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PERINATAL SUICIDALITY: MOTHERS' EXPERIENCES OF RECOVERY FOLLOWING COUNSELLING

BY

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Approval of Thesis

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Submitted by

Vanessa Vandergaag

In partial fulfillment of the requirements for the degree of

Master of Counselling

The thesis examination committee certifies that the thesis
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Dedication

This work is dedicated to all the mothers who felt like they were failing as a mother and left this world to soon.

Acknowledgement

I am grateful to the mothers who came forward to share their lived experiences of suicide during the perinatal period and entrust me with their stories. This research would not be possible without these mothers' courage.

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Abstract

The purpose of this thesis was to better understand mothers' experiences of perinatal suicidality and recovery following counselling. Eight Canadian mothers participated in semi-structured Zoom interviews, which were analysed using interpretative phenomenological analysis (IPA) to identify how their recovery from perinatal suicidality following counselling was experienced. The analysis revealed a key finding and three personal experiential themes. The key finding was that *feeling like a failure as a mother* directly contributed to suicidality for all participants. The personal experiential themes included: (1) Connection with Counsellor as a Catalyst for Change; (2) Connection with Self Minimized Suicidality; and (3) Connection with Extra-Therapeutic Factors Important in Recovery.

Keywords: Perinatal suicidality, recovery, counselling, interpretative phenomenological analysis

Preface

The Every Mum
By Jessica Urlichs

The gentle mum, the yelly mum
The can I just be both? Mum
The tomorrow will be better mum
The just get through today mum

A bit of helicopter, "Here let me"
The risk taker, the adventurer
The just wait and see.
The don't make me laugh or I might pee

The penny for your thoughts mum
The confident outspoken mum
You think you know her story mum
You don't, so just be kind mum

The dressing gown, the coffee in hand
The yoga pants, some self-care planned
Watch 'one born every minute' mum
The ignorance is bliss mum

I'm one and done, or what's two or five?
The only organic, or just eat to survive
The, I need a moment alone, mum
The, cannot be without them, mum

Crunchy, yummy, whatever mum
Postpartum undies, saggy bum
Two year later coz they're comfy, mum

The mum who loves loud, everyone knows
She loves loud too, but with curtains closed.

The frazzled mum, the sweary mum.
"I said truck, don't repeat at kindy," mum.
The I can rap this whole song in the car mum
I got 99 problems… and baby shark is one.

The larger body REAL mum
The skinny body REAL mum
The just stop talking about my body mum
Don't look at it, but what it's done!

The textbook mum, the earthy mum
The I have no idea what I am doing mum
The excuse the mess (but it's tidy) mum
The anxious, hovering, worried mum

The workout kind, pay no mind
The mum tum, mum bun,
5:00 pm wine

The stay home, the working mum
The both are hard on my heart mum
The crafty mom, lets whip up a cake
The I'd rather poke out my eyes than bake

But the thing is this,
you are good enough mum.

It its dark and restful, not a peep
Or if you're cuddling them whispering "go the fuck to sleep"
Because when the day is over and done
I'm a little bit of every mum[1].

Personal Reflection

I started down this path of research after becoming interested in motherhood and identity. During my first pregnancy, I began the Master of Counselling program, and moved from a city to a small town. I developed pre-eclampsia while pregnant and because I lived in such a small town, I ended up being medevacked to Vancouver when my blood pressure became too high. While I was in Vancouver my blood pressure dropped into normal range and I was permitted to leave the hospital. I joined a local yoga class as a way to ground myself and relax. At the end of the first class, when we were in *savasana* with our eyes closed, the teacher directed the attention of everyone to me being pregnant and asked everyone to send their *om* to my growing baby. It was such a lovely

[1] Poem reproduced with permission from Urlichs, (2020); copyright 2020 Jessica Urlichs.

moment of being held and connected to others; people who were complete strangers (who had no idea about my medical experiences) were wishing me well on my journey to becoming a mom and sending positive energy to my growing baby. For the past 15 years, yoga has been my practice to find grounding, quiet my mind, drop into my body, move energy, feel emotions, and guide me into being more present. When the time came for my baby to be born, *ujjayi* breathing is what helped me bring my baby, Grayson, into the world and years later my next baby, Ayla.

Soon after the birth of my son, I travelled home to our small town. When I gave birth to my son many people in the community made comments about how I should be finished with this *silly* school idea and now I could focus full-time on being a mother. I strongly felt this societal pressure for me to be happy with being a stay-at-home mom. As I navigated my new mothering identity, I was committed to pursuing higher education; I was being told that these two identities clashed. I learned feminist language around the social discourses that were shaping my reality. I could name the motherhood myths that others were trying to push on me. I deconstructed the voices that were telling me to give up on schooling and *just* be a mom. Just be a mom. As if anyone is *just* one thing!

Despite my inner identity conflict, I decided to continue with my counselling studies and learn more about maternal mental health. While taking certifications on perinatal mood and anxiety disorders, joining a research and advocacy group for maternal mental health progress in Canada, and scanning the literature on maternal mental health I came to the realization that there was a dearth of knowledge on maternal suicide. This started my path of inquiry on mothers' experiences of perinatal suicide.

A Note About Suicide

I do not have a personal experience with suicidal thoughts. I am grateful and acknowledge that I have not experienced life adversity that would increase the chance of suicidal thoughts present in my day-to-day life. I would like to think that my outlook on life has had a role in safeguarding me from experiencing thoughts of suicide. But that would be naïve of me; there is a risk that anyone can experience thoughts of suicide. I also believe that suicide can ultimately be prevented with proper supports, especially in the perinatal period.

What lead me down the path to study suicide? In university, as a residential advisor for university housing, I received LivingWorks ASIST (Applied Suicide Intervention Skills Training) training. A few years later, I volunteered on a distress centre crisis phoneline. During the phone calls from community members, I heard statements of strength, resilience, loss, pain, struggle, courage, depression, grief, happiness, longing, confusion, loneliness, ambivalence, despair, love, hope, escape, and thoughts of death. In addition to my work at the distress centre, I have also worked with youth in a wilderness setting where there were conversations around suicidal ideation. These past experiences gave me the skills of being able to sit with someone in the emotionally charged contradictory inner conflict of thoughts about life and death. I did not set out to study suicide per se but my training and past work experiences did come in handy as I embarked down this path of inquiry.

Currently, the majority of perinatal suicide research is statistics showing risk factors or information gleaned from death certificates. While this knowledge is important in guiding suicide risk assessment it is missing the lived experiences and voices of

mothers. This research highlights the voices of mothers so that counsellors and health professionals in general can learn about what is helpful to recovery. Looking to the future, my aspiration is that this research will guide my process in becoming a more competent counsellor to mothers experiencing a perinatal mood and anxiety disorder (PMAD). More specifically, I hope to enhance my skills to be sensitive to the nuances that mothers feel when experiencing suicidality in the perinatal period. Further, the knowledge gathered from this research is valuable for not only counsellors but also for all health practitioners who come in contact with a mother during the perinatal period; and it is impactful that as professionals we have the knowledge and training to be able to meet mothers in distress and confidently say "I can help. There is hope. You can heal." The impetus of this research is to further this possibility, to support mothers in this way, and to offer a lifeline.

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List of Abbreviations

Abbreviation	Definition
ACES	Adverse Childhood Experiences
ASI	Active Suicide Ideation
ASIST	Applied Suicide Intervention Skills Training
CBT	Cognitive Behaviour Therapy
EMDR	Eye Movement Desensitization and Reprocessing
EPDS	Edinburgh Postnatal Depression Scale
GAD	Generalized Anxiety Disorder
IMV	Integrated Motivational-Violation Model of Suicide
IPA	Interpretative Phenomenological Analysis
IPTS	Interpersonal Theory of Suicide
IPV	Intimate Partner Violence
NSSI	Non-Suicidal Self-Injury
NEST	Nutrition, Exercise, Sleep, and Time for self
PMAD	Perinatal Mood and Anxiety Disorder
P-OCD	Postpartum Obsessive-Compulsive Disorder
PP	Postpartum Psychosis
PPA	Postpartum Anxiety
PPD	Postpartum Depression
PSI	Passive Suicide Ideation
P-PTSD	Postpartum Posttraumatic Stress Disorder
3ST	3-Step Theory

Chapter 1. Introduction

This thesis is comprised of an introduction to emphasize the importance and purpose of this research. Next a methodology chapter briefly outlines the research paradigm, interpretative phenomenological analysis, and ethical considerations. Chapter three is a review of the literature on perinatal suicidality and prevalent suicide theories. Following are two manuscripts prepared for publication in academic journals. The first manuscript, titled Perinatal Suicidality: Mother's Experiences of Recovery Following Counselling, describes the findings of this study and has been prepared for *Canadian Psychology.* The second manuscript, titled "Feeling like a Failure as a Mother": Stories of Perinatal Suicidality to Recovery, summarizes mothers' stories of perinatal suicidality to recovery and has been prepared for *The Qualitative Report*. The scope of data from the semi-structured interviews had the potential to follow many different directions and open new curiosities. Throughout the thesis document there are briefly mentioned topics, such as a link between trauma and suicide, that requires further investigation. However, the focus of analysis remains on *recovery through counselling*, as such, is reflected in the writing. The thesis concludes with my own reflection on completing research during my postpartum period, the importance of self-care, and the impact this research will have on my career.

The Perinatal Period and Suicidality

The perinatal period is a key developmental stage in a woman's life and becoming a mother is a significant identity transition for woman. Transition to motherhood includes physical, psychological, social, and relations changes that happen to a woman during pregnancy and after the birth of a baby (Hwang et al., 2021). For most

women, pregnancy and childbirth is a time filled with joy, happiness, celebration, and fulfillment but for many women, the transition to motherhood can be a vulnerable time for their mental health (McLeish & Redshaw, 2017).

In Canada, an average of 23% of mothers reported feelings consistent with postpartum depression (PPD) or an anxiety disorder (Statistics Canada, 2019). PMADS include prenatal depression or anxiety, postpartum depression (PPD), postpartum anxiety (PPA), bipolar mood disorder, postpartum psychosis (PP; Williams et al., 2014), postpartum posttraumatic stress disorder (P-PTSD; Rai et al., 2015), panic disorder (Viswasam et al., 2019), and postpartum obsessive-compulsive disorder (P-OCD; McGowan et al., 2007). PMADs affect all aspects of a woman's life with one of the most tragic consequences being suicide (Hardy & Reichenbacker, 2019).

Suicide is a leading cause of maternal death in high income countries (Goldman-Mellor & Margerison, 2019; Grigoriadis et al., 2017; Lega et al., 2020; Oates, 2009; Takeda et al., 2017; Vangen et al., 2017; Weston, 2018). In Canada, the nationwide perinatal suicide statistics are inconclusive due to varying definitions and categorization of maternal deaths (Patrick, 2013; Statistics Canada, 2013). Suicide is the second leading cause of maternal death in British Columbia (Williams et al., 2014). In Ontario, one in 19 women's deaths are attributed to suicide during pregnancy and the year following childbirth (Grigoriadis et al., 2017). While PAMDs have gained more attention over the past few years, suicide remains an under-researched area; even though suicide is considered to be one of the leading causes of maternal mortality in the first 12 months postpartum (Lindahl et al., 2005). The loss of a mother to suicide has devastating

consequences to the family, infant health, and society; therefore, it is a consequence of great concern.

Statement of the Problem

There is a dearth of qualitative research on women's experience of perinatal suicidality and their recovery through counselling. The lack of representation of women's voices and lived experiences in the literature offers little guidance for counsellors to understand the best treatment for women experiencing suicidality in the perinatal period.

Purpose

The purpose of this study is to explore women's lived experiences and perspectives of suicidality during the perinatal period and their recovery through counselling. Providing a rich description of mothers' lived experiences of shifting out of a suicide mind-set with the assistance of counselling may fill the current gaps in knowledge in understanding how counsellors can help women who are at risk for completing suicide in this phase of a woman's life. Most importantly, the study will give voice to mothers who have experienced suicidality and may encourage other women who are currently experiencing suicidality to feel supported in seeking help.

Research Question

What are the lived experiences of mothers' recovery from perinatal suicidality following counselling?

Definition of Terms

Suicidality

According to the DSM-V, suicide is not a psychiatric diagnosis but is listed as a condition for further study (American Psychiatric Association, 2013). In general, there

are certain psychiatric diagnoses that pose a greater risk of experiencing suicidal thoughts, such as major depressive disorder, bipolar disorder, anorexia nervosa, schizophrenia, and borderline personality disorder (Joiner et al., 2009).

Researchers recognize a difference between the following terms: suicidality, suicide, suicidal ideation, a suicide plan, suicide attempt, and self-harm. The American Psychological Association (n.d.) defines suicidality as the risk of suicide including various forms of suicidal ideation, behaviours, and suicide. Suicide is defined as the intentional act of taking one's own life and suicidal ideation refers to thoughts of intending to end one's life (Nock et al., 2008). Suicidal ideations are passive thoughts that can be sporadic or chronic and an individual may never take action towards a suicide attempt (Nugent et al., 2019). Active suicide crisis refers to an individual that has intent to act on the suicidal thoughts and may even try to attempt suicide (Nugent et al., 2019). A suicide plan is a specific method through which a person intends to die, and a suicide attempt is a non-fatal, self-directed potentially self-injurious behaviour with the intent to die (Nock et al., 2008). Suicide and self-harm are sometimes used interchangeably in research, but they are conceptually different (Perlman et al., 2011). Self-harm refers to intentional self-injury with no intent to die (Nock et al., 2008), is often repetitive behaviour, socially condoned, and is used as a coping mechanism for temporary relief from psychological distress (Perlman et al., 2011; Tabb et al., 2013).

Suicide risk can move along a continuum from low, medium, to high risk. Suicide risk assessment is an ongoing process, that utilizes clinical judgement, and is unique to each individual. For example, experiencing suicidal ideation as a fleeting thought, "this is hard and I do not want to be here", is low risk and does not necessarily need treatment

(Michel et al., 2017). This passive suicidal ideation is quite common and not a sign of pathology or a warning sign for the need of urgent help (Perlman et al., 2011). Moving towards medium risk, suicidality would include suicidal ideation where the individual is starting to consider taking action towards suicidal behaviour (Perlman et al., 2011), is experiencing pain and hopelessness, but suicidality is mitigated by a feeling of connectedness and protective factors (Klonsky & May, 2015). Warning signs pose high risk for an individual and include, but are not limited to, the following: talking about a desire to die or kill oneself, seeking means to kill oneself, increasing substance use, withdrawing or feeling isolated, talking about feeling hopeless, having no reason to live (Suicide Prevention Resource Centre & Rodgers, 2011), having a specific and detailed plan, physical pain sensitivity, impulsivity, mental imagery of dying, fearlessness about death, and past suicide behaviour (O'Connor & Kirtley, 2018). Warning signs combined with the presence of multiple risk factors increase the level of risk for the individual.

