' u hekk, u jien. Kelli 'toddler' u 'baby' ta' xahar u nofs, ħeqq ma kontx qegħda sew u, xejn. Kont nagħmel l-iljieli mqajjmin u nfittex fuqha din is-'psychosis', u hekk. Ħeqq ma kontx qegħda sew u. Apparti li kont vera ħassejtni 'guilty' li tipò qisni ma kontx 'aware' tagħha s-sitwazzjoni. 'Plus', li kelli ndaħħlek fis-sala fejn naħdem jien, għedt min jaf il-'gossip' kif ħa jdur ma' kullimkien…mad-Dipartiment kollu. Jaf li daħlet oħt Amanda, min jaf in-nies kif tkellmu fuqha l-ħaġa, il-kollegi… din tkun ħaġa kbira u, tiġri mad-Dipartiment kollu, u jgħidu din kif ma ndunajtx, jew hekk, 'midwife'?

As a survivor, hearing my family and friends express their concerns left me feeling ambivalent. I appreciated their efforts to protect my dignity out of love and concern, for which I'm grateful. Yet, I felt sadness knowing they too had to bear the weight of societal stigma, shielding me from a world that still struggles with mental health. This mix of gratitude and sorrow stays with me as I reflect on those difficult times.

4.6 Theme 6: Healing Hands: The Journey of Treatment and Support

I believe my recovery truly began when Mum sought help at the health centre. That simple act marked the turning point, the first step on a long road to healing. "*U meta għedtli: "Iva", taċċetta li nieħdok għand tabib, dawk il-ħinijiet m'inhix se nsib tabib, ċempilt il-polyclinic tal-Furjana, kellmitni tabiba, u meta bdejt nirrakkontalha dak li għedtli, qaltli: "Ġibha issa!" Għamlitli emfasi: "Ġibha issa!" qaltli: "Mall-ewwel!"*

At the PMHC, Dr Susan expressed deep concern for my condition, emphasising its severity and her urgent desire to help me heal. Her words, filled with empathy, reflected her strong wish to ease my suffering as quickly as possible. *"I know it was an assessment that I had to do on an urgent basis where you were brought to the clinic. My initial response was that of intense focus and I found myself deeply intrigued by the complexity of your experiences and the events occurring around at that time. It always … when you hear these stories, they're always complex and different. And the way you were navigating your experiences, your reality or your world compared to the world that really existed was quite complex. So, it was for me, very, very moving because obviously I could feel that you were going through extreme stress and extreme suffering, that I wanted, obviously, as every professional probably would want to do, is alleviate your suffering and get you better as fast as I could because of your own suffering, that of the family and of the baby. So, it was quite, it was very intense".*

Dr Susan explained that being admitted to a gynaecology ward was a positive aspect, as it allowed me to stay close to my baby, bringing a sense of normalcy amid the uncertainty. "*The fact that you were admitted (in an Obs ward) was, I think, a big plus, a big bonus to all".*

"So you are, confused. So in that state, it is difficult for you to do it (accept treatment). So we needed to find an environment which is calm, which is not home, but which is as well, not a psychiatric hospital. Obviously, the fact that your sister was a midwife, I think that really, really helped, because she could be there with you. Obviously, there are other midwives who would support her, but we had to make sure that you were in a safe environment where you are watched all the time and obviously compliant to treatment. So that was also something that was possible. And obviously the fact that you were admitted because you could have your baby, if not additionally, probably until".

Dr Susan's tone shifted with disappointment when she mentioned that admission to a gynae ward was no longer possible in 2024. I felt grateful for my past admission but sorrowful for mothers now facing admission to a MCH ward during such a vulnerable time. It was a bittersweet realisation. *"But it is also, it was for me, something positive that you could be admitted there with your baby, which unfortunately, now it has been stopped, and it is, I mean, this, we're talking in 2016. So we are now in 2024, and what we had in 2016, now in this age, in this day and age, we are not able to admit because the protocol for admission has changed, which is a loss, which is a loss"*.

"Probably you are the only one who can say and talk about the importance of being in an environment which is safe for the mother, safe for the child, and supported". Hearing my psychiatrist's words reignited my motivation. Despite the responsibility, I saw clearly that writing this dissertation was a meaningful endeavour. Her encouragement deepened my determination to finish it.

