Responding to perinatal suicidality

Evidence brief

Introduction

Although suicide is a leading cause of maternal death in Australia and other high-income countries, research to date has failed to deliver an adequate understanding of suicidality during pregnancy and the following year (a time known as the perinatal period).

Several perinatal studies have examined the incidence of suicidal thoughts and behaviours and associated social and obstetric risk factors,[1-3] or produced descriptions of symptoms, help-seeking, or approaches to coping.[4-6] There remain stark gaps in our understanding of women's experiences of suicidality at this time in their lives.

The Making Sense of the Unseen study was undertaken in response to an urgent need to generate deeper understandings of how suicidality manifests and evolves during pregnancy and the following year, and how recognised risk factors operate within women's lives and within health care interactions.

This evidence brief reports findings from the study and highlights key implications for health policy and practice, and health professional education.

When women feel that they are defective, unworthy of love and belonging, and do not possess what it takes to be a good mother, they can conclude that their family is better off without them.

We have identified that the evolution of perinatal suicidality is driven by experiences of shame and feelings of disconnection and defectiveness. Pathways beyond shame and perinatal suicidality can be facilitated by compassionate and rehumanising relationships and care experiences that enable women to feel worthy, deserving of love and belonging, and that their families are better off *with* them.

Despite the clear importance of compassion in perinatal suicide prevention, health professionals and systems face numerous barriers to providing compassionate care. Improved identification and response to common origins and contexts of shame and removing interpersonal and systemic barriers to compassionate care are critical first steps to addressing perinatal suicide.

The study

This grounded theory[7] (qualitative) study aimed to generate a theory to explain how suicidality evolves in the perinatal period. A total of 139 women who experienced suicidality during pregnancy and/or the following year who had received pregnancy care in Australia in the preceding five years participated (regardless of pregnancy outcome). Data were generated using anonymous online testimonials (119 participants) and in-depth interviews (20 participants).

I had an absent father and a mother that was clinically depressed. I was often left alone and not cared for. I also had an abusive stepfather. This all contributed to my feelings of not being able to be a good mother or love my baby. (Study participant)

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Pathway through shame

Origins of shame

Many participants shared common and often compounding origins of shame; adverse childhood experiences such as abuse or neglect, gender-based violence, and intergenerational trauma. These experiences, often occurring early in women's lives, changed the way they viewed themselves and the world.

Violated expectations

Women's experiences of pregnancy and early parenthood, including their experiences of health care at this time, violated their expectations of themselves as mothers and humans. Participants expressed this as feeling like abject failures; that their bodies had failed them, and that they had in turn failed their children and families. Experiences of disrespectful or dehumanising care, a sense of having failed at pregnancy and birth, breastfeeding, or early parenting, could all be experienced (felt) as clear evidence that they were in fact defective mothers.

Disappearing self

A pregnancy, new baby, or loss of a career or job heralded the disappearing of self (identity). These feelings can be exacerbated by sleep deprivation and the physical toll of pregnancy and early parenthood, as well as care providers and systems, friends, and family who enquire about or prioritise the baby's wellbeing without showing the same care for the woman beyond her role in growing, birthing, and feeding her baby. This loss of self was perceived as permanent; women did not hold hope that the 'self' would return.

Psychological isolation

Psychological isolation[8] relates strongly to, and may be considered an outcome of, shame; the knowledge that your defectiveness means you are not worthy or able to experience love, safety, and belonging, and that the love you have to offer your family is not worth a lot. As this shame (defectiveness) is sensed as permanent, feeling alone and disconnected is also understood as permanent — leading to desperation and intolerable feelings of being trapped and needing to escape.

The only option

If you 'know' (feel at the time) you are defective, unworthy of love and belonging, and do not possess (and will not possess) what it takes to be a good mother, you can conclude that your family is therefore better off without you. This understanding of the situation led women to feel that the only option available to them, and the one that best expressed their love and care for their family, was to die by suicide.

Re-defining the good mother and re-imagining self

Stories of the pathway beyond shame commonly featured experiences of compassionate rehumanising care from friends or family, or mental health, perinatal, and primary health professionals. These experiences of connection and safety demonstrated to women their worth as people, and that they were in fact deserving of love and belonging. Within compassionate and safe relationships women were able to feel that their families were better off *with* them.

The evolution of perinatal suicidality

The developed theory contains three components: shame talk (capturing the way women express themselves relating to their perinatal experiences); contexts of shame (reflecting the contexts in which women experience shame or exacerbate feelings of shame); and pathway through shame (the core pathway that characterises the process of perinatal suicidality). These processes all hold shame as a core concept. Our definition of shame is based on Brown's Shame Resilience Theory: an intensely painful feeling or experience of believing that we are defective and have failed, and are therefore unworthy of love and belonging.[7]

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PATHWAY THROUGH SHAME

STRONGERFUTURES.ORG.AU LAURA BIGGS et al. (2023) QUALITATIVE HEALTH RESEARCH ILLUSTRATION BY ROWENA COE

What is already known?

Despite the fact that women and families are often in frequent contact with health professionals during pregnancy and the early years of their children's lives, suicide is a leading cause of maternal death in Australia and other high-income countries.

Existing literature has so far failed to deliver an adequate understanding of women's experiences of perinatal suicidality or their preferences for support and care at this time.