Traditionally in academic research, the words *completed suicide* and *committed suicide* is used to describe people who have died by suicide. Freedenthal (2017) argued that completed suicide is simply suicide, so one should just use the word *suicide*. Furthermore, she stated that both words, completed and committed, perpetuate the stigma associated with suicide and can prevent people from seeking help (Freedenthal, 2017). Throughout the study, I will use the language, died by suicide or suicide when discussing those who have committed suicide. My choice in using this language is to respect those who have died by suicide and individuals who are currently struggling with suicidality, as well as, to lessen the stigma associated with suicidality.

Suicide Recovery

Recovery from suicide risk is not that an individual is cured but can be conceptualized as the process of moving away from the desire to die and towards the desire to live (Surgenor, 2015).

Perinatal

Perinatal encompasses pregnancy and the postpartum period. Postpartum period starts when the mother has delivered the baby and placenta (Berens, 2017). The end of the postpartum period is often considered to be six to eight weeks after delivery but in some studies women are considered postpartum for up to 12 months after delivery (Berens, 2017). For this study, perinatal is defined as the time during pregnancy up to 12 months after the birth of a child (Williams et al., 2014).

Chapter 2. Methodology

Paradigm

A feminist social constructivist research paradigm suits this research topic focused upon suicide as a multifaceted contextual phenomenon involving an interplay of social, biological, neurological, and psychological factors (Surgenor, 2015). A researcher within this paradigm respects participants' lived experience and recognizes that there are external factors influencing the way a participant interprets their reality. The feminist constructivist ontological assumption includes the perspective that there are multiple realities and individuals' realities are socially constructed based upon their lived experience and interaction with others, which are dependent on time and context (Ponterotto, 2005). As well, a feminist view contributes an understanding that power dynamics is an integral element of the process of the construction of our realities (Locher & Prügl, 2001). More specifically, "motherhood, occurs within the context of a larger social order, that is characterized by structural inequalities and power imbalances of gender, race, ethnicity, nationality, age, sexuality, and ability" (Minaker, 2012, p. 126). Indeed, as highlighted in the risk factors for perinatal suicidality presented in the literature review, social disparities increase the risk for suicidality.

Constructivist epistemological beliefs include that reality is socially constructed between the researcher and the participant, which makes the interactions between the researcher and participant key to understanding the lived experience of the participant (Ponterotto, 2005). A feminist researcher is aware of power dynamics and the influence of the power dynamics on the researcher-participant relationship (Locher & Prügl, 2001). In today's society, there are mothering discourses, such as: the perfect mother, intensive

mothering, attachment mothering, or the bad mom, influencing how a woman socially constructs her identity of motherhood (Wong, 2012). Identity construction involved in motherhood necessitates a feminist approach in order to bring awareness of power dynamics and social discourses while honouring participants and their lived experiences in a non-judgemental way. Likewise, given the sensitivity of the topic of suicidality (Perlman et al., 2011), the researcher must be empathetic, understanding, non-judgmental, and culturally competent, to allow the participant to freely share their experiences.

Within the constructivist axiological view, individuals' values are acknowledged and honoured (Ponterotto, 2005). The knowledge to be gained from this study is created through the respectful and authentic interactions between the researcher and the participants (Socholotiuk et al., 2016). Since the researcher's values are part of the research process, as a feminist researcher, I am acutely aware of the importance of reflection and transparency regarding my personal beliefs, bias, values, perspectives, and ways of knowing, as they shape my interpretation of the experiences that participants share (Socholotiuk et al., 2016).

Methodological Considerations

Three alternative qualitative methods were considered before choosing IPA: narrative inquiry, critical incident technique, and phenomenology. Approaching the topic of perinatal suicide through the lens of narrative inquiry would shift the focus to telling stories of the mothers' experiences with recovery from perinatal suicide. Narrative inquiry is not just an exploration of the individual but includes the social, cultural and institutional narratives that shape the individual's experiences (Connelly & Clandinin,

1990). The goal of analysis would be to keep the chronological story of the participants' experience together to understand how participants create meaning in their lives (McAlpine, 2016). Narrative inquiry was considered because participants' experiences would be captured in great detail with the consideration of the influences of societal discourses but there would be not be a focus on shared themes (McAlpine, 2016). As a novice researcher, the lack of clearly defined steps of analysis within narrative inquiry is daunting. The narrative researcher does not bracket themself out of the research and often has their own experience to reflect upon, weave throughout the analysis, and share (Clandinin, 2006). While I have my own narrative with motherhood, I do not have a personal experience with a PMAD or perinatal suicidality, so I did not commit to narrative inquiry as a methodology for this particular study.

Critical incident technique, as first described by Flanagan (1954), helps to understand the key activities that a person does or does not do to have the best chance of achieving their goal. There is a specific focus on the *critical requirements*, these are actions that have demonstrated to help or hinder an individual reaching their goal (Viergever, 2019). When considering critical incident technique for the study, it narrowly focuses on the activities that participants engaged in that helped or hinder recovery to perinatal suicidality and is limited in the degree to which it considers participants psychological and sociological backgrounds. Originally, critical incident technique is based in a positivist approach to scientific inquiry which is incongruent with a constructivist approach (Viergever, 2019) but has been adapted over the years to fit within a constructivist approach (Watkins et al., 2022). However, researchers have acknowledged challenges with analysing the data utilizing CIT (Watkins et al., 2022).

Given the lack of research around recovery of perinatal suicidality it is important to take an approach to the research that is more exploratory and less narrowly focused.

Phenomenology is the study of experience (Smith et al., 2009) and given that I am curious about the experience of recovery from perinatal suicidality it would seem to be an appropriate methodological fit. Phenomenology was considered based on describing the common meaning or universal essence of a phenomenon (van Manen, 2007); however, I believe this fails to align with a constructivist approach and honouring participants' multiple perspectives. Unlike phenomenology, IPA researchers recognize that it is *interpretative* because the researcher is trying to make sense of the participants' experiences (Smith, 2004). Given these consideration and philosophical distinctions between narrative inquiry, critical incident technique, phenomenology, and IPA, I chose IPA, as it suits an exploratory study capturing mothers' recovery of perinatal suicidality following counselling.

Interpretative Phenomenological Analysis

The method for this exploratory qualitative study will be interpretive phenomenological analysis (IPA). Smith (1999), a UK health psychologist, developed IPA. In the mid-1990s the early work of IPA researchers focused on health psychology but has expanded to include clinical, counselling, social, and educational psychology (Smith et al., 2009). The philosophical roots of IPA are phenomenology, hermeneutics, and idiography; this method is an attempt to operationalize one way of working with those philosophical ideas combined (Smith et al., 2009). Historically, hermeneutics began as a theory to help the interpretation of biblical texts (Smith, 2007).

In the simplest form, phenomenology is focused on describing the common meaning or universal essence of a phenomenon (van Manen, 2007). According to phenomenology, we can never entirely know the other's experience; therefore, the participant's descriptions are filtered through the researcher's embodied nature of their relationship with the world. (Smith et al., 2009). Hermeneutics is the theory of interpretation and is a major theoretical influence on IPA (Smith et al., 2009). Smith (2004; 2011) asserted that IPA involves a double hermeneutic in that the participant is trying to understand their social and psychological world and the researcher is trying to apprehend what the participant shared of their social and psychological world. The hermeneutic circle is a concept that defines a dynamic relationship between the whole and a part, "to understand the part, you look to the whole; to understand the whole, you look to the part" (Smith, 2007, p. 5). Idiography is concerned with the particular, which means the analysis is detailed, systematic, and in depth (Smith et al., 2009). IPA is concerned with *particular* experiential phenomena, for example, this study is committed to understanding how recovery from perinatal suicidality has been understood from the perspective of mothers who participated in counselling. This means that IPA studies utilize purposive selected samples (Smith et al., 2009).

A feminist constructivism research paradigm, informed by an IPA methodological approach, is appropriate for studying the phenomenon of perinatal suicidality as the focus is on the mothers' experience of counselling and recovery from perinatal suicidality. Given limited qualitative data available about mothers' experiences of suicidality, an IPA method is a starting point to explore mothers' lived knowledge. From a feminist paradigm, storied experiences of mother's recovery from perinatal

suicidality following counselling were also gleaned from the IPA research interviews to further amplify mothers' voices.

Ethical Considerations

Conducting research with mothers who have experienced perinatal suicidality and recovery following counselling is an honour and a privilege that is guided by respect for the mothers, concern for their welfare, and justice. The American PATF (Psychiatric Association Task Force) on Research Ethics (2006) highlight the important ethical considerations when research participants have experienced a mental illness. For example, they accentuate that mental illness can have an impact on cognitive function, decisional capacity, stigma, and limited social and political opportunities (American PAFT on Research Ethics, 2006). The American task force was not suggesting that individuals who have experienced a mental illness should be excluded from research but that there needs to be integrity in safeguarding the dignity and wellness for participants. Mental health research has important ethical issues to consider related to voluntary participation, informed consent, confidentiality and anonymity, minimizing harm to the participant, and communication of the study results. All these aspects were taken into consideration as this research progressed.

Informed Consent

Informed consent from the participants is a continuous process from data collection to analysis and publication. Participants were provided with an information letter and an informed consent form. Participants had the opportunity to read and ask questions about the consent form so that they had an adequate understanding of their involvement in the study. Written consent was obtained by those confirming their

decision to participate in the study. Participants were made aware that they can withdraw their consent at any time during the interview, participants could withdraw their transcripts up to one month after the interview, or participants could withdraw particular comments from the themes derived during analysis when completing member checks.

Confidentiality and Anonymity

The participant's data was kept confidential within encrypted files on a password-protected laptop. The raw transcripts were only be seen by myself and my supervisor, Dr. Gina Wong. Names were removed prior to supervisor review. With regards to data analysis and publication, there was the inclusion of verbatim extracts and were anonymized as much as possible, such as removing identifiable characteristics and locations. Participants were asked to provide a pseudonym, or they were assigned one. Participants were informed of the limits of confidentiality such as cases where the participant disclosed imminent risk of harm to self (immediate suicidal intention), or harm to others.

Minimize Harm

There is no statistically significant evidence that discussing suicide leads to an increase of suicidal ideation or suicide (Bambridge et al., 2017; Dazzi et al., 2014; Nugent et al., 2019). Moreover, acknowledging and talking about suicide decreases the likelihood of suicidal behaviour (Bambridge et al., 2017) and may lead to improvements in mental health in treatment-seeking populations (Dazzi et al., 2014). Nevertheless, being interviewed on the topic of suicidality may be distressing for the participants and bring up difficult sensations, thoughts, emotions, or memories. Therefore, to minimize risk to the participants were informed of the focus and purpose of the interview, were

given the opportunity to decline to talk about a certain inquiry and had the opportunity to terminate the interview at any time, or to request a break.

Participants had the opportunity to be emailed the interview schedule prior to the interview so that they could review the questions in advance. I have completed maternal mental health professional training through Postpartum Support International and 2020 Mom (see Appendix G) to enhance my awareness of maternal mental health. As well, as a counsellor-in-training, I possess a sensitive communication style throughout the interview. However, I was aware that I was not in the role of a counsellor, but rather as a researcher. My curiosity with the participants was about gaining a rich description of their experience with suicidality and recovery through counselling.

During the process of obtaining informed consent, each participant was provided with local counselling resources and crisis telephone numbers that they can contact for emotional support in the event that the research interview is upsetting to them. At the end of the interview, I provided a reminder of the counselling and crisis resources regardless of their response.

Chapter 3. Review of the Literature

Perinatal suicidality is a serious mental health concern that can have devastating consequences. The following literature review includes English peer-reviewed publications from 2010-2022. The search terms were the following: perinatal, prenatal, postpartum, pregnant, suicide, suicidal ideation, self-harm, maternal, women, and mothers. The databases used were psycINFO and Google Scholar. I provide a brief overview of predominant suicide theories to aid in the conceptualization of suicide. I will also provide a synthesis of recent literature about perinatal suicide risk and protective factors, perinatal psychiatric diagnosis, and current counselling approaches for the treatment of suicide. The literature in these areas helped form the foundation of understanding suicidality and the conceptualization of perinatal suicidality.

Suicide Theories

Traditional psychological suicide theories focus on single factors such as suicide as an escape from the self (Baumeister, 1990), suicide caused by hopelessness (Beck et al., 1990), intense psychological pain (Shneidman, 1993), a feeling of entrapment (Li et al., 2018), or a lack of problem-solving skills (Schotte, & Clum, 1987). DeBeurs and colleagues (2019) identified the following psychological factors to be uniquely related to suicidal ideation: perceived burdensomeness, internal entrapment, depressive symptoms, and history of suicidal ideation. Recent theoretical models of suicide incorporate biological, environmental, psychological and social factors (Joiner et al., 2009; Klonsky & May, 2015; O'Connor & Kirtley, 2018). Herein, I provide a summary of the interpersonal theory of suicide (IPTS), 3-step theory (3ST), and the integrated

motivational-volitional (IMV) theory. These theories were chosen given their current salience among modern suicidologists (DeBeurs et al., 2019).

Interpersonal Theory of Suicide

Joiner and colleagues (2009) developed IPTS and asserted that the following three factors are indicative in suicidality: acquired capability, perceived burdensomeness, and failed belongingness. *Acquired capability* refers to being habituated to the fear of pain or self-injury to the point of a person being capable of death by suicide. The desire to die arises from experiencing perceived burdensomeness and failed belongingness. *Perceived burdensomeness* is defined by Joiner and colleagues (2009) as low self-esteem so extreme that one's existence is a burden to family, friends, and society. *Failed belongingness* is similar to loneliness and social alienation; this can be defined as not being part of a family, group of friends, work, or another valued community (Joiner et al., 2009).

Applying IPTS to perinatal suicidality, there are mothers who described that the emotional distress and lack of social support was so intense that they did not want to be around anymore (Mcleish & Redshaw, 2017). It can be presumed that there comes a point where a mother believes her children will be better off without her, and her desire to take her own life is stronger than her belief that she needs to live in order for her children to have a mother.

3-Step Theory of Suicide

Klonsky and May (2015) proposed a 3-step theory of suicide involving the following four factors: pain, hopelessness, connectedness, and suicide capacity. The first step towards suicide ideation is experiencing a combination of pain and hopelessness.

Klonsky and May (2015) specified that *pain* is loosely defined as psychological or emotional pain. *Hopelessness* refers to the person believing that the pain will not improve, and they are hopeless about the future.

