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Perinatal women's views and experiences of discussing suicide in maternity care settings: A qualitative study

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ABSTRACT

Background: Suicide is a leading global cause of maternal death in the first year after birth. Limited research has explored which factors may support or prevent women from disclosing suicidality. This is important for informing appropriate approaches to identifying perinatal women who may require support.
Aims: (i) explore perinatal women's views and experiences regarding the barriers, facilitators, and implications of identifying and disclosing suicidality in maternity care settings; and (ii) explore their perspectives on appropriate approaches for healthcare practitioners (HCPs) to take when asking about suicide during pregnancy or after birth.
Methods: Twenty-one semi-structured interviews with perinatal women in the UK. Of these women, 17 had experienced self-reported perinatal mental health (PMH) problems and/or suicidality. Inductive thematic analysis was used to explore the data and identify themes.
Results: Four themes, comprising 11 subthemes were identified. Barriers that affected women's willingness and capacity to disclose suicidality included: stigma, social expectations of motherhood, not recognising symptoms, not being asked about PMH and/or rushed appointments, lack of care continuity, and HCPs interpersonal skills. Important facilitators were the provision of PMH information and peer support. Women also suggested providing more choice in how PMH and suicide-related questions are administered (e.g., via a form and in-person) and for HCPs to frame these discussions sensitively.
Conclusions: Significant barriers impact perinatal women's disclosure of suicidality. Appropriate approaches for identifying suicidality in maternity contexts need to be developed that take account of these barriers and support women to feel safe, comfortable, and able to answer suicide-related questions honestly.

Statement of Significance

Problem or issue

Suicide is a leading cause of maternal death in many countries. Up to 50 % of pregnant and postnatal women experiencing mental health problems in the UK are not identified by maternity care services.

What is already known

Multi-level barriers and complex risk factors affect perinatal women's engagement with specialist mental health services in the UK and their willingness to disclose suicidal thoughts and/or behaviours in these settings.

What this paper adds

This paper adds specific insights of perinatal women's views regarding the barriers, facilitators, and implications of identifying and disclosing suicidality in maternity care settings. These insights are important for the development of appropriate approaches for identifying women who may require support during pregnancy or after birth.

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1. Introduction

Approximately one in five pregnant or postnatal women[2] experience mental health problems in the United Kingdom [1,2], with maternal mortality due to mental health related causes now accounting for almost 40 % of all deaths between six-weeks to one-year post birth [3]. Suicide remains the leading direct cause of death in the UK during this time [3]. Maternal suicide is also a pressing global issue. Prevalence estimates from high-income countries suggest that the occurrence of perinatal suicide is between 5 % and 20 % of maternal deaths [2,4,5], and in low- and middle-income countries, rates of pregnancy-related suicide are between 1 % and 5 % [6]. Whilst the UK prevalence of perinatal suicide is relatively low (3.84 per 100,000 live births) [7], evidence suggests that many more women will attempt suicide during pregnancy or after birth [8]. The pooled prevalence of global suicide attempts in pregnancy is estimated to be 680 per 100,000, and 210 per 100,000 in the postnatal period [8]. Identifying and supporting perinatal women who are experiencing suicidal ideation and/or behaviours, or who may be at risk of suicide is therefore an important public health concern. Targeted approaches for the identification, intervention, and prevention of perinatal suicide need to be developed. However, these need to take account of the complex risk factors, and numerous barriers and facilitators that may affect women's engagement with maternity services and their willingness to disclose suicidality during pregnancy and after birth. Such efforts may help to provide more timely access to the appropriate care for those who require support, and to improve outcomes for mothers and their babies.

It is estimated that up to 50 % of pregnant or postnatal women experiencing mental health problems and/or suicidality in the UK are not identified by healthcare professionals during the perinatal period [1,9]. Of those who are identified, less than 10 % are referred to specialist perinatal services [10]. Common perinatal mental health (PMH) problems include depression, anxiety disorders, post-traumatic stress disorder, and adjustment disorders. Women may also experience more severe difficulties including postpartum psychosis or suicidality, which are often comorbid with other common PMH problems [2,11]. Suicidality is understood as an umbrella term for someone experiencing suicidal ideation, suicidal behaviours and/or plans, or who has made a suicide attempt [12]. However, these are distinct processes with differing levels of risk and/or implications in terms of care needs. Universal screening for PMH problems has been considered as one approach for identifying women who may need additional support. However, there is little consensus on the best measures to use and screening recommendations vary across countries [13,14]. Likewise, whilst screening and assessment for PMH problems appears to be acceptable to women generally [15–17], factors such as question content, mode of administration, relationship with healthcare practitioners (HCPs), information about the purpose and outcome of screening, and the perceived stigma associated with mental health problems can significantly affect women's comfort in answering these questions, and/or answering them honestly [18–23]. Less is known about women's experiences of being asked about suicidality. Comprehensive evidence also shows that women face multi-level barriers to accessing PMH care, which influence their help-seeking behaviours [24]. A focus on woman-centred approaches, professional training and knowledge, and developing therapeutic and trusting relationships have been identified as important determinants for improving women's care and access to PMH services [25].

Identifying pregnant and postnatal women who may be experiencing suicidality presents a further challenge. Perinatal women are not asked about suicide as part of their routine maternity care in the UK, and to date, no measure has been specifically designed to identify suicidal ideation and/or behaviours in this group. Likewise, whilst the risk factors, prevalence, and correlates of perinatal suicidality are well-documented in the literature [11, 26–33], there is limited research that has specifically examined women's views and experiences of discussing suicide in maternity settings, or the unique barriers and facilitators that may affect disclosure in this context. Such insights are important for developing appropriate approaches to the initial identification of suicidality during pregnancy or after birth. Previous qualitative studies have mainly focussed on the experience of perinatal suicidality, suicide attempts and associated factors, and/or tried to theorise this phenomenon [34–39]. Other research has looked at the factors that mental health professionals perceive as important for identifying and reducing suicidal ideation and/or behaviours during pregnancy or after birth (including contributory factors) [40], and has explored possible psychological intervention priorities for those experiencing perinatal suicidality [41]. Dudeney et al. [42] also assessed the acceptability and content validity of different suicide-related screening items with pregnant and postnatal women using the Theoretical Framework of Acceptability [43]. Their findings indicated that these items were largely unacceptable to perinatal women in their current form, which has important implications for existing approaches to screening and assessment. The content, differing response options and recall periods affected women's comprehension of the items, their attitudes towards them, and influenced their willingness to answer the items, with perceived stigma, judgement, and fear being central barriers for non-disclosure.