The staff at Obs 3 showed great commitment to my recovery, allowing Silvio, an outsider, to visit me. I often asked for him, as my hallucinations involving colleagues didn't feature him. His presence brought me much-needed reassurance and validation. With my family's consent, the midwives permitted him to visit at night, and his updates from work, along with my employer's eventual visit, played a crucial role in my recovery. *"Bdejt tibżà li ħa titkeċċa. Bdejt tibżà li ħa tispiċċa bla xogħol. U jien niftakar kont anki tkellimt ma' Mr Savona, li kien dak iż-żmien l-'employer' tagħna, u niftakar kien qalli: "Serrħilha moħħha, li jekk għandha bżonn tieħu anki xhur, aħna nħobbuha, aħna nirrispettawha, aħna nafuha dejjem magħna u dejjem ħabbitna…" u jien kont għedtlek: "Ismà, Mr Savona qed jgħidlek ħu kemm trid żmien ta' 'sick leave'", ħa ngħidu hekk, u niftakar anki kien ġie l-isptar, fil-fatt. Darba minnhom kien qalli, naħseb mar iktar minn darba. Darba minnhom naf li tlajt miegħu jien stess u qalli: "Ismà, ejja ħalli mmorru narawha lil Debbie l-isptar"*.

My sister helped my recovery by regularly taking me out during my hospital stay, with the ward staff's permission. These outings, though small, were an important part of my healing.

Amanda: Imbagħad f'dawk il-ħmistax kont niġi kważi kuljum ħdejk, kien ikun hemm il-'mummy' miegħek il-ħin kollu, 'plus' il-'constant watch'… u kienu qed ifasslu pjan u x'ħa jagħmlu, bit-'treatment' u riedu jagħmlulek ix-xokkijiet….

Debbie: Probbabli ma bediex jaħdem ma' l-ewwel ġimgħa, la riedu jagħtuni l-ECT…

A: Ma nafx, imma qalu ħa nibdew bit-'treatment' l-ewwel…. Imbagħad wara l-ewwel ġimgħa kienu qalulek li tista' tibda' toħroġ għal ftit sigħat u terġà tidħol. Kont niġi għalik u noħorġu bil-karozza.

D: Fejn konnha mmorru?

A: Darba morna l-Mistra niftakar, konnha morna nimxu hemmhekk; darba morna Għajn Tuffieħa…

D: Bil-baby…

A: Bil-baby tiegħi żgur… Neil ma nafx kienx magħna…

D: E għandi ritratt bih fil-pushchair…

A: Kien magħna. U kont noħroġ bik kuljum, speċi. Sakemm kont l-isptar.

Recovery was a long, challenging journey with moments of progress and setbacks that tested my resolve.

After my psychosis subsided and I was discharged, I entered a period of depression, struggling with low self-esteem, memory, and attention issues. Flashbacks haunted me, but I regained my appetite, slept better, and became more coherent. I was no longer suicidal.

I began therapy, including EMDR, to process the trauma, and was prescribed anti-depressants alongside anti-psychotics. The PMHC team closely monitored me for months, advising against another pregnancy due to relapse risks. However, my husband and I decided to try for a sibling for Neil, stopping the medication during pregnancy. After our baby's birth in 2017, I resumed medication under supervision. The clinic staff closely monitored me, reintroducing anti-depressants as a precaution, and thankfully, everything went well.

My PMHC appointments ended in 2020, but in February 2023, I relapsed due to work, study stress, and treatment non-compliance. I was diagnosed with bipolar disorder and started on lithium, with an increase in my anti-psychotic medication. Since then, I've been seeing my psychiatrists regularly, staying committed to my treatment and managing the condition.

During my recovery, my family was very cautious around me, tiptoeing with their words and actions. Their constant vigilance, though born from love, sometimes made me feel as if I were under a microscope.