Step two involves connectedness as a protective factor against ideation escalating towards an attempt. *Connectedness* was defined as a person's attachment to a perceived purpose or meaning that keeps an individual invested in living such as connection to people, a job, role, or hobby. A person can experience pain and hopelessness, but this is moderated by their connection to life and if their connection to life is greater than the pain felt the person will not progress to an active attempt of suicide. An example of perinatal suicidality understood from 3ST would be a mother who experiences daily pain and hopelessness, but is connected to her children, she may have passive suicide ideation and will not progress to an active desire for suicide. However, if there is pain, hopelessness, and lack of connection to her children, partner, friends, and family the mother may progress to a greater risk of suicide (Klonsky & May, 2015).

The third step involves a progression of ideation to a suicide attempt(s) by understanding a person's capability to take their own life (Klonsky & May, 2015). *Suicide capacity* is explained by the following three variables: depositional, acquired, and practical. Dispositional refers to genetics such as pain sensitivity. Acquired refers to "habituation to experiences associated with pain, injury, fear, and death can lead over time to a higher capacity for a suicide attempt" (Klonsky & May, 2015, p. 119). Practical refers to factors that make it easier to complete the act of suicide, such as access to lethal weapons or drugs. An example of a mother progressing from suicidal ideation to attempt could be that this particular woman has lowered impulse control, has a history of

childhood abuse (Ammerman et al., 2019; Sit et al., 2015) and self-harm (Gavin et al., 2011; Gold et al., 2012; Gressier et al., 2017) making her habituated to pain and fear, and can easily access rope for hanging herself.

The Integrated Motivational-Volitional Model of Suicide

IMV is also a 3-part model consisting of the following phases: pre-motivational phase, motivational phase, and volitional phase (O'Connor & Kirtley, 2018). IMV is situated in the diathesis-stress model, which stipulates that diathesis refers to an individual predisposition to increased risk of suicide as a coping mechanism as a stress response. O'Connor and Kirtley (2018) described the pre-motivational phase as including the biopsychosocial context, identifying vulnerability factors, and triggering life events. Individual vulnerability factors include biological, genetic or cognitive vulnerabilities, for example, perfectionism or early life adversity. In the motivational phase, defeat, humiliation, and entrapment are the key factors for suicidal ideation. Lack of social problem solving, lower coping skills, memory biases, and rumination can increase entrapment. The following motivational moderators influence the transition to the volitional phase: thwarted belongingness, burdensomeness, future thoughts, goals, norms, resilience, social support, and attitudes. The volitional phase is the movement from suicidal ideation to action and volitional moderators govern the transition from ideation to action. Volitional moderators can be environmental, psychological, social, or physiological, for example, access to means, planning, exposure to suicide, impulsivity, physical pain sensitivity, fearlessness about death, imagery, or past suicide attempts (O'Connor & Kirtley, 2018).

Utilizing IMV theory, an example of a woman experiencing perinatal suicidality would go through the premotivational phase including diathesis, environment, and life events. Diathesis could be a woman who has a predisposition to depression; environmental factors could be living with intimate partner violence (IPV; Alhusen et al., 2015; Ammerman et al., 2019; Gausia et al., 2009; Gavin et al., 2011; Gold et al., 2012; Onah et al., 2017), inadequate housing (Gausia et al., 2009; Goldman-Mellor & Margerison, 2019; Kim et al., 2015), and food insecurity (Onah et al., 2017); and the life event could be having a new baby. In the motivational phase suicidal ideation and intention start to form because it could be this woman experiences hormonal imbalance, loss of sleep due to caring for a new infant, isolation, and feeling entrapped by her new role as it does not meet her expectations of motherhood. The volitional phase is when suicidal ideation changes to behavioural enaction. This is modified by access to means (a gun or rope), exposure to suicide (perhaps she has friends or other family members who have died by suicide), fearlessness (this woman may not fear death), physical pain sensitivity, etc. Under these conditions and through the lens of the IMV it is understandable how woman in the perinatal period may consider suicide.

Summaries of IPT, 3ST, and IMV provide perspectives and understanding of suicidal behaviour in the general population. A reoccurring theme across the presented suicide theories is the experience of deep emotional pain, a lack of connectedness or belonging, and the means of which to complete suicide. Compared to IPT, the 3ST and IMV theories focus on the progression of suicidal ideation to the action or behaviour of suicide. Hjelmeland and Knizek (2020) argued IPT is considered too simplified, ignores the contextual biography of individuals, and is uncritically embraced by suicide

researchers. Similarly, Valach (2020) reasoned IPT and IMV do not provide a specific model of suicide action but of suicide related cognitions. Conversely, Ajdacic-Gross and colleagues (2019) introduced the idea that suicide is a mental accident. They argued suicide happens when multiple impulse control mechanisms fail. Furthermore, Michel and colleagues (2017) argued that suicide happens in an altered state of consciousness, where in an emotional crisis, suicide is a chosen action that, in retrospect, most people would regret. No one single theory can explain the complexities of suicidality.

Prevalence of Perinatal Suicidality

In Canada, it is difficult to ascertain the exact statistics, for maternal deaths due to suicide because of varying definitions and categorizations of maternal deaths, as well as the potential for under-reporting (Patrick, 2013; Statistics Canada, 2013). Maternal death is defined as the death of a woman occurring during pregnancy, childbirth, or within 42 days after delivery or termination of pregnancy (Statistics Canada, 2013). Furthermore, maternal death is divided into direct and indirect. Direct deaths are resulting from obstetric complications, during pregnancy, labour, or postpartum, or from interventions, omissions, or incorrect treatment. Indirect deaths are resulting from a previous existing disease. When suicide occurs during pregnancy, childbirth, or postpartum it will be considered a direct maternal death (Hasegawa et al., 2020). In contrast, if the woman is previously diagnosed with a mental health disorder and died by suicide during pregnancy it could be considered indirect (Hasegawa et al., 2020). The time limitation of 42 days after delivery poses an issue for suicide statistics because the highest risk for suicide is 9 to 12 months postpartum (Grigoriadis et al., 2017). Canada does not have a national enquiry process to review maternal deaths (Cook et al., 2017). This discrepancy in

reporting suicides under the maternal death definition makes it difficult to determine prevalence.

In Canada (excluding Quebec), in 2018, the maternal mortality rate was 8.3 per 100,000 live births (Statistics Canada, 2018). In Ontario, over a 15-year period, the perinatal suicide rate was 2.58 per 100 000 live births which is comparable to results found in the UK of 2.5 per 100 000 live births (Khalifeh et al., 2016). In a recent Canadian study, the women (n=6,558) who reported thoughts of self-harm since the birth of their child was 10.4% (Palladino et al., 2020). However, suicide occurs at a lower rate during the perinatal period than in the general population (Healey et al., 2013; Lindahl et al., 2005; Mota et al., 2019). It would appear that perinatal suicide is a rare event and that perinatal suicidal ideation is more common. Nevertheless, women who died by suicide during the perinatal period, compared to women who are in the non-perinatal phase, are more likely to use a violent method of suicide such as hanging, drowning, jumping or a firearm (Grigoriadis et al., 2017; Khalifeh et al., 2016; Knasmüller et al., 2019; Lindahl et al., 2005), indicating that these women had a strong intent to die or may reflect greater illness severity. Currently, evidence indicates perinatal suicide being a rare event, but the inconsistency with tracking and defining maternal deaths leads to incomplete data about perinatal suicide. It is likely that Canada's reported maternal mortality rate underestimates the problem of perinatal suicide. Considering the absence of comprehensive Canadian data, this study is important for bringing awareness to the lived experiences of perinatal suicidality.

Perinatal Suicide Risk Factors

Health professionals would benefit from understanding the risk factors surrounding perinatal suicide and suicidal ideation to effectively decrease suicide in women during the perinatal period (Gavin et al., 2011; Gold et al., 2012; Gressier et al., 2017; Rodrigues Farias et al., 2013; Sit et al., 2015). Risk factors for perinatal suicide and suicidal ideation include the following: family history of psychiatric diagnosis (Huang et al., 2012; Khalifeh, 2016; Sit et al., 2015), current psychiatric diagnosis, psychiatric comorbidity, history of self-harm, history of past pregnancy complications (including still birth, miscarriage, and abortion), lower level of education, (Gavin et al., 2011; Gold et al., 2012; Gressier et al., 2017; Huang et al., 2012; Lysell et al., 2018; Rodrigues Farias et al., 2013; Shi et al., 2018; Sit et al., 2015, Tavares et al., 2012), young age (Palladino et al., 2020), single partner status (including partners who reject paternity or being unmarried), smoking (Gavin et al., 2011; Gressier et al., 2017; Healy et al., 2013; Huang et al., 2012; Tabb et al., 2019; Taylor et al., 2016), unintended or unwanted pregnancy (Ishida et al., 2010), substance abuse (Gold et al., 2012; Gressier et al., 2017; Johannsen et al., 2016), exposure to IPV (Alhusen et al., 2015; Ammerman et al., 2019; Gausia et al., 2009; Gavin et al., 2011; Gold et al., 2012; Onah et al., 2017), history of childhood abuse (Ammerman et al., 2019; Muzik et al., 2016; Sit et al., 2015), sleep disturbances (Sit et al., 2015), high number of chronic health conditions (Gavin et al., 2017), psychosocial stress (Alhusen et al., 2015; Gavin et al., 2017; Gold et al., 2012; Tabb et al., 2013), food insecurity (Onah et al., 2017), social and gender inequalities, experiencing social, racial and religious discrimination, inadequate housing (Gausia et al., 2009; Goldman-Mellor & Margerison, 2019; Kim et al., 2015), and living in a rural

area (Grigoriadis et al., 2017). In contrast, Kubota and colleagues (2020) reported that higher education was a risk factor for perinatal suicidal ideation in Japanese women. These researchers speculated that this discrepancy has to do with highly educated women having to leave their jobs after childbirth because they cannot find support to balance work and childbearing. The majority of the above listed risk factors for perinatal suicide are socioeconomical or environmental, which highlights the need for context specific research to be able to understand how an embodied experience of these risk factors influences suicide.

Perinatal Mood and Anxiety Disorders

One of the main factors that contribute to increased risk of suicidal ideation among perinatal women, as mentioned earlier, is the presence of a PMAD which include the following: PPD, PPA, bipolar disorder, PP (Williams et al., 2014), P-PTSD (Rai et al., 2015), panic disorder (Viswasam et al., 2019), and P-OCD (McGowan et al., 2007). According to the DSM-5, there are no individual perinatal psychiatric diagnoses but are listed as a general mental disorder with a *peripartum onset* (American Psychiatric Association, 2013). Despite the lack of representation of a specific PMAD diagnosis, the World Health Organization (2018) estimated approximately 10% of prenatal women and 13% of postpartum women worldwide experience a perinatal mental health disorder. In Canada, 33% of mothers were concerned about their mental health (Statistics Canada, 2019). Furthermore, Williams et al. (2014) reported that one in five women in British Columbia will experience a perinatal mental health disorder. There is the potential that all women can develop a PMAD (World Health Organization, 2018), but not all women with a PMAD will develop suicidal ideation (Perlman et al., 2011).

For perinatal women, depression is considered to be the strongest risk factor for suicidal ideation (Gavin et al., 2011; Khalifeh et al., 2016) and suicide (Gold et al., 2012; Grigoriadis et al., 2017). In a recent study, Lysell and colleagues (2018) concurred that perinatal suicide is strongly associated with PPD, PP, and substance abuse disorders. An audit study of women referred to a perinatal mental health team over a 12-month period in a hospital in the UK involved 73 women referred for previous PPD and, of these women, 58% disclosed an episode of self-harm with the intent of suicide (Healey et al., 2012). Additionally, Khalifeh and colleagues (2016) found that prenatal women who died by suicide were more likely to be diagnosed with schizophrenia or bipolar disorder. Although experiencing a PAMD is considered a risk factor for suicide, PMADs are treatable with counselling and medication, although hospitalizations may be required (MacQueen et al., 2016). Risk factors are only one side of the coin and it is imperative to understand protective factors.

Protective Factors

Protective factors are not just the absence of risk factors but are a different variable that modifies the strength of the relation between a risk factor and a behavioural outcome (Cha & Nock, 2009). More specifically, protective factors are characteristics that make it less likely that individuals will consider suicide (Suicide Prevention Resource Center & Rodgers, 2011). Accordingly, from a counselling perspective, recognizing protective factors for individuals who are suicidal can identify personal strengths, resiliency, and encourage hope (Perlman et al., 2011). Furthermore, Surgenor (2015) argued for recovery from suicidal ideation, in the general population, through developing participants' protective factors in counselling. Specifically, the protective

factors that increased from therapy were if the participants felt they were in control, if they felt confident about ability to cope with most of the problems in their life, if they felt that life was worth living, and if they felt confident about plans for the future.

Protective factors for perinatal suicidality are social support (Kubota et al., 2020; Onah et al., 2017; Tabb et al., 2013), religion or spirituality (Glasser et al., 2018; Tabb et al., 2013), being an older age (Kubota et al., 2020), the feelings of hope or idea of future happiness (Tabb et al., 2013), not wanting to harm the fetus, and having older children (Johannsen et al., 2016; Tabb et al., 2013). However, Onah and colleagues (2017) reported that women who had more than two living children, were twice as likely to experience suicidal ideation than women with no living children. This highlights the importance of assessing each individual on a case-by-case basis. The lack of attention and research on protective factors specifically for perinatal women experiencing suicidality impedes prevention and care for perinatal women.

Previous Research

Prevention of perinatal suicidality has been managed through a crisis model of attending to risk factors, protective factors, and safety planning to try to mitigate the act of suicide (Williams et al., 2014). In my review, there has been limited research to inform counsellors of treatment options for perinatal suicidality. Likewise, there are no best-practice guidelines for counselling women experiencing perinatal suicidality. While the crisis model is initially helpful in providing a safety plan, it does not provide direction for treatment in counselling. It is important, given the prevalence of perinatal suicidality that further investigations into treatment options are much needed to inform counsellors.

Gallo and colleagues (2019) completed a content analysis on literature in professional counselling journals over a 21-year time period and found that the topic of suicide was represented by 78 articles, which is only 0.74% of the total published literature. Similarly, Winter and colleagues (2014) conducted a systematic review of the literature on counselling for the prevention of suicide in the general population and found a perceived lack of support and training for counsellors in relation to treatment of clients with suicidal behaviour. Gallo and colleagues (2019) found 9 articles focusing on preparation, training, and supervision around suicidality in the general population. Typically, this focus is lacking, which makes it difficult for counsellors to enter the field with confidence in their skills to provide treatment for suicidality. This study specifically gives voice to individuals struggling with perinatal suicidality and adds to the literature for counsellors.

Chapter 4. Manuscript I. Perinatal Suicidality: Mothers' Experiences of Recovery Following Counselling

Abstract

Purpose: The current exploratory qualitative research investigates mothers' experiences of perinatal suicidal thoughts and recovery following counselling.