This study therefore sought to: (i) explore perinatal women's views and experiences regarding the barriers, facilitators, and implications of identifying and disclosing suicidality in maternity care settings; and (ii) explore their thoughts and ideas about the most appropriate approaches for HCPs to take when asking about suicide during pregnancy or after birth. It is also important to note that this study included women who had experienced PMH problems and/or suicidality, and those who had not. Hence, some of the views expressed come from personal experience, and some are based on women's speculative thoughts about how they might feel regarding this topic.

2. Participants, Ethics, and Methods

2.1. Ethics

Research ethics approval was granted by the School of Health and Psychological Sciences Research and Ethics Committee at City, University of London prior to recruitment and data collection (reference number: ETH2122-0757). All participants provided informed consent before their interview. Specific procedures were also developed to minimise any signs of distress and to ensure participant safety. No adverse effects were observed or reported.

2.2. Design

This was a qualitative interview study that explored perinatal women's views and experiences regarding the barriers, facilitators, and implications of identifying and discussing suicidality in maternity care settings. The research adopted a pragmatist approach which posited women's experiences, perspectives, and meaning making as being central to generating knowledge that also serves to address their specific interests in real-world contexts.

2.3. Participants, recruitment, and data collection

Recruitment took place between June and November 2022, via social media and snowball sampling. Details of the recruitment procedure, participant inclusion criteria and sample size approach are reported elsewhere [42]. Twenty-one pregnant and postnatal women participated in a one-to-one interview with the first author, lasting between 60

[2] The authors recognise that not all birthing people identify as being a 'woman' or 'mother' or 'female' (e.g.,). Although these terms have been used throughout this paper, we aim to include any birthing person.

and 120 minutes (mean 82 minutes), either online or via the telephone. To address the research aims, the sample included women who had and who had not experienced self-reported PMH problems and/or suicidality. This was important for gaining wider insight regarding the potential barriers and facilitators for disclosing suicidality in maternity care settings from multiple perspectives. To reduce participant burden and make efficient use of research resources, each interview comprised two-components: a semi-structured interview (reported here), and a more structured interview using cognitive techniques. Findings addressing the research questions from the cognitive interviews are reported elsewhere [42].

The first and second authors developed a topic guide which drew upon relevant literature and their experience of conducting research in this area. The guide explored factors that may affect perinatal women's willingness to disclose suicidality and/or engage in conversations about suicide in maternity care settings, and explored their experiences and thoughts regarding the most appropriate approaches for HCPs to take when discussing this. Interview questions were open-ended which allowed for similar questions to be asked of all participants yet provided flexibility in responses and follow-up questions. The interview schedule was piloted with one perinatal woman and refined accordingly. All interviews were audio-recorded, and later transcribed verbatim and deidentified by the first author. Transcripts were analysed in NVivo 14 [44].

2.4. Data analysis

Data analysis was guided by Braun and Clarke's [45,46] approach to Thematic Analysis. Following familiarisation with the dataset, initial codes were applied line-by-line to each transcript to capture the semantic content or latent concepts expressed. These codes were then organised into broader themes and sub-themes through an iterative process of combining or splitting codes, and removing those that did not meaningfully contribute to the emerging themes. The first author conducted the initial coding and generation of themes. Themes were then reviewed and further refined by the first and second authors to ensure accuracy and trustworthiness of the analysis. A PhD student also independently conducted confirmatory coding for 20 % of the transcripts, with any minor discrepancies discussed and/or amended as needed. Final themes and subthemes were agreed by all authors. Reporting adheres to the Standards for Reporting Qualitative Research (SRQR) [47].

2.5. Researcher reflexivity

The authors acknowledge that their positioning, backgrounds, and experiences may have influenced data collection and interpretation of findings. The first and second authors met regularly to challenge and discuss this throughout the interview and analytic phases of the research. The first author is a female doctoral researcher who has completed training in identifying and signposting suicide risk, and of conducting sensitive qualitative interviews for research purposes. The first author conducted all interviews and sought to create a safe and non-judgemental environment for participants to share their thoughts and feelings, whilst being cognisant not to privilege any particular views or opinions or impose her own. The second and third authors both have extensive expertise and experience in PMH and measurement research, and the fourth author specialises in professional-patient communication in mental health care research, including how to improve outcomes for those who experience suicidality and/or self-harm. All authors are also mothers.

3. Results

3.1. Sample characteristics

Twenty-one women took part, three were pregnant at the time of their interview and 19 had a child under the age of two. Ages ranged from 29 – 42 years (mean 33.9). Sixteen women were White British, and 20 spoke English as a first language. Most women (n = 19) held a bachelor's degree or above. Full sociodemographic information is presented in Table 1.

Self-reported PMH problems and/or suicidality were endorsed by 17 women, although these women were not asked to specify their diagnosis. Five of these women had not experienced any mental health problems and/or suicidality prior to pregnancy. Mental health problems and/or suicidality prior to most recent pregnancy was reported by thirteen women. Of these, only one participant did not experience PMH problems. Fifteen women reported having received some type of treatment or support for their mental health problems, either before or during the perinatal period.

3.2. Overview of findings

Thematic analysis identified four main themes, comprising 11 subthemes: (i) Barriers to the identification and disclosure of perinatal suicidality: social and individual determinants; (ii) Barriers to the identification and disclosure of perinatal suicidality: determinants within the maternity care context; (iii) Approaches for identifying and discussing perinatal suicidality; (iv) Opportunities to facilitate the identification and disclosure of perinatal suicidality.

In the following sections, themes and subthemes are discussed using illustrative participant quotes to support them. All themes and subthemes are also presented in Fig. 1.