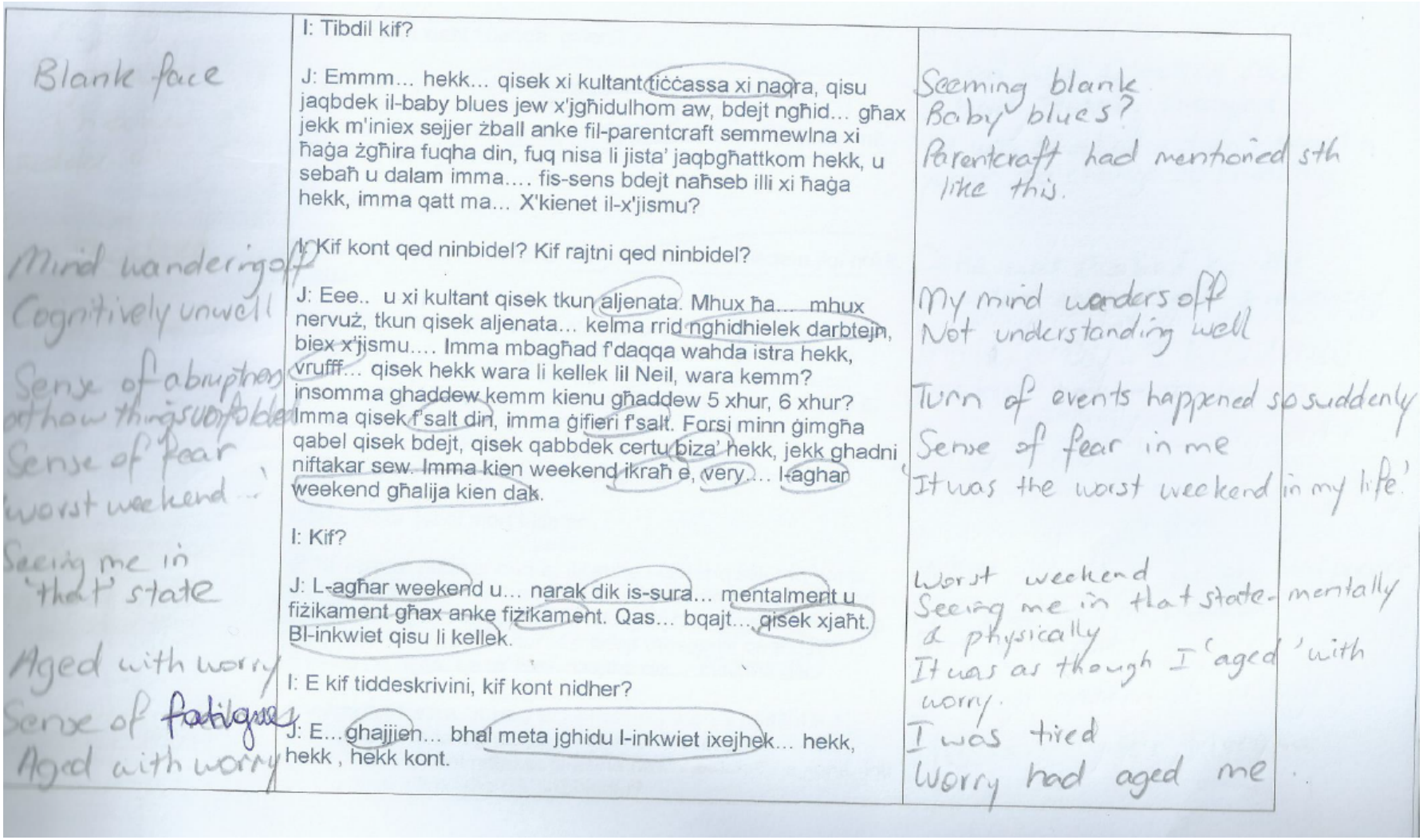
Through every twist and turn, I am surrounded by those who wish me well, their support a steady source of strength.

I will be discussing these findings in the next chapter.

Appendix H

Audit Trail

AUDIT TRAIL



Blank face	I: Tibdil kif?	Seeming blank
	J: Emmm... hekk... qisek xi kultant tiċċassa xi naqra, qisu jaqbdek il-baby blues jew x'jgħidulhom aw, bdejt ngħid... għax jekk m'iniex sejjer żball anke fil-parentcraft semmewlna xi ħaġa żgħira fuqha din, fuq nisa li jista' jaqbgħattkom hekk, u sebaħ u dalam imma.... fis-sens bdejt naħseb illi xi ħaġa hekk, imma qatt ma... X'kienet il-x'jismu?	Baby blues? Parentcraft had mentioned sth like this.
Mind wandering off Cognitively unwell	I: Kif kont qed ninbidel? Kif rajtni qed ninbidel?	
Sense of abruptness of how things suddenly	J: Eee.. u xi kultant qisek tkun aljenata. Mhux ħa... mhux nervuż, tkun qisek aljenata... kelma rrid nghidhielek darbtejn, biex x'jismu.... Imma mbagħad f'daqqa waħda istra hekk, vrufff... qisek hekk wara li kellek lil Neil, wara kemm? insomma għaddew kemm kienu għaddew 5 xhur, 6 xhur? Imma qisek f'salt din, imma ġifieri f'salt. Forsi minn ġimgħa qabel qisek bdejt, qisek qabbdek certu biża' hekk, jekk ghadni niftakar sew. Imma kien weekend ikraħ e, very... l-aghar weekend għalija kien dak.	My mind wanders off Not understanding well Turn of events happened so suddenly Sense of fear in me It was the worst weekend in my life'
Sense of fear 'worst weekend'	I: Kif?	
Seeing me in 'that' state	J: L-aghar weekend u... narak dik is-sura... mentalment u fiżikament għax anke fiżikament. Qas... bqajt... qisek xjaħt. Bl-inkwiet qisu li kellek.	Worst weekend Seeing me in that state- mentally & physically
Aged with worry	I: E kif tiddeskrivini, kif kont nidher?	It was as though I 'aged' with worry.
Sense of fatigue Aged with worry	J: E...ghajjien... bhal meta jghidu l-inkwiet ixejhek... hekk, hekk , hekk kont.	I was tired Worry had aged me..