Methods: Eight Canadian mothers participated in semi-structured Zoom interviews, which were analysed using interpretative phenomenological analysis to identify their experience of recovery from perinatal suicidality following counselling.

Results: An analysis revealed a key finding and three personal experiential themes. The key finding was, *feeling like a failure as a mother* directly contributed to suicidality for all participants. The personal experiential themes included: (1) Connection with Counsellor as a Catalyst for Change; (2) Connection with Self Minimized Suicidality; and (3) Connection with Extra-Therapeutic Factors Important in Recovery. A description of the key finding, personal themes, and related subordinate themes is presented with analysis of the findings related to extant literature.

Conclusions: Practice implications derived from the research include the centrality of counsellors creating a safe therapeutic relationship. Secondly, mothers who discuss suicidality in counselling benefit from counsellors who provide psychoeducation about perinatal mood and anxiety disorders (PMADs). Additionally, mothers contemplating suicide greatly valued when counsellors were validating and actively addressed mothers' sense of *feeling like a failure as a mother*. Lastly, counsellors are encouraged to use direct and clear language when talking about suicide. A limitation to the study is the lack

of diversity; consequently, future research in the area would benefit from including more diverse perspectives.

Keywords: Perinatal suicidality, recovery, counselling, Interpretative phenomenological analysis, IPA

Perinatal Suicidality: Mothers' Experiences of Recovery Following Counselling

The perinatal period is a vulnerable time for women's mental health. Perinatal mood and anxiety disorders (PMADs) are a common complication of childbearing (Howard & Khalifeh, 2020). PMADs include prenatal depression or anxiety, postpartum depression (PPD), postpartum anxiety (PPA) or panic disorder, bipolar mood disorder, perinatal obsessive-compulsive disorder (P-OCD), postpartum post-traumatic disorder (P-PTSD), and postpartum psychosis (PP; Byrnes, 2018; Williams et al., 2014). PMADs can affect all aspects of a woman's life with one of the most tragic consequences being suicide (Hardy & Reichenbacker, 2019).

Suicide represents a major public health problem worldwide. Suicide is the leading cause of maternal death in New Zealand (Weston, 2018), Japan (Takeda et al., 2017), Italy (Lega et al., 2020), and Sir Lanka (Fernando, 2013) and the second leading cause of maternal death in the United Kingdom (Oates, 2009). Suicide is the fourth leading cause of maternal death in Nordic countries (Vangen et al., 2017). In California, one in six postpartum maternal deaths are attributed to drug overdose and suicide (Goldman-Mellor & Margerison, 2019). For Canada, however, the nationwide perinatal suicide statistics are inconclusive due to varying definitions and categorization of maternal deaths (Patrick, 2013; Statistics Canada, 2013). However, in the province of British Columbia, suicide is the most common cause of death during pregnancy and the first postpartum year (Williams, et al., 2014). While in the province of Ontario, one in 19 women's deaths are attributed to suicide during pregnancy and the year following childbirth (Grigoriadis et al., 2017).

The loss of a mother to suicide has devastating consequences, obviously to the woman's loss of life, and to the individual development of surviving children, the family, surrounding community, and society. As such, this study provides an opportunity to understand the lived experiences of mothers who have considered suicide along with their perceptions of recovery following counselling in order to understand prevention strategies through the mothers' first-hand experiences.

Definition of Terms

Suicide is defined as the intentional act that leads to death, whereas suicidal ideation refers to thoughts and intentions to end one's life (Nock et al., 2008). *Suicidal ideations* are passive thoughts that can be sporadic or chronic, and an individual may never take action towards a suicide attempt (Nugent et al., 2019). *Active suicide crisis* refers to intent to act on suicidal thoughts (Nugent et al., 2019). A *suicide plan* is a specific method through which a person intends to die; and a *suicide attempt* is a non-fatal, self-directed potentially self-injurious behaviour with the intent to die (Nock et al., 2008). *Suicidality* is a multifaceted contextual phenomenon involving an interplay of social, biological, neurological, and psychological factors (Surgenor, 2015). In this study, we define *suicidality* as the risk of killing oneself, including various forms of suicidal ideation, behaviours, and possible suicide attempts.

Suicide and self-harm are sometimes used interchangeably in research, but they are conceptually different (Perlman et al., 2011). *Self-harm* or *non-suicidal self-injury* (NSSI) refers to deliberate self-injury with no intent to die (Nock et al., 2008), is often repetitive behaviour, not socially condoned, and can be used as a coping mechanism for temporary relief from psychological distress (Perlman et al., 2011; Tabb et al., 2013).

Common examples include cutting, burning, scratching, and hitting (Klonsky, 2007; Nock et al., 2008). Further, the function of NSSI can be divided into self-focused (e.g., self-punishment) or other-focused (e.g., enacting physical harm as a signal of emotional distress as a way to ask for help; Klonsky et al., 2014). NSSI is associated with increased risk of transitioning from suicide ideation to attempt (Kiekens, 2018). *Recovery* from suicide risk is not that an individual is cured (i.e., is never suicidal again); recovery is conceptualized as the process of moving away from the desire to die and towards the desire to live (Surgenor, 2015).

Considering time-period, *perinatal* is an all-encompassing duration including conception/pregnancy and continues into the postpartum period (Garcia & Yim, 2017; Hardy & Reichenbacker, 2019). The *postpartum period* is known to start when the mother has delivered her baby and placenta (Berens, 2017). The end of the postpartum period is often considered to be six to eight weeks after delivery some researchers, extend the postpartum period to 12 months after delivery (Berens, 2017). To note, Grigoriadis and colleagues (2017) found that postpartum suicides occurred most frequently at nine to twelve months postpartum. In this study, we identified the *perinatal period* to include conception up to 12 months after the birth of the baby.

Counselling for Suicide Recovery

As with suicide at other developmental phases in a person's life, suicide during the perinatal period is preventative with proper treatment (Tripathy, 2020). Cognitive behavioural therapy (CBT) and interpersonal therapy are the suggested evidence-based clinical guidelines for the treatment of depressive disorders in pregnant and breastfeeding women (MacQueen et al., 2016). Furthermore, best practice guidelines for the treatment

of PMADs in general includes medications, electroconvulsive therapy, psychoeducation, psychodynamic therapy, group therapy, bright light therapy, and self- care (Williams et al., 2014). Winter and colleagues (2013) indicated in a meta-analysis that there is strong evidence for the treatment of suicide in the general population through CBT, dialectical behaviour therapy, and problem solving. While research focused upon recovery of perinatal mood disorders through counselling exists, along with counselling research exploring recovery from suicidality in the general population (non-PMAD), there exists a dearth of research focusing specifically on mothers' experiences of perinatal suicidality and recovery through counselling.

Method

A feminist social constructivist research paradigm suited this investigation. The feminist constructivist ontological assumption includes the perspective that there are multiple realities and individuals' realities are socially constructed based upon their lived experience and interaction with others, which are dependent on time and context (Ponterotto, 2005). Identity construction involved in the experience of suicidality in motherhood necessitates a feminist approach in order to bring awareness of power dynamics and social discourses while honouring participants and their lived experiences in a non-judgemental way. A feminist view contributes an understanding that power dynamics is an integral element of the process of the construction of our realities (Locher & Prügl, 2001). More specifically, the experience of suicidality in motherhood occurs within the context of our society, "that is characterized by structural inequalities and power imbalances of gender, race, ethnicity, nationality, age, sexuality, and ability" (Minaker, 2012, p. 126). As well, a feminist researcher is aware of the influence of power

dynamics on the researcher-participant relationship (Locher & Prügl, 2001). Constructivist epistemological beliefs, in research, include reality that is socially constructed between the researcher and the participant, which makes all the interactions between the researcher and participant (e.g., language used in emails, formulation and flow of interview questions, etc.) key to understanding the lived experience of the participant (Ponterotto, 2005). The topic of suicide is sensitive to investigate, for that reason the researcher must be empathetic, understanding, non-judgemental, and culturally competent, to allow the participants to unreservedly share their experiences.

Interpretative phenomenological analysis (IPA), a qualitative methodology, was chosen for its focus on subjective experiences and emphasis on the detailed analysis of lived experiences (Smith, et al., 2009). The philosophical roots of IPA are phenomenology, hermeneutics, and idiography; this method is an attempt to operationalize one way of working with those philosophical ideas combined (Smith et al., 2009). IPA is concerned with *particular* experiential phenomena, for example, this study is committed to understanding how recovery from perinatal suicidality has been understood from the perspective of mothers who participated in counselling. Approval was obtained from the Athabasca University Research and Ethics Board (AU REB). The procedures used in this study adhere to the tenets of the Tri-council policy statement: Ethical conduct for research involving humans (TCPS 2: core).

Sampling

Purposive sampling was utilized to gain insight from mothers who experienced the particular phenomenon of perinatal suicidality recovery following counselling. The inclusion criteria specified participants were a minimum of 6 months recovered from

perinatal suicidality based on their own subjective accounts. Recovery was considered as moving towards the desire to live. The participants were not in an active suicidal crisis during the time of the interview. Participants delivered their child a maximum of 20 years ago. Recruitment was open to Canadian and United States of America citizens. Participants were English speaking and indicated they were willing to talk about their personal experiences related to perinatal suicidality. These participants were able to access technology for Zoom Video Communications Inc. interviews.

Participants were recruited through advertisements posted on Facebook groups and web resources. The recruitment advertisement was posted on Maternal Mental Health Progress in Canada, Perinatal Mental Health Coalition Canada, Postpartum Support International, Canadian Postpartum Depression Support Network, Perinatal Mental Health Research Group, Northern BC Moms, and the Psychologist Association of Alberta. In keeping with IPA methodology, the study aimed to recruit 3 to 8 participants, allowing for detailed accounts of individuals' lived experiences and analysis of patterns of similarities and differences (Smith et al., 2009).

Participants

Seventeen women responded via email to recruitment postings of which 12 met the criteria for participation. Of these 12, four respondents were excluded because of a dual relationship with the principal investigator. Four respondents declined participation after their initial interest (one respondent was experiencing homelessness due to natural disaster in their home province; one respondent felt they did not meet the inclusion criteria as their depression had extended beyond the postpartum period; two respondents stopped replying to correspondence). One respondent was excluded because of active

suicidal ideation and was in the process of starting to see a counsellor. The remaining eight respondents were contacted via email and phone, informed of the research, and invited to participate if they met eligibility criteria. Four respondents requested and were shown the interview schedule prior to signing the informed consent. In summary, eight women participated in the study.

Table 1

Demographics of Study Sample

Characteristics	N
Age	
20-29	1
30-39	6
40-49	1
Gender	
Female	8
Sexual Orientation	
Heterosexual	7
Bisexual	1
Cultural Background	
Caucasian	6
Chinese	1
Caucasian & Indigenous	1
Relationship Status	
Single	1
In a relationship	1
Married	5
Widowed	1
Current location	
Western Provinces	7
Eastern Provinces	1
Time when suicidality was most prominent	
3rd trimester	2
Birth-6 months postpartum	2
6-12 months postpartum	3
12-18 months postpartum	1
Engaging in NSSI	
Pregnant	2
Postpartum	3
No NSSI history	5
No thoughts of suicide before pregnancy	5
Suicide attempt	1

PMAD Experiences

Four women shared they received a diagnosis of PPD or PPA; one mother received a diagnosis of PPD/A and P-OCD; one mother self-identified as having PPD/A; one mother self-identified as having PPD/A; and one mother was diagnosed with

generalized anxiety disorder (GAD). Six of the eight mothers reported that they took medication for their PMAD and one mother discussed medication options with their care providers but opted not to take medication.

Data Collection

Data collection occurred over 5 months (August to December 2021). Informed consent was obtained for video and audio recording of the interview. The mothers were interviewed by the first author (V.V.), over Zoom Inc. in a private home office and participants located in their respective homes. Mothers were encouraged to find a private and comfortable location within their home for the duration of the interview. Four of the interviews were interrupted once by their children. When this happened, the interview was paused while the mothers attended to their children's needs. When the mother returned to the screen the last question was repeated and the interview resumed. The interviews ranged from 59 minutes to 1 hour and 50 minutes with an average time of 1 hour and 22 minutes. There was no recompense for participation. Mothers shared that telling their story provided cathartic release, liberation, and connection to other mothers struggling with PMADs. Indeed, mothers provided feedback, during and post-interview, of how much they appreciated participating in the research.

As suggested by Smith and colleagues (2009) a semi-structured interview schedule with open-ended questions was prepared prior to the interview (see Appendix B). This ensured key questions were addressed and allowed for appropriate use of language that was inclusive, respectful, and sensitive. Before the interview commenced, mothers were reminded that they had the opportunity to pause the interview, take breaks, end the interview and reschedule, or rescind consent to participate. This was to ensure the

safety and well-being considering the sensitive nature of the interview topic of suicidality. Typical questions or prompts included “What were your expectations about pregnancy and motherhood?”, “If you feel comfortable, please share an example of suicidal thoughts”, and “Please describe your recovery from suicidality”.

The interview schedule was not followed in a strict or linear way but rather I followed the direction of the mothers. Consistent with IPA methods, I was interested in the psychological and social world of the mother and sought to uncover a rich description of their said world, which included following the direction of each mother (Smith & Osborn, 2008). A process of building rapport and gauging the level of comfort with the mother allowed me to start with general questions before arriving at a sensitive question. I closely monitored the mother’s non-verbal communication (e.g., crying, silences, body language, etc.) and held appropriate space for the connection with emotions during the interview. I was mindful of the ethical responsibilities towards the mothers. If a mother was showing signs of intense emotions, I reminded the mother of their options to pause, reschedule, or opt out of the study. The interviews ended with an opportunity for the mother to clarify or add any further information. Online and local maternal health resources were provided to each participant.

Zoom recordings were transcribed verbatim by me (the first author) to allow myself to be fully immersed in the data. After the creation of the transcripts, I completed member checks where mothers provided feedback and approval of the transcripts before the data analysis process commenced. One mother provided minor clarification changes and one mother emailed their approval of the original transcript. The other mothers indicated approval through non-reply to my email. Mothers were engaged a second time

for the purpose of credibility checking and were provided a summary of personal experiential statements and subthemes. Three mothers provided approval of the personal experiential statements and subthemes. The other mothers indicated approval through non-reply to my email.