Table 1
Sample characteristics (n = 21)

Sociodemographic variable	*M (range)* or *n* (%)
Age	33.9 (29 – 42 years)
Perinatal phase (at time of interview)	2 (9 %)
Pregnancy	18 (86 %)
Postnatal (≤ 24-months)	1 (5 %)
Pregnant and postnatal*	
Number of additional children	14 (67 %)
0	4 (19 %)
1	3 (14 %)
2	
Mental health problems and/or suicidal thoughts during most recent pregnancy and/or after birth	17 (81 %)
Yes	4 (19 %)
No	
Mental health problems and/or suicidal thoughts at any other time in life	13 (62 %)
Yes	8 (38 %)
No	
Treatment and/or intervention for mental health problems at any time in life (including perinatal period)	15 (72 %)
Yes	3 (14 %)
No	3 (14 %)
Not applicable	
English as first language	20 (95 %)
Yes	1 (5 %)
No	
Education	1 (5 %)
Secondary school (e.g., GCSE, SVQ level 1)	1 (5 %)
Post-secondary (e.g., A-level, National Diploma	8 (38 %)
Bachelor's degree, or equivalent	7 (33 %)
Master's degree, or equivalent	4 (19 %)
Doctorate	
Cultural background	16 (77 %)
(White) English/Welsh/Scottish/Northern Irish/British	2 (9 %)
(White) Irish	2 (9 %)
Any other White background	1 (5 %)
(Mixed/multiple ethnic groups) White and Asian	

Notes: *One participant was pregnant at the time of their interview and had a child under two years old.

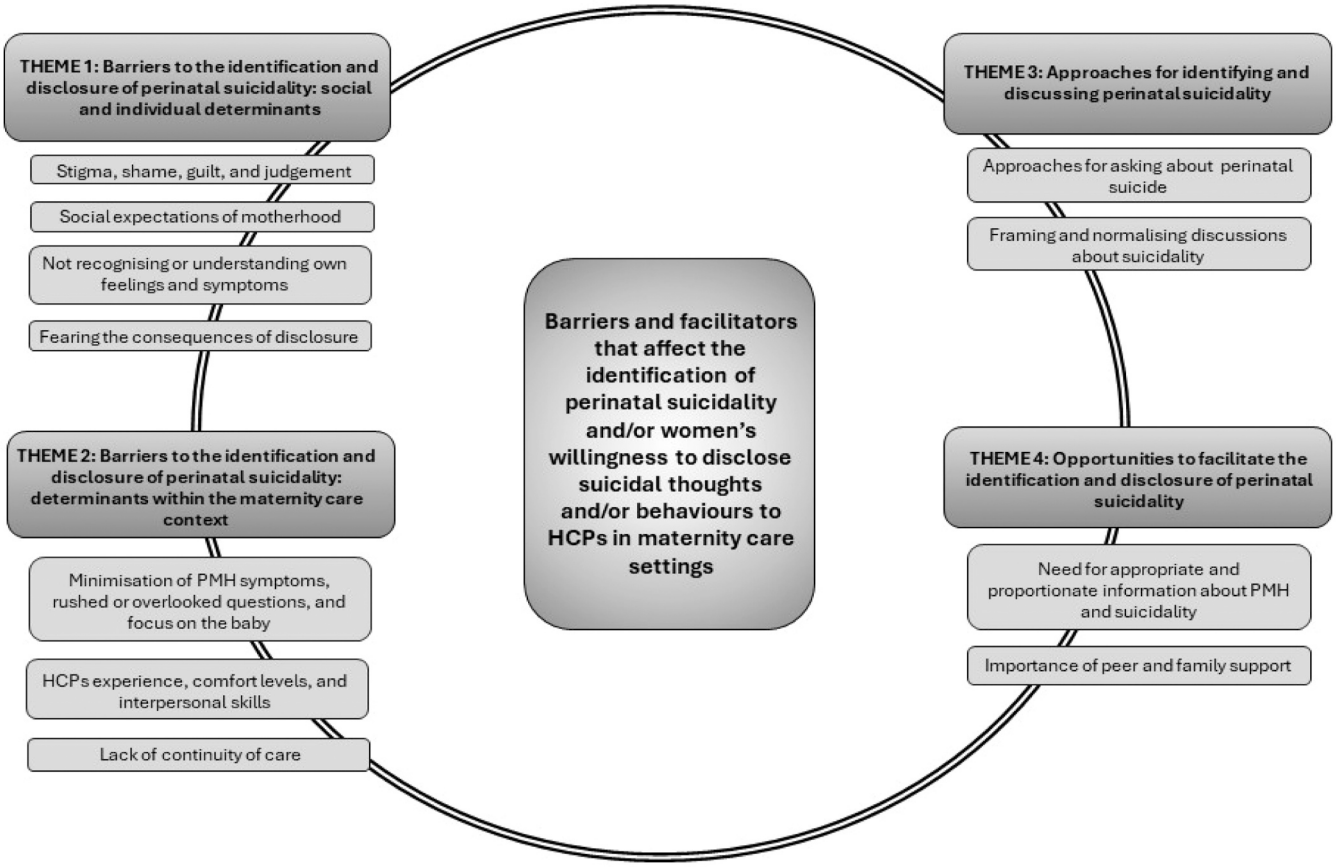

Fig. 1. Overview of themes and subthemes.

3.2.1. Theme one: Barriers to the identification and disclosure of perinatal suicidality: social and individual determinants

This theme concerns the individual and social factors that impacted women's willingness and capacity to disclose suicidal thoughts and/or behaviours to HCPs. Women talked about how the wider social narratives regarding suicidality and motherhood created barriers to their help-seeking behaviours, and how a lack of understanding about PMH also affected their recognition of symptoms.

3.2.1.1. Stigma, shame, guilt, and judgement. Stigma was a central barrier for disclosing suicidal thoughts and/or behaviours. Women described how the negative associations surrounding suicide created feelings of guilt and shame, and prevented them from sharing their concerns or symptoms with HCPs. Many women felt that HCPs would judge and/or perceive them as a 'bad mother' if they revealed suicidal thoughts.

> *"It's the intent and shame I think, you know, it's quite shameful and it used to be a crime right, so I think there's a lot of issues there with the concept of suicide, there is a lot of stigma attached… like, I would feel uncomfortable [disclosing suicidality] if I were suicidal because of everything that's associated with that". (p13)*

3.2.1.2. Social expectations of motherhood. Women's sense of shame and judgement was further exacerbated by societal norms and expectations of motherhood. They felt a sense of loss for their pre-pregnancy lifestyle and identity and described a disconnect between their own challenging experiences of being a new mum and the wider perceptions of how they 'should' be feeling and behaving. Women said that this tension would prevent them from wanting to share how they were feeling with HCPs.