What this evidence brief adds

Perinatal suicidality is a complex multidimensional phenomenon, influenced by socio-cultural expectations of motherhood and interpersonal, systemic, and intergenerational experiences of trauma. We have identified that the evolution of perinatal suicidality is driven by experiences of shame and feelings of disconnection and defectiveness. Origins and contexts of shame reflect current epidemiological understandings of risk for perinatal suicide, including experiences of gender-based violence, adverse childhood experiences, and a history of mental health difficulties. Experiences of dehumanising or disrespectful healthcare function as powerful evidence for women experiencing perinatal suicidality that they are in fact defective mothers.

When women feel that they are defective, unworthy of love and belonging, and do not possess what it takes to be a good mother, they can conclude that their family is better off without them. Importantly, pathways beyond shame and perinatal suicidality can be facilitated by compassionate and rehumanising relationships and care experiences that enable women to feel worthy, deserving of love and belonging, and that their families are better off *with* them.

Considerations for policy and practice

Health Services

- The experiences and challenges women and families face in the perinatal period are unique, including experiences of suicidality. Specialist services, with expertise in perinatal mental health and suicide prevention, are best placed to meet these unique needs. It is important that women and families have information about how to contact specialist services, and that telephone support is available 24/7.

- Services need to focus on the provision of compassionate humane care. This will require investment in identifying, understanding and removing systemic and interpersonal barriers to compassionate, trauma informed perinatal care.

- All services in contact with women and families during and after pregnancy, including maternity, primary, early childhood, and mental health services, need to be aware of the risk of perinatal suicidality. Health professionals under pressure in busy services can inadvertently contribute to women's sense that they have failed as a mother or unknowingly exacerbate feelings of psychological isolation. Compassionate care takes time, a genuine concern for women's wellbeing, and the capacity to listen. At a policy level, this means enabling flexible models of care which prioritise time and the building of relationships between care providers and women and families, removal of financial and other systemic barriers, and investment in health professional wellbeing as a crucial antecedent of compassionate care provision.

...in my head I knew they'd all be better off without me. I decided I loved him and my husband and older child enough to leave them so they could be happy. (Study participant)

Considerations for policy and practice

Health and Social Care Professional Education

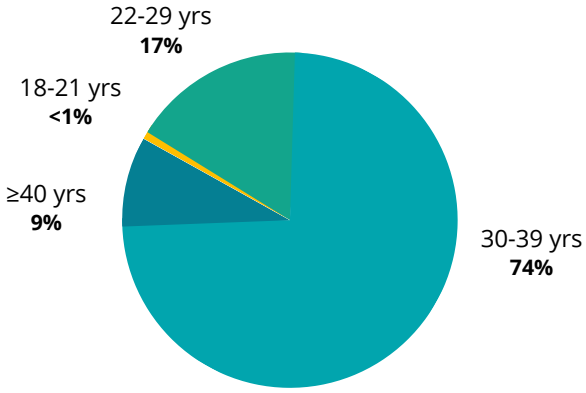
- In order to respond with compassion to common origins and contexts of shame known to influence perinatal suicidality, health and social care professionals working with women and families in the perinatal period require a stronger knowledge and skill base in compassionate trauma informed approaches to care, including a practical understanding of the impacts of childhood maltreatment, intergenerational and complex trauma. Increasing the prominence of perinatal suicide prevention within education, supervision, mentorship, and practice guidance, is an important first step to achieving this goal.

Community

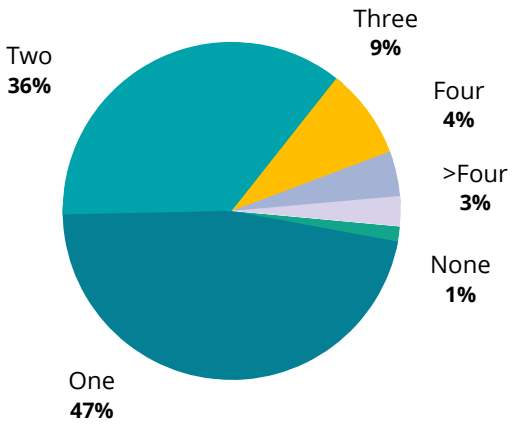
- As a societal issue, suicidality should be supported within communities. Compassion, connection and belonging can be fostered in a range of community settings, including local businesses, early parenting support services, childcare and early childhood education centres, faith communities, and local sporting clubs. At a policy level, this means governments prioritising women's mental health and wellbeing by investing in paid parental leave, family support services, affordable childcare and a range of options for women experiencing perinatal suicidality to seek support at a local community level. It also means encouraging and incentivising employers to offer paid parental leave and greater flexibility to fathers and non-birth parents, enabling them to share responsibility for care of their children.

About the research participants

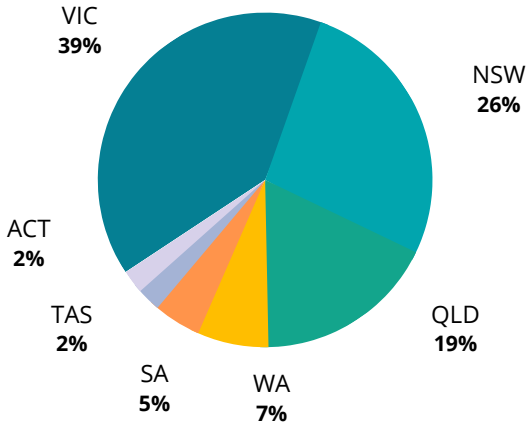
Age at time of participation



Number of children



State or Territory of residence



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I hope that women who go through a similar thing can get to this point because it's such a nice space. I think I'd just given up on myself, that I'd ever find this sort of headspace where I really valued myself and my life too... So, hopefully, other women will get the same support or help to find it - because I love being a mum. It just brings me so much joy now. (Study participant)

Read more about the study

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