IPA Analysis

Data was analyzed by the following stages recommended by Smith and Osborn (2008) and Smith and colleagues (2009): (1) reading the text, (2) initial noting, (3) developing emergent themes, (4) searching for connections across emergent themes, (5) analyzing other cases, and (6) looking for patterns across cases. Smith (personal communication, September 30, 2021) introduced new terminology to better represent the analytical process: *exploratory notes* replaced initial comments; *experiential statements* replaced emergent themes and *personal experiential themes* replaced superordinate themes. Subsequently, Smith's new terminology is utilised herein. In accordance with IPA principles, an idiographic approach to data analysis was adopted by fully examining one case at a time, in detail, before creating generalized categories across cases (Smith & Osborn, 2008). Qualitative software, NVivo 12, was used to manage, code, and analyze data. I immersed myself into the data by reading the transcript while listening to the audio once and then subsequent readings of the transcript without audio. During exploratory noting, I made comments in a Word document on the descriptive (focus on the mothers meaning of suicidality and recovery), linguistic (specific use of language) and conceptual (interpretative) elements of the transcript (Smith et al., 2009). Utilizing NVivo 12, I coded experiential statements. I examined connections between the experiential statements to construct a table of personal experiential themes with sub-

themes. The process of analysis was repeated with subsequent transcripts. In order to analyse patterns across cases, I created a large visual representation containing each experiential statement to allow reconfiguration, collapsing, and relabeling of personal experiential themes. In an excel spreadsheet I checked that the final personal experiential themes were present in other cases and supported by mother's quotes.

Rigour

To ascertain data quality and trustworthiness through reflexivity (Clancy, 2013), I completed member checks (Birt et al., 2016), created an audit trail, and worked closely with my supervisor (G.W.). Mothers were engaged in member checks of the transcript and a summary of personal experiential statements and subthemes. I documented in my reflexive journal about my thoughts on the phenomenon being studied, my own experiences with postpartum, after each interview, and about initial observations in order to be aware of these ideas while analyzing the data.

Positionality

As the first author, I was aware that my experience of being a white, academic, heterosexual, married, cisgendered, able-bodied woman who has experienced pregnancy and motherhood, has impacted the way I relate to the data. I received my ethics approval weeks after I had given birth to my second child. While conducting the interviews I was also in the midst of my second postpartum journey. Although I do not have lived experience of a PMAD or suicidality, I am aware of what it is like to be a mother in society. I am early on in my career of specializing in perinatal mental health counselling and have received advanced training on perinatal mental health. I have completed training in suicide intervention, as a counsellor I have intervened with individuals

experiencing suicidality, and I have been a distress centre phone line volunteer. I have knowledge of the phenomenon being studied but no lived experience of the phenomenon. It was imperative to utilize a reflexive journal ensuring during analysis I focused on the lived experience of the participants and the phenomenon of recovery from perinatal suicidality following counselling.

Findings

During the analysis, a key finding was discovered that all eight mothers shared: *feeling like a failure as a mother* was identified to directly contribute to increased feelings of suicidality. These mothers described the embodied experience of suicidality in the perinatal period. Three personal experiential themes emerged from the analysis that were relevant to data from all eight participants: (1) Connection with Counsellor as a Catalyst for Change, (2) Connection with Self to Minimize Suicidality, and (3) Connection with Extra-Therapeutic Factors Important for Recovery. This key finding and personal experiential themes are described in greater detail followed by a discussion of the study's strengths, limitations, recommendations and conclusion.

Feeling Like a Failure as a Mother Directly Contributed to Suicidality

This key finding illustrated mothers' sense of inadequacy as a mother, which led them to believe *someone else could probably do a better job than me*[2] (Patricia[3]) and *I need to die, just let me die* (Xena). Overall, they described that suicide emerged as a viable option to escape reality when the adverse feelings and symptoms of PMADs became unbearable; this led them to believe they were failing as a mother. That is,

[2] Quotes from mothers are represented by italicized writing
[3] Pseudonyms were used to protect the anonymity of participants. Publication is in process, 'Feeling like a failure as a mother': Stories of perinatal suicidality to recovery, which includes further description of each mothers experiences.

PMADs were like a thick fog that settled into the mothers' lives and clouded all aspects of their existence. While each mother had unique pregnancy, birth, and postpartum experiences they shared similar symptoms of PMADs characterized centrally as *feeling like a failure as a mother*. They also experienced PMAD symptoms of anger, guilt, shame, self-criticism, isolation, loneliness, exhaustion, and intrusive thoughts. Mothers reported comparing themselves to other moms, feeling the pressure to put on a façade of a happy mom, that it was tiring to make an effort to parent, and struggling to complete household daily tasks.

Mothers described increasingly negative self-critical thoughts spiraling to suicidal ideation. During analysis, the metaphor of a downward spiral of thoughts emerged for me. That is, mothers described a fast, repetitive, panicked, downward spiral of thoughts, a tornado swirling out of control (see Figure 1). Just as a tornado picks up debris that causes damage when circulating around, I pictured the thoughts as debris circulating around in the mothers' minds negatively affecting their mental health. Joanne shared, *when you are having like a spiral of negative thoughts and that [suicide] is the bottom of the pit, you know, kind of like that panic attack kind of feeling*. The tornado of thoughts was found to be triggered by a negative experience (e.g., a painful breastfeeding, little frustrations adding up throughout the day, hours of baby crying at night, etc.). Altogether, the mothers' depictions were best captured through this imagery. The tornado of thoughts, for example, would begin as *I don't know what I am doing* (Patricia), and progress to *It would be better for everybody if I wasn't here because I am just a roadblock* (Marie), and intermingled with intense guilt and shame, would end with *I just need to die* (Xena).

Figure 1

Tornado of Thoughts

Note. There is an image of a tornado surrounded by thoughts from the mothers.

Delineating Suicidal Thoughts

Debate abounds with in the research literature about the use of terms *passive* suicidal ideation and *active* suicidal ideation (Liu et al., 2020). In this study, I use the term passive suicide ideation (PSI) to capture fleeting thoughts of death that popped in and out of the mothers' mind. Whereas active suicide ideation (ASI) was described by mothers when they purposefully thought about killing themselves and were planning for suicide, which some mothers strongly considered.

Mothers described PSI as the opportunity for suicide presenting itself and they *could find death in any scenario* (Sophia). For example, Grace shared:

> *I was really scared to drive because that is what I would think about when I was driving, I could drive into that, I could pull off of this*.

Similarly, Mel described:

> *I started getting thoughts, like, I'm done, I'm done, I'm just going to drive into that pole. I'd see scissors and be like I'm just going to slit my wrists and then I don't have to feel like this anymore.*

Comparably, Joanne articulated that PSI was a desire to temporarily escape from her life circumstances:

> *…just the not wanting to be alive, more not wanting this to be my life.*

Similarly, Xena described:

> *I sometimes would like pray, but not to a specific god but I would just pray and say, 'end my life now, please just let me die'…because I did not want to take my own life.*

Mothers described their reaction to the PSI as fear, alarm, self-judgement, shame, and a warning sign that they needed to get help. This added to the spiralling thoughts and increased the self-critical inner voice. Courtney explained:

> *I was so ashamed. So horrified by it. It almost seemed like it was somebody else. How could I be thinking this? Like you're having a baby… this is somebody's life and so it just compounded it. You are terrible.*

Grace shared:

> *I would have a fleeting suicidal thought and I would think, 'Oh my gosh, I can't believe I think that? I am the worst person ever. What is wrong with me?' And then you start to dwell on it, and you get more… and you feel more shame and more guilt and then that starts to build.*

Mothers in this study experienced both PSI and ASI. Grace portrayed ASI, *as a frontal lobe suicidal thought, where I am really thinking about it.* Sophia considered suicide to be a good solution to her problems. She stated:

> *When I had the suicidal thoughts, I entertained them, I played them out. I thought, 'hmmm that might be a solution'.*

Mothers described ASI as helpful in the moment in that ASI provided a sense of control, relief, escape, and hope that the pain could end.

Nonsuicidal Self-Injury

NSSI occurred to release negative emotions that came with the self-critical thoughts of 'feeling like a failure as a mother', to control the suicidal ideation, and to take action against the suicidal ideation. Xena explained:

> *I would actually hurt myself; I would punch myself; I would bite myself really hard, just to stop the [suicidal] thoughts from continuing*.

Marie shared:

> *That [postpartum rage] started to scare me, which adds a whole new layer of doubt, confusion, self-judgment, critical, critical thoughts, and self-criticism. I just kept cycling, spiralling, and getting worse… I would just sit in the kitchen on the floor and pound the rug …enough to make it hurt, I really needed to just feel pain*.

Grace performed NSSI as a way to punish herself for having suicidal thoughts while pregnant but also to prevent herself from suicide. Grace vividly shared:

> *I can't kill myself, but I can hurt myself. I remember thinking and saying to myself as I was doing it, 'this is how much I hate you' and then I had those burns on my arms for a while and it felt so shameful*.

Whereas NSSI served as a call for help from Courtney as she described:

> *It was a little late in life to start, but I started self-harming … like now I realize probably just desperate for someone to notice that this [suicidal thoughts] was happening*.

In contrast, Sophia described NSSI as a coping mechanism to deal with intrusive thoughts of harm occurring to her children, which is a symptom of postpartum OCD (Starcevic et al., 2020).

Connection With Counsellor as a Catalyst for Change

The therapeutic relationship was a pivotal point in mothers psychological shift towards wanting to live. When the tornado of suicidal thoughts threatened to take over the mothers, they described finding shelter in the relationship with the counsellor. The

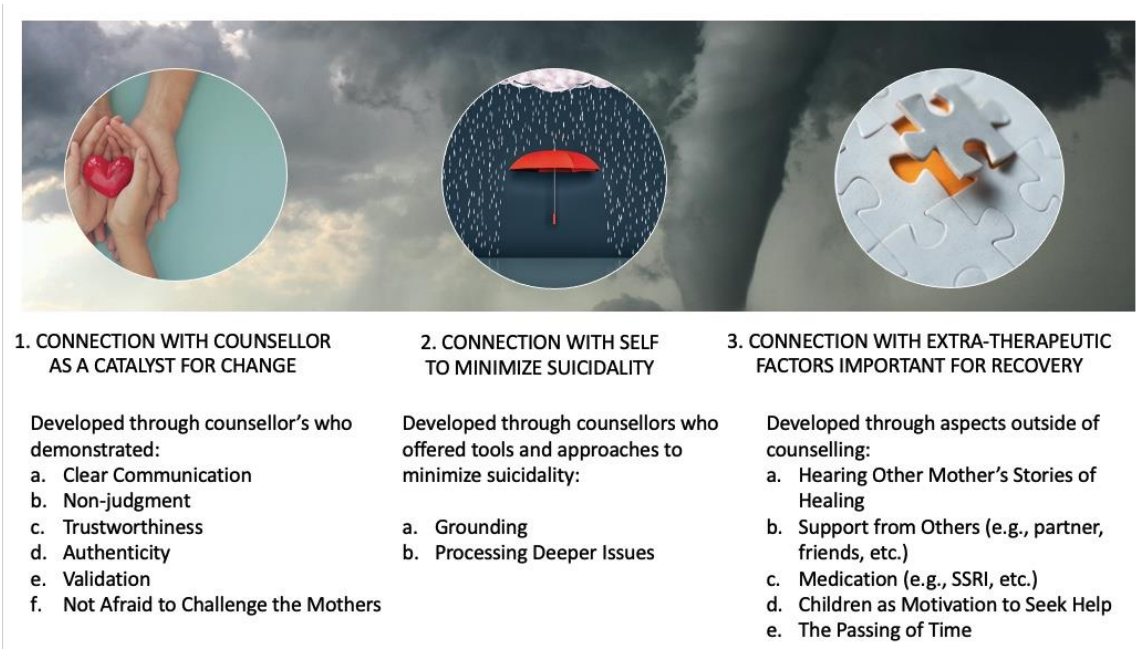
counsellor was not afraid of the storm. Within the therapeutic relationship, mothers expressed that the counsellor created a space that was safe and secure. Then they were able to be vulnerable about their struggles with PMADs and suicidality. This safety was described by Xena:

> *non-judgemental and just created so much safety…it feels like you [the counsellor] cradled me as a baby and you [the counsellor] are just rocking me, like that is how safe I feel after our sessions, or during our sessions, especially during those really emotional, really intense releasing moments.*

The imagery that Xena provided of feeling like she is being cradled and rocked like a baby highlights the importance of how the counsellor, being non-judgemental, generates enough safety for her to experience *really intense releasing moments*. It can be interpreted that Xena's counsellor intentionally created a safe space for Xena to express herself and grow, much like a mother who cradles and rocks her baby to soothe, calm, nurture, and connect with the baby. Xena stating, *after our sessions* can be interpreted that the work completed during the counselling sessions continues after the session is finished. Counsellors were described as intentionally creating a safe space by providing clear communication, non-judgment, trustworthiness, authenticity, validation, and were not afraid to challenge the mothers. Mothers' relationship with the counsellor were described as *immensely valuable* (Marie).

Figure 2

Overview of Personal Experiential Themes



Note. Image of a tornado in the background with hands holding a heart to represent the first theme; image of an umbrella with rain falling to represent the second theme; image of a puzzle piece fitting into the puzzle represents the third theme.

The Counsellor was a Clear Communicator

Mothers reported appreciating that their counsellors were articulate, professional, and thoughtful when asking the tough questions around suicide behaviour. The counsellor's ability to talk about suicide directly and in a comfortable manner was demonstrated with the use of well-defined terminology and plainly explaining the symptoms of PMADs in laymen's terms. Mothers reported feeling relief in understanding the PMAD symptoms. For the majority of the mothers, disclosing thoughts of suicide to the counsellor in the sessions was the only time they had ever talked about their experiences of suicide thoughts and they appreciated being asked directly. Patricia pointed out:

> *I know for my experience, if you ask the question [are you suicidal?] the answer is a lot easier to come out then having to volunteer that*.

The Counsellor Accepted Suicidality Without Judgement

Mothers explained it was imperative to not feel judged as they were sharing their most shameful thoughts and experiences surrounding suicide. Courtney recounted:

> *I needed someone at that point who I felt was not going to judge because even though they are all professionals, there were certain people who just made me feel more judged… My main person [counsellor] that I had…it did not feel like she was judging what I was going through, she just kind of accepted it.*

The Counsellor was Always Very Honest

Like other mothers in this study, Joanne depicted, *there needs to be a certain level of trust*. Mothers clarified trust was built when counsellors were *always very honest … about what she [the counsellor] did, when she [the counsellor] would do it* (Sophia). While some mothers reported trust in their counsellor was a gut instinct that they followed. In contrast, three mothers described being fearful of social services being contacted and their children being taken away; making it difficult to fully trust the counsellor. As illustrated by Courtney:

> *I had worries that somehow because I had gotten myself into the [provincial healthcare] system that one day a social worker was going to land on my doorstep and tell me that I wasn't fit to be a mom.*

The Counsellor Showed Their Authentic Self

Mothers described the counsellor's behaviour as natural, authentic, and genuine. These behaviours allowed mothers to feel *very at ease with her [the counsellor] very quickly* (Grace). Marie enthusiastically stated, *I felt confident about her [the counsellor]*. Grace described her counsellor as *caring without being…like a fuzzy, sweet syrup person.*

I did not ever feel like she was putting it on as part of it. The relationship that they felt was *a big, big part of it is who she [the counsellor] is* (Xena). The repetition of *big* in Xena's words amplifies that the connection comes from the counsellor's authentic personality.