> *"You feel a little bit in denial, like you don't necessarily want to admit that there's something wrong because of the societal pressures about being happy and feeling like this should be the best days of your life". (p7)*

3.2.1.3. Not recognising or understanding own feelings and symptoms. Some women also struggled to understand their distressing thoughts and behaviours, and were unsure as to whether these were 'normal' attributes of motherhood. They described feeling confused, fearful, and lonely as they tried to navigate their experiences, often not even recognising that they were having suicidal thoughts until it was discussed.

> *"I think for myself, and maybe a lot of other people, it's confusing… especially around suicidality, the thoughts are so abstract, so it's not until you actually answer the question, like until you actually sort of say out loud, that you're like, 'oh, shit'… and that feels to me like a really important step in the sort of process of reflecting and getting help". (p12)*

3.2.1.4. Fearing the consequences of disclosure. Women's struggle to identify and acknowledge their difficult thoughts and emotions were further compounded by an intense apprehension about the consequences of disclosing suicidality. Many said that a lack of knowledge about the possible outcomes would prevent them from being honest. A common concern was that their babies would be taken away, but women also feared being hospitalised against their will, and that personal information would be passed on to family members and/or other services.

> *"I think there's that fear of losing your child, I personally found that quite difficult at the start, because if you sort of say 'yes, I feel like I'm gonna hurt myself' you're scared of the consequences, you know, does that mean you're gonna have your child taken away from you, and I think that's what a lot of women do fear". (p14)*

3.2.2. Theme two: Barriers to the identification and disclosure of perinatal suicidality: determinants within the maternity care context

This theme concerns factors within the maternity care context that women felt contributed to their suicidality not being identified, and/or affected their engagement with HCPs. Women described how a lack of priority or focus on their mental health created feelings of unimportance and frustration, and how the quality of their interactions with HCPs was pivotal to their help-seeking decisions.

3.2.2.1. Minimisation of PMH symptoms, rushed or overlooked questions, and focus on the baby. Many women reported that their mental health was either not discussed during perinatal appointments, or if questions were asked, these were rushed through and/or presented in a manner that did not allow for an honest or meaningful response. This created an environment where women felt unable to share their difficulties because they perceived HCPs to be disinterested in their mental health needs.

> *"… they kind of assume you're not [suicidal] because you've turned up and you seem happy on the outside, and they've kind of dismissed you because they're kind of rushing through it, you know, whereas if they're serious about it, I'd feel more serious about answering honestly". (p20)*

For those women who did attempt to initiate or engage in a conversation about how they were feeling, many felt that their symptoms were either minimised by HCPs and/or they received a non-validating response such as, *'oh well actually, that's not that often' (p5)*. Women described feeling alone and overlooked, with the focus being disproportionately centred around baby's care.

> *"I didn't feel like [HCP] was there for me, she was just there for baby, which of course is important, but I'm the one looking after baby, so I need to be OK, you know… my postnatal care was terrible, I felt completely alone, I really struggled, they just turned up at my house and it felt like they were just ticking boxes, it wasn't about me". (p15)*

3.2.2.2. HCPs experience, comfort levels and interpersonal skills. Women also talked about the importance of HCPs interpersonal skills, experience, and approach for managing difficult and personal conversations. Many women felt that their disclosure of suicidal thoughts and/or behaviours was highly dependent on the quality of the relationship they had with HCPs and their level of comfort in asking suicide-related questions.

> *"They [HCPs] aren't comfortable asking these questions, I think they are really really uncomfortable which then makes me uncomfortable, so that is a major issue, I mean people will still whisper things like 'are you depressed', and you think like 'oh my god, why are you whispering that". (p4)*

> *"The factors that you would want to get an honest response would be like a trusted relationship, someone who's in touch with you fairly regularly, so that you knew that you could trust them through experience, someone who showed that like extra level of emotional intelligence and not just thinking about 'is your baby physically well, are you meeting milestones etc". (p21)*

3.2.2.3. Lack of continuity of care. However, women said that it was extremely difficult to build rapport and trusting relationships in the maternity care context because they rarely saw the same HCPs. Women found this distressing and difficult to manage, especially in terms of discussing suicide.

> *"When I was pregnant, I don't think I ever saw the same midwife twice, so to have some complete stranger asking you if you are feeling anything like that [suicidality], I mean, you'd have to be extremely trusting or perhaps in a really bad place to go 'yeah, actually I am, please help me". (p10)*

The need for continuity of care was further reflected through women's reactions to being asked suicide-related questions during the perinatal period. Those who were asked talked about the importance of introducing these questions from the booking appointment and continuing to ask them at regular intervals throughout pregnancy and after birth. Women felt that this familiarity would help to normalise these discussions, allow them to expect and prepare for them, and they could track the severity and/or frequency of their thoughts and feelings.

> *"If you're expecting the question, you kind of go into your appointment thinking 'how am I feeling, is something going on, this might be my opportunity to talk about it'… I think if it was just more routine and people knew that they were gonna be asked about it [suicide], you can give a more open and honest answer because you've had time to sort of think about it in advance". (p11)*

3.2.3. Theme three: Approaches for identifying and discussing perinatal suicidality

This theme concerns factors that women felt were important, appropriate, and necessary in terms of the approach taken to ask about suicidality in maternity settings, and for eliciting more receptive and honest responses. Women shared their preferences for how suicide-related screening questions might be administered, and how HCPs could frame these types of conversations to support disclosure.

3.2.3.1. Approaches for asking about perinatal suicidality. All women suggested that PMH and suicidality should be discussed during the perinatal period, given certain conditions. Women highlighted the importance of providing a safe and private space, without partners or family members being present (at least initially). Many women also talked about the need for choice in how screening questions are administered and/or how such conversations might take place. Some women described feeling more comfortable talking face-to-face with HCPs, whereas others initially preferred to answer these types of questions on their own using a form. Most women felt that implementing a combination of these approaches was useful and appropriate because it aligned more with person-centred care.