The Counsellor Listened and Offered Validation

Majority of the mothers found it very powerful when the counsellor validated their feelings and experiences; specifically, that motherhood has difficult moments. Mothers explained it was a huge relief to feel seen, heard, and to not have to defend their reality. Marie shared:

> *I think probably the most helpful and she [the counsellor] helped name that pressure and the overwhelmed-ness as normal, it's ok, and I don't have to, I guess it's the stereotypical, I don't have to do it all*.

Likewise, Patricia shared:

> *She [the counsellor] was really skilled in her relational practice and in letting me talk and hearing my heart and just leaving counselling with her felt a little bit lighter because it was off my chest, it was not swirling around my head, and I had gotten it out.*

The Counselor was not Afraid to Challenge the Mothers

While feeling supported mothers also conveyed that counsellors who were not afraid to challenge them were very helpful. Indeed, five of the mothers reported that the counsellors challenged PMAD beliefs they heard. For example, Patricia shared:

> *Instead of accepting the passing thought as truth, you can challenge it with a "Oh I wonder why I am thinking that way?" or "I wonder why I am feeling that way?" More of a curiosity about the thoughts instead of the thoughts being real or truth… I think counselling demonstrates that questioning in a gentle way, so you'll say, "I'm a bad mom" and the counsellor will say, "tell me why you think that", or "what evidence do you have to believe that?"… watching them [the counsellor] challenge your thought also gives you tools to question it yourself when they come up.*

Mel described hating her counsellor for constantly challenging her. Nevertheless, she still found her effective and attributed her recovery to challenging her thoughts:

> *…the counsellor, she really challenged my thinking…you're in this dark hole, everything is dark, everything is negative, everything is overwhelming. That's probably why she grinded my nerves because she challenged all of that and she made me start making the effort.*

Connection to Self Minimized Suicidality

This next personal experiential theme captured within the mothers' description was that they were guided back to themselves through counselling. Mothers explained being connected, or being guided back to themselves helped them to feel calmer, more grounded, settled, patient, and able to think clearly. This, in turn, slowed the downward spiral to active suicidal thoughts. The relationship with the counsellor, particularly the safe holding space, contributed to the mothers being willing to talk about their suicidal thoughts, PMAD, and many of the different struggles with motherhood. Mothers gained a greater compassion for themselves, a deeper understanding of their current behaviour, and skills that helped them feel connected back to themselves. These insights that were gleaned were further categorized into sub-themes of *grounding* and *processing deeper issues (see Figure 2)*.

Grounding

There is an old Norwegian saying that goes like this: there is no bad weather, only bad clothes. This idiom can be likened to how mothers described their counsellor equipping them with skills, like a rain jacket or umbrella, to help them navigate the stormy fog of PMADs and the tornado of swirling suicidal thoughts. Mothers experienced these skills as helpful to minimize suicidal ideation and connect back to a

more grounded version of themselves. Skills and approaches included: mindfulness, self-compassion, self-care, emotional regulation, affirmations, and CBT.

Mindfulness. Mothers described mindfulness as developing self-awareness of their thoughts and feelings, acknowledging the suicidal thought instead of supressing it, *letting it be and not latching on to it with guilt* (Grace). Three mothers explained that they viewed the suicidal thoughts as separate from the core of who they were as demonstrated by Courtney:

> *Detaching that [suicidal thoughts] from who you are as a person, what kind of mother you are going to be, all of that, if you can just separate that out.*

Self-Compassion. A few mothers took mindfulness a step further and implemented self-compassion. This was conveyed as meeting themselves with empathy, kindness, and checking their needs. Mothers described how the way the counsellor spoke to them was an example of how they could internally respond to their thoughts with compassion. Marie stated, *Self-compassion as an antidote to the self-criticism has been a massive lesson for me.*

Self-Care. Mothers portrayed during the fog of PMADs they were unable to articulate what to do for self-care or their needs; therefore, the counsellor guided mothers to self-reflect on what they could do to bring more joy back into their lives. Instead of counsellors saying "you need to do more self-care" they helped mothers come up with a concrete plan of how to implement self-care. All the mothers described many forms of self-care from simple things like a cup of coffee or showering, to intense exercise, massages, or being in nature. Mel stated, *doing things that I enjoyed, that is when my morning coffee became my morning meditation*. Equally, Patricia stated:

> *I knew what I needed to do to feel good about myself and that was based on…what brought me joy, intense physical exercise, being outdoors, having time with friends… Starting to implement those things into my life, it took a lot of effort because when you are depressed, you do not want to go out and see people, you do not want to exercise and do all of that.*

Emotional Regulation. Mothers described that the counsellors would help them name, express, and embody the full range of an emotion. The majority of the mothers described the process of learning emotional regulation to be hard work, exhausting, and time-consuming to practice. Mothers explained that the techniques or skills that were most useful were things that would take them out of their tornado of thoughts and ground them in the present moment. They gravitated towards implementing skills that they could do in the presence of their children. They found the following techniques to be most helpful: box breathing, splashing cold water on the face, cold showers, standing outside in the cold, ice cubes on the wrist or forearms, 5-4-3-2-1 technique (five things you can see, four things you can feel, three things you can hear, two things you can smell, one thing you can taste), taking their finger and writing on their opposite hand, and distraction by repeating comforting bible verses, listening to music, or podcasts. Xena explained:

> *Letting the suicidal thoughts dissipate is about feeling the whole and the full emotion and letting it play out, physically, emotionally, mentally… letting it play out in a non-judgemental safe space. Really after that for me, I don't really need to do anything else with it. Like I know the solutions, I know I'm pretty smart, I know what I need.*

Affirmations. Three of the mothers found affirmations to be a powerful tool for healing. One mother described listening to a recording of affirmations, whereas other mothers posted them around their house. Affirmations were simple self-statements such as *I am a great mom, I am enough, I am ok, I want to live, etc*. Grace shared:

> *There were times when I was not doing as well, then I would read the affirmations out loud. The [affirmations] were all over our house. When I closed my son's door, when putting him down for a nap then I would see it [an affirmation], inside our bathroom, on our cupboard doors…that was good. Honestly, I thought it [repeating affirmations] was a little hoax-y but it turned out to be worthwhile.*

Cognitive Behavioural Therapy. Over half the mothers described their counsellors working from a CBT perspective and found thought stopping and reframing to a neutral or positive thought to be helpful in their recovery. At first it was difficult for mothers to notice their negative or self-critical thoughts and stop them. When they would replace their thoughts with, *I am doing the best I can* (Mel), or *I want to live* (Mel) they did not fully believe them. The words felt empty, but over time the words started to carry more meaning. CBT was helpful in taking away the power of negative thoughts as demonstrated by Patricia:

> *Then in saying it out loud we recognize that it is not actually true, you know, it is just a passing negative feeling, it is not a core belief about yourself.*

Processing Deeper Issues.

Once the initial suicidal crisis was acknowledged, the mothers described their counsellors going deeper into topics that may have been causing acute distress in their lives. The topics included the following: suicidal thoughts stem from past traumas, processing family relationships, societal influences on motherhood, and identity transition to becoming a mother.

Suicidal Thoughts Stemming From Past Traumas. It is notable that 5 of the 8 mothers disclosed a history of trauma (e.g., adverse childhood experience or sexual abuse in adulthood). Through counselling, mothers learned that trauma could be a contributing factor to perinatal suicidality and it was necessary to process the trauma. Sophia shared:

> *I have a lot of triggers and thoughts that probably stem from trauma, so now that's what I am working on. I think that is kind of like the root cause of it [suicidal thoughts].*

Mothers explained that processing past traumatic experiences helped them understand current triggers, their *large emotional dysregulations*, and their lower distressed tolerance to stress. Within the safety built in the therapeutic relationship, trauma-informed counselling permitted mothers to process trauma in an embodied way. Mothers described emotions that were experienced on a somatic and physical level. Trauma-informed counselling allowed mothers to relearn how to trust their own instincts, thoughts, and feelings, essentially connecting them back to themselves. This is illustrated by Xena when she participated in eye movement desensitization and reprocessing therapy:

> *We would talk about a situation where I was triggered and having suicidal thoughts… she [the counsellor] would get me to breathe and pay attention to my body… often I would be bawling, or screaming, or most of the time crying really hard, kind of shaking, and it just happens… I released it.*

Processing Family Relationships. Mothers described talking to the counsellor about their relationship with their own parents, specifically their relationship with their mother as helpful to their recovery. Topics discussed were expectations, boundaries, and accountability for adverse childhood experiences. Patricia explained:

> *My expectations of my relationship with my mom were that she would be nurturing, supportive, listening, and compassionate, the counsellor was helping me learn to have reasonable expectations for what you know of people. So, has my mom ever been that way? No. So, why do you think she is going to be that way now when you kind of need it in this postpartum period? And then managing those expectations.*

Societal Influences on Motherhood. Through counselling, it became evident to the mothers that their expectations of themselves were based in societal discourses of motherhood. When they could not meet these unrealistic expectations, they equated it

with failing as a mother. The societal expectations included the following: *my body should know how to do this* (Courtney), *I should know what I am doing* (Marie), *I should be happy* (Mel), *I thought I would give birth in July and do the race in September* (Sophia), *I should know how to breastfeed* (Patricia), *how I should present as a mother*, and *I should know how to get my baby to sleep* (Patricia). Furthermore, Xena described the image of a super mom:

> *They [super moms] are always caring for their children. They are responsible for all or the majority of the childcare responsibilities such as, making food, pickup/drop off, play dates, doctor appointments, camps, buying toys, and medical stuff. They love, LOVE every minute of it. They love it all and they don't get tired… even the late-night wake ups and the sleep deprivation.*

Xena depicts the unrealistic societal expectations placed on mothers leading to these mothers striving for perfection and comparing themselves against an illusion of an ideal mother. Within counselling, being able to name the expectations granted the mothers the freedom to define their competency in mothering on their own terms. Additionally, Xena shared:

> *Knowing that on the bigger scale, we live in kind of a world, in our society where the expectations on mothers, is quite unfair, and we are almost, set up to fail in some ways. So for me, I feel very empowered by knowing that there is a bigger societal pressure at large and that I am not alone in it.*

Identity Transition to a Mother. Mothers described that they felt like they went through a *major, major identity shift* (Patricia) when they became a mother. As illustrated by Marie:

> *Two years of transitioning into parenthood… I should be accepting the fact that I do not have a day job outside of the house, I have less outings, and I should be settled into being at home.*

Marie's repeated use of *I should* illustrates her not meeting her expectations of motherhood and finding the transition difficult. Counselling sessions were a safe place

for these mothers to explore their evolving identity as described by Xena, *I went through an identity crisis, it [counselling] helped me solidify who I am as a mom*. Through counselling the mothers came to a place where they considered or could believe that they could be good moms. Mothers also shared that their mothering identity was further developed through books, podcasts, and mom groups.

Connection With Extra-Therapeutic Factors

The final personal experiential theme describes extra-therapeutic factors developed outside of counselling sessions that helped mothers with recovery from suicidal thoughts which included: other mothers' stories of healing; support from others; medication; children as motivation to seek help; and the passing of time helped in recovery.

Other Mothers' Stories of Healing

Most of the mothers reported that they never heard of any other mothers experiencing thoughts of suicide and this exacerbated feeling broken and alone. Courtney shared:

> *I would have loved to have found a group… of mothers who were feeling the same way or have experienced it in some way, I would have loved to have had some stories to follow, to just, make me feel so not alone.*

All of the mothers shared that it was very empowering to hear other women speak their truth about mothering, their struggles with mental health, and recovery from a PMAD. The stories were usually in passing, from one mother to another mother, and the person sharing the story did not necessarily know the strong impact that their story had on the mother struggling with a PMAD. Mothers' stories of healing came in the form of podcasts, books, nurses, and peers. These stories connected mothers to the larger

mothering community and to other PMAD sufferers which permitted them to feel less alone in their experience and provided hope for their future. Patricia shared:

> *Here she [an older mom friend] is, her kids are fine, and I remember that being a little bit of light in that dark time of having that really experienced mom being like, 'Oh I had a really hard time too' and her kids turned out fine*.

The mom sharing, *oh I had a really hard time too*, is an example of normalizing the less than perfect parts of motherhood. Essentially, this friend acknowledged Patricia's struggles and let her know that she was not alone in her experience. Patricia repeats, *her kids are fine* which can be interpretated to show that it gives her hope that her children will also turn out fine, eases the anxiety that she is not messing up her own kids, and it counteracts the suicidal thought that Patricia's kids would be better off without her.

Support From Others

Mothers described support from other people as lifesaving. Support came from participant's partners, friends, family, midwives, nurses, community groups, help lines, online videos explaining PMADs, coworkers, and paid babysitters. Sophia stated, *I am fortunate that I had a partner who was willing to play a role in keeping me safe* and Courtney relayed, *to just form that network around me was probably the biggest part of recovery from that [suicidality]*. Mothers acknowledged there is vulnerability in being willing to ask for help and accept support. Especially since there *is stigma around mental health and around perinatal mental health, because there is this pressure around when you have your child* (Mel). Xena and Mel chose to share all of their experiences with a PMAD including thoughts of suicide with a few trustworthy friends. Courtney, Patricia, and Grace were more guarded in who they shared their experiences of suicidality with. In contrast, Sophia, Marie, and Joanne did not share their experiences of suicidality with

others except their counsellor; *I have yet to discuss anything about the suicide. I doubt if I ever will* (Sophia). Regardless of the amount of disclosure of suicidal thoughts, all mothers reported benefiting from support and openly talking about motherhood experiences with others.

Medication

Six mothers took medication for a perinatal mental illness and found it to be extremely helpful in conjunction with counselling. Sophia shared, *I'll give medication its due, but I think therapy is the most important*. Counselling is the first-line treatment option for mothers with mild to moderate PPD, whereas counselling in combination with medications is suggested for mothers experiencing moderate to severe PPD (Guille et al., 2013; MacQueen et al., 2016; Williams et al., 2014). SSRI's have the largest evidence base for treatment and are recommended for moderate to severe PPD (Guille et al., 2013). In contrast, medication discontinuation during the perinatal period is a risk factor to suicide (Admon et al., 2021). Hardy and Reichenbacker (2019) suggested that treatment decisions must be individualized based on the needs of the mother and current research on available medications. The decision to take medication for PMADs during the perinatal period had its own challenges with stigma, as well as, fear of safety for the baby, as illustrated by Patricia when she shared:

> *I now explain it to people as, we do not guilt a diabetic for needing insulin so why do we guilt someone with a brain chemical need, needing medication?... It [medication] just makes sense, as long as it is safe for me, and it is safe for the baby.*

Children as Motivation to Seek Help

Courtney and Grace experienced thoughts of suicide while pregnant. At first the growing baby was motivation to not complete suicide. While Grace was pregnant, she

decided to seek help because of the growing baby and her other children. In contrast, Courtney started to strongly consider suicide while pregnant when she thought about her child potentially having to deal with the pain and struggles of poor mental health. Four of the mothers who experienced thoughts of suicide in the postpartum period were motivated to seek help because of their children. Mel shared: *I wanted my baby to grow up with a mom…it was the baby that actually helped pull me through*. When the process of recovery was difficult, they thought about wanting to be around and living for their children as demonstrated by Sophia, *I wanted the chance to make it up to my kids.*

The Passing of Time Helped in Recovery

Mothers reported *time was one of the biggest factors* (Xena) that helped with their recovery. As time passed the baby settled into a sleep routine, *could speak, and he developed more of a personality* (Xena). Marie shared, *the long-term recovery is having lived through those early years… we are past, what I experienced as the hardest years*. The passing of time is interwoven into other themes such as medication and mothering identity. Indeed, medication for PMADs or any mental illness can take time to work- medication often eases the symptoms of PMADs (Williams et al., 2014) as evidenced through the mothers in this study. Furthermore, with the passing of time some mothers became more confident and accepting of their mothering identity or had integrated their vocation back into their identity.

Discussion

The purpose of this study was to answer the research question: *What are the lived experiences of mothers' recovery from perinatal suicidality following counselling?* Analysis revealed a key finding about the experiences of suicidality before the mothers

attended counselling. That is, all eight mothers reported *feeling like a failure as a mother* directly contributed to suicidality. While there were other suicide risk factors present such as the desire to escape from self (Baumeister, 1990), hopelessness (Beck et al., 1990), intense psychological pain (Shneidman, 1993), a feeling of entrapment (Li et al., 2018), and NSSI (Klonsky et al., 2014), 'feeling like a failure as a mother' was most prominent in these mothers' descriptions of suicide ideation during the perinatal period. In a recent grounded theory study, Reid and colleagues (2022) identified that mothers felt attacked by motherhood which mothers then concluded, that they were a failure as a mother and this increased desire for suicide[4]. The results of 'feeling like a failure as a mother' increasing the desire for suicide is similar to this study but the difference is that mothers in this study did not report feeling attacked by motherhood.

'The feeling like a failure as a mother' that mothers in this study described is similar to Joiner and colleagues (2009) concepts of perceived burdensomeness and failed belongingness. *Perceived burdensomeness was defined as* low self-esteem so extreme that one's existence is a burden to family, friends and society. *Failed belongingness* was defined as loneliness and social alienation therefore not being part of a family, group of friends, or valued community. Joiner et al. (2009) proposed failed belongingness and high perceived burdensomeness combine to bring about the desire for suicide, which was the case for postpartum mothers in this current study. In contrast, Klonsky and May (2015) asserted that perceived burdensomeness and failed belongingness contributed to a person's experience of *pain*.

[4] The study by Reid and colleagues (2022) was published after the analysis for this study was completed and the findings were written by this author.

In their framework, a 3-Step Theory of Suicide (3ST)of suicide, the experience of pain and hopelessness were the first step towards suicide ideation. Klonksy and May (2015) also described connectedness as a moderating protective factor that prevents escalating ideation. *Connectedness* is defined as one's attachment to a perceived purpose or meaning that keeps an individual invested in living; this is attachment to other people, a job, project, role, or interest. Consistent with this perspective, if a mother experiences daily pain and hopelessness but is connected to their children and role as a mother, they may have PSI but not progress to suicide. In this study, mothers described their connection to their counsellor as immensely valuable in their recovery. However, if there is pain, hopelessness, and a lack of connection to role as a mother, Klonsky and Main's 3ST would suggest, she would progress to suicide. Furthermore, mothers in this study reported feeling like they struggled with their identity transition to motherhood which may add to the disconnection to a meaningful role.

Nonsuicidal Self-Injury

In this study, mothers performed NSSI to release negative emotions that came with the self-critical thoughts of *feeling like a failure as a mother,* to control the suicidal ideation, and to take action against the suicidal ideation. It is commonly supported in research literature that NSSI reduces negative emotions as well as is followed by feelings of peace and relief (Klonsky et al., 2014). Mothers described NSSI as a result of punishing themselves for having suicidal thoughts while pregnant or in the postpartum period. NSSI as a type of self-directed anger or self-punishment is consistent with current research on NSSI (Klonsky et al., 2014). Whereas, some of the mothers described implementing NSSI to stop the self-critical thoughts of feeling like a failure spiraling in

their mind. In other words, the mothers explained that they knew that NSSI was not a healthy coping mechanism and took it as a warning sign that they needed to seek help for their mental health.

Connection With the Counsellor

Understanding the direct influence of 'feeling like a failure as a mother' has on the experience of suicidality is helpful in conceptualizing recovery through counselling. In the following section I will discuss the personal experiential theme of connection with the counsellor as a catalyst for change and how counselling helped the mothers in the study recover from perinatal suicidality.

Qualitative evidence from the study suggests that counselling contributes meaningfully to the recovery of perinatal suicidality. The first personal experiential theme of connection with the counsellor as a catalyst for change highlights the mothers experience of the therapeutic relationship being central for their healing. Indeed, there is strong evidence for the therapeutic relationship as an important factor in the effectiveness of counselling (Norcross, 2010). Mothers experiencing suicidality are in utmost distress. For that reason, the counsellor is doing more than building rapport within a therapeutic relationship, they are creating a deep connection with the mother in a *holding* environment.

Winnicott (1955, as cited in Knight, 2020) first described the theoretical concept of *holding* to explain the relationship between a mother holding and caring for her infant to parallel the counsellor-client therapeutic relationship. Indeed, Xena described her counsellor metaphorically holding her and rocking her like a baby to explain the level of genuine acceptance, safety, and non-judgement she felt in her relationship with her

counsellor. Kleiman (2017) adapted the concept of holding as a fundamental intervention for the healing of postpartum depression. When working with mothers in the perinatal period, the concept of symbolic holding, enables the counsellor to contain high levels of distress in a way that develops the therapeutic relationship (Kleiman & Wenzel, 2017). Holding mothers in distress is accepting everything that they are disclosing with unconditional positive regard, which is showing complete support and acceptance of a person (Rogers,1957). In this study, healing came from the counsellor coming alongside the mother and holding her pain, confusion, despair, distress, thoughts of suicide, and feeling like a failure as a mother. Furthermore, Rogers (1957) emphasized the counsellor should be genuine which means that "within the relationship he (sic) is freely and deeply himself" (p. 828). In this study, the mothers described these characteristics exemplified by their counsellors, which deepened the trust and connection. The prominent theme of connection with the counsellor as a catalyst for change was the co-creation of a relationship that became a safe place of healing that came from mothers being able to talk honestly without fear of judgment. From the relationship, the counsellors could then provide insights and skills for the mothers to practice minimizing suicidality. When active suicidal thoughts were no longer a great threat, the effective counsellors were described as addressing deeper issues to lessen acute distress for the mothers. One of the topics that the mothers described was processing past traumas.

Trauma and Suicidality

Felitti and colleagues (1998) originally demonstrated the link between adverse childhood experiences (ACES) and poor physical and mental health outcomes in adulthood, including suicide. Indeed, researchers have shown that a mother's history of

ACES is significantly associated with an increased risk of PMADs (Hsing-Fen et al., 2021; Sexton et al., 2015; Tebeka et al., 2021) and suicide during the perinatal period (Ammerman et al., 2019; Muzik et al, 2016; Reid et al., 2022; Sit et al., 2015). In the general population, a history of ACES (Dube et al., 2001) and traumatic events experienced as an adult, especially sexual and IPV, consistently show a strong association with suicidal ideation (Stein et al., 2010). Furthermore, a mother's exposure to IPV increases the risk of suicide behaviour (ideation, planning, attempts, and death) in the perinatal period (Alhusen et al., 2015; Ammerman et al., 2019; Gavin et al., 2011; Gold et al., 2012; Onah et al., 2017). A fuller discussion about the role of trauma in PMADs and perinatal suicidality is beyond the scope of this manuscript. There are recent articles highlighting the importance of trauma-informed counselling for PMADs (See Krzemieniecki & Doughty, 2022 and Nunnery et al., 2021).

Strengths

This investigation is the first qualitative study, to my knowledge, that addresses the lived experiences of mothers' recovery from perinatal suicidality following counselling[5]. Through this study, women's voices are illuminated and their experiences are gleaned through *thick description* (Smith et al., 2009), which lends insight into the unique experiences of suicidality while pregnant or in the postpartum period. This research illustrated the devastating spiral of thoughts and extraordinarily painful feelings that build to suicidality, providing firsthand accounts of the content of mothers' suicidal thoughts. Further, this study highlights mothers' perspectives and firsthand accounts of

[5] As this research was post analysis and in the final stages of editing, Reid and colleagues (2022) published a grounded theory study identifying psychological factors involved when mothers experience suicidal thoughts that lead to an attempt.

what was helpful in counselling to promote recovery. It was found that the mother's connection with the counsellor and other supports, can literally save her life.

Limitations and Future Research

Limitations in the present study include recognition of the lack of diversity in the participants. The majority of participants were white, heterosexual, married, and had post-secondary education. Researchers are encouraged to include more diverse population in terms of ethnic, socio-economic class, relationship status, gender, sexual orientation, and location in future studies. Currently, the majority of research focuses on risk factors pertaining to perinatal suicidality. It would be beneficial for researchers to investigate protective factors, as found in this study, such as support, self-care (e.g., exercise, time in nature, etc.), or the sense of connection and empowerment when hearing other mothers' stories of overcoming PMADs. Considering the link between a mother's history of trauma or exposure to IPV and the increased risk of suicide during the perinatal period, prospective studies exploring trauma-informed therapy as a necessary treatment for perinatal suicidality are needed.

Implications for PMAD Trained Clinicians

It is important to have a clinician specifically trained in PMADs for mothers to receive proper assessment, diagnosis, and treatment. A PMAD clinician will understand the unique experiences of mental illness in the perinatal period. Recommendations for PMAD clinicians involve emphasising the need for developing a safe therapeutic relationship. The relationship becomes the container that holds and witnesses the distress that perinatal mothers with a PMAD are experiencing (Kleiman, 2017). More specifically, regarding a client who is a mother experiencing suicidality in the perinatal

period, the approach of the clinician holding safe space is important because the client is sharing their deepest, darkest, most shameful thoughts (e.g., thoughts of suicide, feeling like a failure as a mother, or intrusive thoughts). Indeed, mothers feel a tremendous amount of guilt and shame when talking about suicide (Reid et al., 2022). In this study, to create a safe container for the mothers to express their suicidal thoughts the clinicians displayed the following: clear communication, non-judgement, trustworthiness, authenticity, validation, and were not afraid to challenge the mothers.

Clinicians are encouraged to use direct and clear language when talking about suicide, which is in line with current suicide risk assessment guidelines (Perlman et al., 2011). In this study, clear communication also increased the trust mothers felt towards the counsellor; therefore, making them more willing to honestly share their experiences. It is well documented in the literature that mothers suffering from a PMAD do not feel comfortable revealing the level of their distress for fear of child welfare service and their baby being removed from them (Goldman-Mellor & Margerison, 2019; The Lancet, 2012; McLeish & Redshaw, 2017). A few mothers in this study shared having this specific fear. Clearly explaining that disclosure of suicidal thoughts will not necessarily lead to contacting child welfare services may increase the willingness to talk about their distress.

Furthermore, if a mother is sharing thoughts of suicide as a concern in the perinatal period the clinicians should listen for key phrases such as “feeling like a failure as a mother”, “bad mom”, “horrible mother”, or “my children would be better off without me”. It is important for clinicians to differentiate between intrusive thoughts, passive suicidal ideation, and active suicidal ideation. Mothers go through great effort to keep the

façade of being seen as a capable, happy mother (Bilszta et al., 2010; McLeish & Redshaw, 2017) so they may not willingly disclose up front thoughts of feeling like a failure as a mother. The mother disclosing *feeling like a failure as a mother* could indicate suicidal ideation is more than passive, which requires further risk assessment. To minimize suicidality, counsellors should listen, validate, and work with clients' *feelings of a failure as a mother*.

Finally, having perinatal mental health training gives clinicians the ability to assess, diagnose, and provide psychoeducation with mothers potentially experiencing a PMAD. In this study, some of the mothers explained they did not know they had a PMAD, they just assumed they were failing as a mother. Explaining the symptoms of the particular PMAD a mother is experiencing provides her with relief, a new lens to understand her experience, and reduces shame. Sharing with the mother that the passing of time can ease the symptoms of a PMAD may provide hope. Equipping mothers with knowledge of a PMAD destigmatizes and normalizes mental health struggles.

Importantly, when the PMAD storm blew into the mothers' lives and the tornado of suicidal thoughts threatened to take the mothers' lives, the mother's relationship with their PMAD clinician, her relationship with herself and others, and factors outside of counselling, led to the road to mental health recovery for these mothers. Counsellors benefit from understanding that they are not the only person sheltering the mother from the storm and should encourage the mother to connect with and build social support. Moreover, this research contributes to stories of hope for other mothers and the trajectory in overcoming perinatal suicidality; in other words, the PMAD storm does not last forever. The tornado of suicidal thoughts diminishes through a revival in being able to

choose to live through active participation in therapy. These mothers' stories conveyed counselling is life-sustaining.