> *"I think giving women the option to answer the questions beforehand, or in the session is good… having a really easy questionnaire that you complete just before your appointment, and then if anything sort of flags as a risk, then the midwife can go into that a little bit more in your appointment". (p12)*

3.2.3.2. Framing and normalising discussions about suicidality. Women stressed the need for HCPs to sensitively frame and normalise suicide-related questions, both to enable transparency of why they are being asked, and to emphasise their purpose for identifying support needs. Women said that this would help to provide context regarding the occurrence of these thoughts and feelings, and lessen their fears regarding disclosure and outcomes. One participant suggested the following framing:

> *"I've got a few questions, we know they don't tell us the whole story, so I will be asking you some other questions as well, we ask these questions to everyone, it's not based on anything you've said, and the reason we ask these questions is so we can make sure that we're putting in the right kind of support for you". (p3)*

3.2.4. Theme four: Opportunities to facilitate the identification and disclosure of perinatal suicidality

This theme concerns the factors that women felt would help facilitate their willingness and capacity to disclose suicidal thoughts and/or behaviours with HCPs. Women talked about the need for clear and accurate information about PMH and suicidality, and described the value of developing supportive networks around them.

3.2.4.1. Need for appropriate and proportionate information about PMH and suicidality. Women reported having received little or no information about PMH or suicidality, unless they had been referred to specialist services. This lack of knowledge about the possible occurrence of mood changes (including depression, anxiety etc.), services available within maternity care, and/or how to access these, created a significant barrier to their help-seeking behaviours. Women said that providing appropriate and proportionate information about PMH and suicidality from the earliest opportunity would have helped them to better recognise and understand their symptoms, feel more comfortable sharing their concerns with HCPs and reduced their fears about the outcomes of disclosure. Some women also stressed the importance of PMH information being made accessible to partners and family too.

> *"My initial fear of answering these questions was that I didn't have the information and knowledge… I had no idea that a perinatal team even existed in the NHS, but if that information was given upfront, I think it would have felt a bit of a safer environment where 'it's OK, I don't mind being honest and doing these questionnaires because the men in white coats aren't gonna come and drag me away', but if hospitalisation is something that has to be done, there's 'mother and baby units', I didn't know anything about that…". (p9)*

3.2.4.2. Importance of peer and family support. Access to peer support networks also appeared to be an important facilitator for helping women to acknowledge and share their suicidal thoughts in a safe and supportive environment. Women described how hearing other mothers' stories and building meaningful relationships made them feel more confident to discuss and address their own mental health struggles.

> *"I only made it through because I made a group of friends in [support group], and we would regularly meet together, and having that support network, and knowing that you're not the only one going through it, and you're not the only one that has these thoughts is just priceless isn't it, maybe just a support group, a coffee morning where new mums can go and meet, that's all I needed". (p16)*

4. Discussion

This study explored the barriers, facilitators, and implications that influence pregnant and postnatal women's disclosure of suicidality in the maternity care context and inhibit the identification of those who may require support. It also explored women's views regarding the most appropriate approaches for HCPs to take when asking about suicide in these settings. Findings indicated that perinatal women face complex and interrelated barriers that affect their capacity and willingness to share suicidal ideation and/or suicidal behaviours with HCPs. Women reported that their help-seeking behaviours were influenced by individual and societal factors (including stigma, social expectations of motherhood, and fearing the consequences), and by factors within the maternity context itself (such as HCPs interpersonal skills, continuity of care and the provision of PMH information). Whilst these findings are consistent with research that has identified multi-level barriers and facilitators to women's access of PMH care more broadly [25], this study adds knowledge regarding perinatal suicidality specifically.

For pregnant and postnatal women there is a conflicting and nuanced interplay between the social stigma of suicidality and dominant expectations of what motherhood should look like. Women described how this tension created feelings of guilt and shame, which led them to believe they were failing in their role, both in terms of their own inner-voice and the perceived judgement from others including HCPs. Whilst this finding is in line with previous research [34,37,38] women further talked about the impact this had on their help-seeking behaviours, and particularly their fears regarding the consequences of disclosure in maternity settings. Many women said that they would struggle to answer suicide-related questions honestly because they believed their baby would be taken away. Such fears have been reported in other studies examining barriers to PMH care and disclosure (e.g., [21,24]), but this fear appeared to be amplified in relation to discussing suicidality. It is therefore important for HCPs to approach conversations about suicide in a sensitive manner which does not unwittingly reinforce unconscious biases, but instead positively reframes women's perceptions of motherhood and addresses their disclosure concerns by focusing on available support. Likewise, given that women reported a lack or absence of PMH and suicidality information during their pregnancies and post-birth care, many felt unable to make informed decisions about discussing distressing thoughts and emotions because they were unaware of the possible symptoms, outcomes, and services available should they require support. There is a need for appropriate and proportionate PMH information to be made available from the earliest opportunity. It would also be helpful for HCPs to signpost women to peer support services as this was identified as an important facilitator for improving help-seeking behaviours.

Women who did attempt to engage with HCPs about their mental health often felt that their experiences were minimised or overlooked whilst HCPs disproportionately focussed attention on the baby's care, which is consistent with previous research [35]. Women reported that mental health and/or suicidality questions were rushed through (if asked at all) which made them feel dismissed and disinclined to speak further about their feelings. Evidence also suggests that HCPs may negatively frame suicide-related questions to prompt a 'no' response and/or use closed questions that inhibit further discussion [48]. Such approaches are unhelpful for eliciting authentic or meaningful responses, so it is important for HCPs to ask about suicidality in a way that allows women to share their individual experiences and to explore protective factors. Similarly, women talked about the need to build a strong and trusting rapport with HCPs to facilitate disclosure. However, many described their experiences as uncomfortable because HCPs did not appear to have the experience, training, and/or interpersonal skills to hold difficult conversations, nor did the women generally see the same HCPs at their appointments. This meant that the opportunity to develop a trusting relationship was not presented. Previous research examining perinatal women's experiences of depression screening and PMH care has reported similar findings [20,49]. Likewise, research from Australia found that some midwives and maternal and child nurses do not feel comfortable assessing suicide risk with perinatal women [50,51], and other HCPs are fearful about engaging in suicide-related conversations in case it produces iatrogenic effects [52]. This underscores the need for HCP-related and interpersonal barriers for identifying perinatal suicidality to be addressed. Whilst systemic factors such as lack of resources, competing demands, financial constraints, and staff shortages heavily impact upon continuity and women's maternity care experiences, there is a need for maternity HCPs to receive more mental health, suicidality, and communication skills training to build their confidence, knowledge, and ability to create a safe and welcoming environment for women to share suicidal ideation and/or behaviours.

Whilst women felt that it was important and necessary for HCPs to ask about suicidality at regular intervals throughout the perinatal period, their preference for how this might occur differed, and their receptiveness was heavily influenced by the factors outlined above. Most women saw value in being asked suicide-related items alongside current depression and anxiety questions and they generally felt that answering a brief screening questionnaire was an appropriate initial step for identifying those who may require further assessment and support. Screening measures do offer a pragmatic solution in busy maternity care services; however, HCPs also need to be aware of the limitations of screening tools. For example, the content of suicide-related items might not be acceptable to perinatal women [42], and screening measures should not be used to diagnosis or to predict suicide risk. Furthermore, women said that it was important for HCPs to sensitively frame and normalise why mental health and suicide-related questions are being

asked to help facilitate disclosure, and it was clear that women wanted more choice and agency in how questions might be administered to allow for individual differences. Some women felt more comfortable completing these questions on their own prior to an appointment because it allowed for privacy and time to reflect on their answers without feeling 'put on the spot', whereas others preferred to be asked face-to-face in a conversational style. Previous research similarly found little consensus regarding pregnant women's preferences for mental health screening [19], which suggests that having options may help to overcome some barriers to disclosure. It is important that all approaches give women the opportunity to discuss PMH and/or suicidality in-person, should they wish.

4.1. Strengths, limitations, and future research

Recruiting pregnant and postnatal women for suicide-related research is challenging. A strength of this study was the sample size and inclusion of women from across the UK. However, most participants were White British and had attained a bachelor's degree or above. Future research should seek to recruit perinatal women from more diverse ethnic and minority groups as their views may differ to those reflected here. Evidence suggests that women from these backgrounds encounter greater inequalities and unique barriers to accessing PMH care [53], so it is important that their experiences and views are explored. It would also be useful to look at the perceptions of perinatal women in treatment settings, women with neurodiversity, birthing persons who do not identify as women, and HCPs who work in maternity care to further inform approaches for identifying those who may require additional support. Lastly, some women who participated in this study were pregnant or had a young baby during the COVID-19 pandemic and UK lockdowns. Given the pressure on the UK National Health Service at that time, it is possible that their care was negatively affected, which may have also influenced their views and experiences.

4.2. Conclusions

Pregnant and postnatal women experiencing suicidality face complex barriers and facilitators that influence their willingness and capacity for disclosure in maternity care settings. HCPs need to consider these factors when asking perinatal women about suicide to prevent barriers from being reinforced, and to create a safer environment for these conversations to take place. Appropriate approaches for discussing suicidality in maternity contexts need to be developed that offer women choice in how suicide-related questions are administered. Such approaches may help to identify those who require further assessment and support sooner. It is also important for HCPs to provide proportionate information regarding PMH and suicidality from the earliest opportunity.

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Ethical statement

This research was approved by the School of Health and Psychological Sciences Research and Ethics Committee (SHPS REC) at City, University of London prior to recruitment and data collection (reference number: ETH2122-0757).

CRediT authorship contribution statement

ED and RM were responsible for conceptualisation of the study. ED developed the topic guide, with support from RM. ED led the ethics application submission, with input from RM, SA, and RMc. ED communicated with all participants, conducted all interviews, and transcribed all the data. ED conducted the initial coding and generation of themes. ED and RM further reviewed and refined the themes and the interpretation of findings. ED drafted the first version of manuscript. RM, SA, and RMc reviewed and edited the manuscript drafts. All authors contributed to and approved the final manuscript.

Declaration of Competing Interest

All authors declare that they have no conflicts of interest.

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References

[1] Bauer A., Parsonage M., Knapp M., Lemmi V., Adelaja B. The costs of perinatal mental health problems. Centre for Mental Health and London School of Economics. (2014). Available from: https://www.centreformentalh ealth.org.uk/sites/default/files/2018-09/costsofperinatal.pdf.

[2] L.M. Howard, H. Khalifeh, Perinatal mental health: A review of progress and challenges, World Psychiatry 19 (3) (2020) 313–327, https://doi.org/10.1002/wps.20769.

[3] Knight M., Bunch K., Felker A., Patel R., Kotnis R., Kenyon S., et al., Eds. on behalf of MBRRACE-UK. Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21. Oxford: National Perinatal Epidemiology Unit. (2023).

[4] S. Grigoriadis, A.S. Wilton, P.A. Kurdyak, A.E. Rhodes, E.H. VonderPorten, A. Levitt, et al., Perinatal suicide in Ontario, Canada: a 15-year population-based study, Can. Med Assoc. J. 189 (2017) e1085–e1092, https://doi.org/10.1503/cmaj.170088.

[5] Trost S.L., Beauregard J., Chandra G., Njie F., Berry J., Harvey A., et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services. (2022). Available from: https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/pregnancy-related-deaths-data-mmrcs-2017-2019-h.pdf.

[6] D.C. Fuhr, C. Calvert, C. Ronsmans, P.S. Chandra, S. Sikander, M.J. De Silva, et al., Contribution of suicide and injuries to pregnancy-related mortality in low-income and middle-income countries: a systematic review and meta-analysis, Lancet Psychiatry 1 (3) (2014) 213–225, https://doi.org/10.1016/S2215- 0366(14)70282-2.

[7] Knight M., Bunch K., Patel R., Shakespeare J., Kotnis R., Kenyon S., et al. Eds. on behalf of MBRRACE-UK. Saving lives, improving mothers' care: Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit (2022).

[8] W.W. Rao, Y. Yang, T.J. Ma, Q. Zang, G.S. Ungvari, B.J. Hall, et al., Worldwide prevalence of suicide attempt in pregnant and postpartum women: a meta-analysis of observational studies, Soc. Psychiatry Psychiatr. Epidemiol. 56 (5) (2021) 711–720, https://doi.org/10.1007/s00127-020-01975-w.

[9] National Childbirth Trust (NCT). The Hidden Half. Bringing postnatal mental illness out of hiding. (2017). Available from: https://www.nct.org.uk/get-involved/campaigns/hidden-half-campaign

[10] Royal College of Obstetricians & Gynaecologists (RCOG). Maternal mental health - women's voices. (2017). Available from: https://www.rcog.org.uk/media/3ijbpfvi/maternal-mental-health-womens-voices.pdf

[11] L. Orsolini, A. Valchera, R. Vecchiotti, C. Tomasetti, F. Lasevoli, M. Fornaro, et al., Suicide during perinatal period: Epidemiology, risk factors and clinical correlates, Front Psychiatry 7 (2016) 138, https://doi.org/10.3389/fpsyt.2016.00138.

[12] American Psychological Association (APA). APA Dictionary of Psychology. (2018). Available from: https://dictionary.apa.org/suicidality

[13] N. Reilly, D. Kingston, D. Loxton, K. Talcevska, M.P. Austin, A narrative review of studies addressing the clinical effectiveness of perinatal depression screening programs, Women Birth 33 (1) (2020) 51–59, https://doi.org/10.1016/j.wombi.2019.03.004.

[14] A. Waqas, A. Koukab, H. Meraj, T. Dua, N. Chowdhary, F. Batool, et al., Screening programs for common maternal mental health disorders among perinatal women: report of the systematic review of evidence, BMC Psychiatry 22 (2022) 54, https://doi.org/10.1186/s12888-022-03694-9.

[15] S.D. Brealey, C. Hewitt, J.M. Green, J. Morrell, S. Gilbody, Screening for postnatal depression – is it acceptable to women and healthcare professionals? A systematic review and meta-synthesis. J. Reprod. Infant Psychol. 28 (4) (2010) 328–344, https://doi.org/10.1080/02646838.2010.513045.

[16] S. El-Den, C.L. O'Reilly, T.F. Chen, A systematic review on the acceptability of perinatal depression screening, J. Affect Disord. 188 (2015) 284–303, https://doi.org/10.1016/j.jad.2015.06.015 0165-0327.
[17] D.E. Kingston, A. Biringer, S.W. McDonald, M. Heaman, G.C. Lasiuk, K. M. Hegadoren, et al., Preferences for mental health screening among pregnant women, A Cross-Sect. Study M J. Prev. Med. 49 (4) (2015) e35–e43, https://doi.org/10.1016/j.amepre.2015.03.026.
[18] M.P.V. Austin, N. Reilly, V. Mule, D. Kingston, E. Black, D. Hadzi-Pavlovic, Disclosure of sensitive material at routine antenatal psychosocial assessment: The role of psychosocial risk and mode of assessment, Women Birth 35 (2) (2022) e125–e132, https://doi.org/10.1016/j.wombi.2021.04.005.
[19] Bayrampour H., McNeil D.A., Benzies K., Salmon C., Gelb K., Tough S. A qualitative inquiry on pregnant women's preferences for mental health screening. (2017) 17 (1):339. doi:10.1186/s12884- 017-1512-4.
[20] W.J. Hsieh, M.D. Sbrilli, W.D. Huang, T.M. Hoang, B. Meline, H.K. Laurent, et al., Patients' perceptions of perinatal depression screening: A qualitative study, Health Aff. 40 (10) (2021) 1612–1617, https://doi.org/10.1377/hlthaff.2021.00804.
[21] P.M. Forder, J. Rich, S. Harris, C. Chojenta, N. Reilly, M.P. Austin, et al., Honesty and comfort levels in mothers when screened for perinatal depression and anxiety, Women Birth 33 (2) (2020) e142–e150, https://doi.org/10.1016/j.wombi.2019.04.001.
[22] D.E. Kingston, M.P. Austin, M. Heaman, S. McDonald, G. Lasiuk, W. Sword, et al., Barriers and facilitators of mental health screening in pregnancy, J. Affect Disord. 186 (2015) 350–357, https://doi.org/10.1016/j.jad.2015.06.029.
[23] D.E. Kingston, A. Biringer, A. Toosi, M.I. Heaman, G.C. Lasiuk, S.W. McDonald, et al., Disclosure during prenatal mental health screening, J. Affect Disord. 186 (2015) 90–94, https://doi.org/10.1016/j.jad.2015.07.003.
[24] R. Webb, N. Uddin, G. Constantinou, E. Ford, A. Easter, J. Shakespeare, et al., Meta-review of the barriers and facilitators to women accessing perinatal mental healthcare, BMJ Open 13 (2023) e066703, https://doi.org/10.1136/bmjopen-2022-066703.
[25] R. Webb, E. Ford, J. Shakespeare, A. Easter, F. Alderdice, J. Holly, et al., Conceptual framework on barriers and facilitators to implementing perinatal mental health care and treatment for women: the MATRIx evidence synthesis, Health Soc. Care Deliv. Res 12 (2) (2024) 1–87, https://doi.org/10.3310/KQFE0107.
[26] B. Arditi-Arbel, S. Hamdan, M. Winterman, Y. Gvion, Suicidal ideation and behavior among perinatal women and their association with sleep disturbances, medical conditions, and known risk factors, Front Psychiatry 13 (2023) 987673, https://doi.org/10.3389/fpsyt.2022.987673.
[27] A.M. Bright, O. Doody, T. Tuohy, Women with perinatal suicidal ideation – A scoping review of the biopsychosocial risk factors to inform health service provision and research, PLoS ONE 17 (9) (2022) e0274862, https://doi.org/10.1371/journal. pone.0274862.
[28] K. Chin, A. Wendt, I.M. Bennett, A. Bhat, Suicide and Maternal Mortality, Curr. Psychiatry Rep. 24 (2022) 239–275, https://doi.org/10.1007/s11920-022-01334-3.
[29] B. Gelaye, S. Kajeepeta, M.A. Williams, Suicidal ideation in pregnancy: an epidemiologic review, Arch. Women's. Ment. Health 19 (5) (2016) 741–751, https://doi.org/10.1007/s00737-016-0646-0.
[30] C. Meurk, L. Wittenhagen, J. Lucke, R. Barker, S. Roberts, K. Moss, et al., Suicidal behaviours in the peripartum period: a systematic scoping review of data linkage studies, Arch. Women's. Ment. Health 24 (2021) 579–593, https://doi.org/10.1007/s00737-021-01102-x.
[31] L. Palagini, E. Cipriani, M. Miniati, A. Bramante, A. Gemignani, P.A. Geoffroy, et al., Insomnia, poor sleep quality and perinatal suicidal risk: A systematic review and meta-analysis, J. Sleep. Res (2023) e14000, https://doi.org/10.1111/jsr.14000.
[32] H.E. Reid, D. Pratt, S. Edge, A. Wittkowski, Maternal suicide ideation and behaviour during pregnancy and the first postpartum year: A systematic review of psychological and psychosocial risk factors, Front Psychiatry 13 (2022), https://doi.org/10.3389/fpsyt.2022.765118.
[33] M. Xiao, Y. Hu, S. Huang, G. Wang, J. Zhao, J. Lei, Prevalence of suicidal ideation in pregnancy and the postpartum: A systematic review and meta-analysis, J. Affect Disord. 296 (2022) 322–336, https://doi.org/10.1016/j.jad.2021.09.083.
[34] L.J. Biggs, B. Jephcott, K. Vanderwiel, I. Melgaard, S. Bott, M. Paderes, et al., Pathways, contexts, and voices of shame and compassion: A grounded theory of the evolution of perinatal suicide, Qual. Health Res 33 (6) (2023) 521–530, https://doi.org/10.1177/10497323231164278.
[35] K. De Backer, A. Pali, F.L. Challacombe, R. Hildersley, M. Newburn, S.A. Silverio, J. Sandall, L.M. Howard, A. Easter, Women's experiences of attempted suicide in the perinatal period (ASPEN-study) – a qualitative study, BMC Psychiatry 24 (2024) 255, https://doi.org/10.1186/s12888-024-05686-3.
[36] C.W. Musyimi, V.N. Mutiso, D.N. Nyamai, I. Ebuenyi, D.M. Ndetei, Suicidal behavior risks during adolescent pregnancy in a low-resource setting: A qualitative study, PLoS ONE 15 (7) (2020) e0236269, https://doi.org/10.1371/journal.pone.0236269.
[37] R. Praetorius, D. Maxwell, K. Alam, Wearing a happy mask: mother's expressions of suicidality with postpartum depression, Soc. Work Ment. Health 18 (4) (2020) 429–459, https://doi.org/10.1080/15332985.2020.1769003.
[38] H.E. Reid, D. Pratt, D. Edge, A. Wittkowski, What makes a perinatal woman suicidal? A grounded theory study, BMC Psychiatry 22 (2022) 386, https://doi.org/10.1186/s12888-022-04015-w.
[39] K.M. Tabb, A.R. Gavin, Y. Guo, H. Huang, K. Debiec, W. Katon, Views and experiences of suicidal ideation during pregnancy and the postpartum: Findings from interviews with maternal care clinic patients, Women Health 53 (2013) 519–535, https://doi.org/10.1080/03630242.2013.804024.
[40] H.E. Reid, D. Edge, D. Pratt, A. Wittkowski, Working with suicidal mothers during the perinatal period: a reflexive thematic analysis study with mental health professionals, BMC Psychiatry 24 (1) (2024) 106, https://doi.org/10.1186/s12888-024-05537-1.
[41] H.E. Reid, D. Pratt, D. Edge, A. Wittkowski, Psychological intervention priorities according to perinatal women who experienced suicidal thoughts and perinatal mental health professionals: a Q-methodology study, Front Psychiatry 14 (2023) 1286500, https://doi.org/10.3389/fpsyt.2023.1286500.
[42] E. Dudeney, R. Coates, S. Ayers, R. McCabe, Acceptability and content validity of suicidality screening items: A qualitative study with perinatal women, Front Psychiatry 15 (2024), https://doi.org/10.3389/fpsyt.2024.1359076.
[43] M. Sekhon, M. Cartwright, J.J. Francis, Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework, BMC Health Serv. Res 17 (88) (2017), https://doi.org/10.1186/s12913-017-2031-8.
[44] Lumivero. NVivo (Version 14) [computer software]. (2023). Available from: https://lumivero.com/products/nvivo
[45] V. Braun, V. Clarke, Using thematic analysis in psychology, Qual. Res Psychol. 3 (2) (2006) 77–101, https://doi.org/10.1191/1478088706qp063oa.
[46] V. Braun, V. Clarke, One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qual. Res Psychol. 18 (3) (2021) 328–352, https://doi.org/10.1080/14780887.2020.1769238.
[47] B.C. O'Brien, I.B. Harris, T.J. Beckman, D.A. Reed, D.A. Cook, Standards for reporting qualitative research: a synthesis of recommendations, Acad. Med. 89 (9) (2014), https://doi.org/10.1097/ACM.0000000000000388.
[48] J. Ford, F. Thomas, R. Byng, R. McCabe, Asking about self-harm and suicide in primary care: Moral and practical dimensions, Patient Educ. Couns. 104 (4) (2021) 826–835, https://doi.org/10.1016/j.pec.2020.09.037.
[49] O. Megnin-Viggars, I. Symington, L.M. Howard, S. Pilling, Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: A systematic review and meta-synthesis of qualitative research, Arch. Women's. Ment. Health 18 (6) (2015) 745–759, https://doi.org/10.1007/s00737-015-0548-6.
[50] K. McCauley, J. Barnfield, L. O'Brien, C. Moss, B. Harrison, S. Elsom, R. Lau, Assessment of depression and suicidality in perinatal women by midwives and maternal child health nurses, Int J. Ment. Health Nurs. 20 (2012) 11.
[51] R. Lau, K. McCauley, J. Barnfield, C. Moss, W. Cross, Attitudes of midwives and maternal child health nurses towards suicide: a cross-sectional study, Int J. Ment. Health Nurs. 24 (6) (2015) 561–568, https://doi.org/10.1111/inm.12162.
[52] P. Quinnett, The role of clinician fear in interviewing suicidal patients, Crisis 40 (5) (2019) 335–359, https://doi.org/10.1027/0227-5910/a000555.
[53] S. Pilav, K. De Backer, A. Easter, S.A. Silverio, S. Sundaresh, S. Roberts, L. M. Howard, A qualitative study of minority ethnic women's experiences of access to and engagement with perinatal mental health care, BMC Pregnancy Childbirth 22 (2022) 241, https://doi.org/10.1186/s12884-022-04698-9.