References

Admon L.K., Dalton V.K., Kolenic G.E., Ettner, L. S., Tilea, A., Haffajee, R. L., Brown-Lee, R. M., Zochowski, M. K., Tabb, K. M., Muzik, M., & Zivin, K. (2021). Trends in suicidality 1 year before and after birth among commercially insured childbearing individuals in the United States, 2006-2017. *JAMA Psychiatry, 78*(2), 171–176. https://doi.org/10.1001/jamapsychiatry.2020.3550

Alhusen, J. L., Frohman, N., & Purcell, G. (2015). Intimate partner violence and suicidal ideation in pregnant women. *Archives of Women's Mental Health, 18*(4), 573-578. http://doi.org/10.1007/s00737-015-0515-2

American Psychiatric Association's Task Force on Research Ethics (2006). *Ethical principles and practices for research involving human participants with mental illness, 57*(4), 552-557. http://doi.org/10.1176/ps.2006.57.4.552

Ammerman, R. T., Scheiber, F. A., Peugh, J. L., Messer, E. P., Van Ginkel, & J. B., Putnam, F. W. (2019). Interpersonal trauma and suicide attempts in low-income depressed mothers in home visiting. *Child Abuse and Neglect, 97,* 104126. https://doi.org/10.1016/j.chiabu.2019.104126

Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review, 97,* 90–113. https://doi.org/10.1037/0033-295x.97.1.90

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *The American Journal of Psychiatry, 147,* 190–195. https://doi.org/10.1176/ajp.147.2.190

Berens, P. (2017). Overview of postpartum care. http://enjoypregnancyclub.com/wp-content/uploads/2017/06/Overview%20of%20postpartum%20care.pdf

Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). Women's experience of postnatal depression -beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing, 27*(3), 44-54. https://www.ajan.com.au/archive/Vol27/27-3_Bilszta.pdf

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Byrnes, L., (2018). Perinatal mood and anxiety disorders. *The Journal for Nurse Practitioners, 14*(7), 507-513. https://doi.org/10.1016/j.nurpra.2018.03.010

Clancy, M. (2013). Is reflexivity the key to minimizing problems of interpretation in phenomenological research? *Nurse Researcher*, *20*(6), 12–16. https://doi.org/10.7748/nr2013.07.20.6.12.e1209

Dube, S. R., Anda, R. F., Felitti, V. I., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: findings from the adverse childhood experiences study. *JAMA, 286*, 3089-3096. https://doi.org/10.1001/jama.286.24.3089

Felitti, V. J., Anda, R. F., Nordenberg, D., Willamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14*(4), 245-258. https://doi.org/10.1016/s0749-3797(98)00017-8

Fernando, R. N. (2013). Maternal suicide is the leading cause of pregnancy-related deaths in Sri Lanka, *Journal of Obstetrics and Gynaecology Research*, *39*(10), 1492-1493, https://doi.org/10.1111/jog.12134

Garcia, E. R., & Yim, I. S. (2017). A systematic review of concepts related to women's empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. *BMC Pregnancy and Childbirth, 17*(347). https://doi.org/10.1186/s12884-017-1496-1

Gavin, A. R., Tabb, K. M., Melville, J. L., Guo, Y., & Katon, W. (2011). Prevalence and correlates of suicide ideation during pregnancy. *Archives Women's Mental Health, 14*(3), 239-246. https://doi.org/10.1007/s00737-011-0207-5

Gold, K. J., Singh, V., Marcus, S. M., & Palladino, C. L. (2012). Mental health, substance use and intimate partner problems among pregnant and postpartum suicide victims in the National Violent Death Reporting System. *General Hospital Psychiatry, 34*(2), 139-145. https://doi.org/10.1016/j.genhosppsych.2011.09.017

Goldman-Mellor, S., & Margerison, C. E. (2019). Maternal drug-related death and suicide are leading causes of postpartum death in California. *Journal of Obstetrics and Gynecology, 221*(489), 1-9. https://doi.org/10.1016/j.ajog.2019.05.045

Grigoriadis, S., Wilton, A. S., Kurdyak, P. A., Rhodes, A. E., VonderPorten, E. H., Levitt, A., Cheung, A., Vigod, S. N. (2017). Perinatal suicide in Ontario, Canada: a 15-year population-based study. *Canadian Medical Association Journal, 189*(34), 1085-1092. https://doi.org/10.1503/cmaj.170088

Guille, C., Newman, R., Fryml, L. D., Lifton, C. K., & Epperson, C. N. (2013). Management of postpartum depression. *Journal of Midwifery & Women's Health, 58*(6), 643-653. https://doi.org/10.1111/jmwh.12104

Hardy, L. T., Reichenbacker, O. L. (2019). A practical guide to the use of psychotropics during pregnancy and lactation. *Archives of Psychiatric Nursing 33*(3), https://doi.org/10.1016/j.apnu.2019.04.001

Howard, L. M. & Khalifeh, H. (2020). Perinatal mental health: a review of progress and challenges. *World Psychiatry, 19*(3), 313-327. https://doi.org/10.1002/wps.20769

Hsing-Fen, T., Skalkidou, A., Lindskog, M., & Gredeback, G. (2021). Maternal childhood trauma and perinatal distress are related to infants' focused attention from 6 to 18 months. *Scientific Reports, 11*(24190). https://doi.org/10.1038/s41598-021-03568-2

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients.* American Psychological Association.

Kiekens, G., Hasking, P., Boyes, M., Claes, L., Mortier, P., Auerbach, R. P., Cuijpers, P., Demyttenaere, K., Green, J. G., Kessler, R. C., Myin-Germeys, I., Nock, M. K., & Bruffaerts, R. (2018). The association between non-suicidal self-injury and first onset suicidal thoughts and behaviours. *Journal of Affective Disorders, 29,* 171-179. https://doi.org//10.1016/j.jad.2018.06.033

Kleiman, K., & Wenzel, A. (2017). Principles of supportive psychotherapy for perinatal distress. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*(6), 895-903. https://doi.org/10.1016/j.jogn.2017.03.003

Kleiman, K. (2017). *The Art of Holding in Therapy: An Essential Intervention for Postpartum Depression and Anxiety* (1st ed.). Routledge.

Klonsky, E. D. (2007). The functions of deliberate self-injury: a review of the evidence. *Clinical Psych. Review*, *27*(2), 226-239. https://doi.org//10.1016/j.cpr.2006.08.002

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory rooted in the "idea to action" framework. *International Journal of Cognitive Therapy*, *8*(2), 114-129.

Klonsky, E. D., Victor, S., & Saffer, B. Y. (2014). Nonsuicidal self-injury: what we know, and what we need to know. *Canadian Journal of Psychiatry*, *59*(11), 565-568. https://doi.org/10.1177/070674371405901101

Knight, Z. G. (2020). Empathy as core to the development of holding and recognition: the case Garret. *Research in Psychotherapy*, *23*(2). 180-188. https://doi.org/10.4081/rippo.2020.457

Krzemieniecki, A. J. & Doughty Horn, E. A. (2022). Counseling clients with postpartum posttraumatic stress disorder: a feminist-trauma approach. *Journal of Mental Health Counselling*, *44*(2), 117-132. https://doi.org/10.17744/mehc.44.2.02

Lega, I., Maraschini, A., D'Aloja, P., Andreozzi, S., Spettoli, D., Giangreco, M., Vichi, M., Loghi, M., Donati, S., the Regional Maternal Mortality Working Group, Alberico, S., Antonelli, A., Asole, S., Basevi, V.,Borsari, S., Cetin, I., Dardanoni, G., Di Lallo, D., Dubini, V., & Germinario, C. (2020). Maternal suicide in Italy. *Archives of Women's Mental Health*, *23*(2), 199–206. https://doi.org/10.1007/s00737-019-00977-1

Li, S., Yaseen, Z.S., Kim, H., Briggs, J., Duffy, M., Frechette-Hagan, A., Cohen, L. J., & Galynker, I. I. (2018). Entrapment as a mediator of suicide crises. *BMC Psychiatry 18*(4) https://doi.org/10.1186/s12888-018-1587-0

Locher, B., & Prügl, E., (2001). Feminism and constructivism: Worlds apart or sharing the middle ground? *International Studies Quarterly*, *45*(1), 111-129. https://www.jstor.org/stable/3096103

MacQueen, G. M., Frey, B. N., Ismail, Z., Jaworska, N., Steiner, M., Van Lieshout, R. J., Kennedy, S. H., Lam, R. W., Milev, R., Parikh, S. V., Ravindran, A .V., & the CANMAT Depression Work Group. (2016). Canadian network for mood and anxiety treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: section 6. Special populations: youth, women and the elderly. *The Canadian Journal of Psychiatry*, *6*(19), 588-603. https://doi.org/10.1177/0706743716659418

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organized peer support in pregnancy and early parenthood: a qualitative study. *BioMed Central, 17*(28), 1-14. https://doi.org/10.1186/s12884-017-1220-0

Minaker, J. (2012). The space between. In G. Wong, (Ed.), *Moms gone mad: Motherhood and madness, oppression and resistance*, (pp. 124-140). Demeter Press.

Muzik, M., Brier, Z., Menke, R. A., Davis, M. T., & Sexton, M. B. (2016). Longitudinal suicidal ideation across 18-months postpartum in mothers with childhood maltreatment histories. *Journal of Affective Disorders, 204,* 138–145. https://doi.org/10.1016/j.jad.2016.06.037

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee S. (2008). Suicide and suicidal behaviour. *Epidemiologic Reviews, 30*(1), 133-154. https://doi.org/10.1093/epirev/mxn002

Norcross, J. C., (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (pp.113-141). American Psychological Association. https://doi.org/10.1037/12075-004

Nugent, A. C., Ballard, E. D., Park, L. T., & Zarate, C. A. (2019). Research on the pathophysiology, treatment, and prevention of suicide: practical and ethical issues. *BMC Psychiatry, 19,* 332-334. https://doi.org/10.1186/s12888-019-2301-6

Nunnery, R., Fauser, M., Hatchuel, E., Jones, M. (2021). The use of dialectical behavioural therapy (DBT) techniques creatively in the treatment of perinatal mood and anxiety disorders. *Journal of Counselling Research and Practice, 6*(2), 16-32. https://egrove.olemiss.edu/jcrp/vol6/iss2/1

Oates, M. (2009). The confidential enquiry into maternal deaths 1997-2005: Implications for practice. *Psychiatry, 8*(1), 13-16. https://doi.org/10.1016/j.mppsy.2008.10.013

Onah, M. N., Field, S., Bantjes, J., & Honikman, S. (2017). Perinatal suicidal ideation and beahaviour: psychiatry and adversity. *Archives of Women's Mental Health, 20*(2), 321-331. https://doi.org/10.1007/s00737-016-0706-5

Patrick, K. (2013). It's time to put maternal suicide under the microscope. *Canadian Medical Association Journal, 185*(13), 1115. https://doi.org/10.1503/cmaj.131248

Perlman, C. M., Neufeld, E., Martin, L., Goy, M., & Hirdes, J. P. (2011). *Suicide risk assessment inventory: A resource guide for Canadian health care organizations*. Ontario Hospital Association and Canadian Patient Safety Institute.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Reid, H. E., Pratt, D., Edge, D., Wittkowski, A. (2022). Maternal suicide ideation and behaviour during pregnancy and the first postpartum year: a systematic review of psychological and psychosocial risk factors. *Frontiers in Psychiatry*, *13*, 765118. https://doi.org/10.3389/fpsyt.2022.765118

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103. https://doi.org/10.1037/h0045357

Sexton, M. B., Hamilton, L., McGinnis, E.W., Rosenblum, K. L., & Muzik, M. (2015). The roles of resilience and childhood trauma history: main and moderating effects on postpartum, maternal mental health and functioning. *Journal of Affective Disorder*, 174, 562-568. https://doi.org/10.1016/j.jad.2014.12.036

Shneidman, E. S. (1993). Suicide as psychache. *The Journal of Nervous and Mental Disease*, 181, 145–147. https://doi.org/10.1097/00005053-199303000-00001

Sit, D., Luther, J., Buysse, D., Dills, J. L., Eng, H., Okun, M., Wisniewski, S., & Wisner, K. L. (2015). Suicidal ideation in depressed postpartum women: Associations with childhood trauma, sleep disturbance and anxiety. *Journal of Psychiatric Research, 66-67*, 95-104. https://doi.org/10.1016/j.jpsychires.2015.04.021

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research.* Sage.

Smith, J. A. & Osborn, M. (2008) Interpretative phenomenological analysis. In J. A. Smith (Ed.) *Qualitative psychology: A practical guide to research methods* (pp. 53-80). Sage.

Starcevic, V., Eslick, G. D., Viswasam, K., & Berle, D. (2020). Symptoms of obsessive-compulsive disorder during pregnancy and the postpartum period: a systematic review and meta-analysis. *Psychiatric Quarterly*, *91*, 965-981. https://doi.org/10.01007/s11126-020-09769-8

Statistics Canada. (2013). *Maternal Mortality in Canada*, Catalogue number HP32-7/2011E-PDF. https://publications.gc.ca/site/eng/403762/publication.html

Stein D. J., Chui, W. T., Hwang, I., Kessler, R. C., Sampson, N., Alonso, J., Borges, G., Bromet, E., Bruffaerts, R., de Girolamo, G., Florescu, S., Gureje, O., He, Y., Kovess-Masfety, V., Levinson, D., Matschinger, H., Mneimneh, Z., Nakamura, Y., Ormel, J., …Nock, M. K. (2010). Cross-national analysis of the associations between traumatic events and suicidal behavior: Findings from the WHO world mental health surveys, *PLoS ONE 5*(5), e10574. https://doi.org//10.1371/journal.pone.0010574

Surgenor, P. W. G. (2015). Promoting recovery from suicidal ideation through the development of protective factors. *Counselling and Psychotherapy Research*, *15*(3), 207-216. https://doi.org/10.1002/capr.12035

Tabb, K. M., Gavin, A. R., Guo, Y., Huang, H., Debiec, K., & Katon, W. (2013). Views and experiences of suicidal ideation during pregnancy and the postpartum: Findings

from interview with maternal care clinic patients. *Women's Health 53*(5), 519-535. https://doi.org/10.1080/03630242.2013.804024

Takeda, S., Takeda, J., Murakami, K., Kubo, T., Hamada, H., Murakami, M., Makino, S., Itoh, H., Ohba, T., Naruse, K., Tanaka, H., K, Kanayama, N., Matsubara, S., Sameshima, H., & Ikeda, T. (2017). Annual Report of the Perinatology Committee, Japan Society of Obstetrics and Gynecology, 2015: Proposal of urgent measures to reduce maternal deaths. *Journal of Obstetrics Gynaecology*, *68*(6), https://doi.org/10.1111/jog.13184

Tebeka, S., Le Strat, Y., De Premorel Higgons, A., Benachi, A., Dommergues, M., Kayem, G., Lepercq, J., Luton, D., Mandelbrot, L., Ville, Y., Ramoz, N., Tezenas du Montcel, S., IGEDEPP Groups, Mullaert, J., & Deubertret, C. (2021). Prevalence and incidence of postpartum depression and environmental factors: The IGEDEPP cohort. *Journal of Psychiatric Research, 138,* 366-374. https://doi.org/10.1016/j.jpsychires.2021.04.004

The Lancet (2012). Bring postnatal depression out of the shadows. *The Lancet, 380*(9854), 1621. https://doi.org/10.1016/S0140-6736(12)61929-1

Tripathy, P. (2020). A public health approach to perinatal mental health: Improving health and wellbeing of mothers and babies. *Journal of Gynecology Obstetrics and Human Reproduction, 49.* https://doi.org/10.1016/j.jogoh.2020.101747

Vangen, S., Bødker, B., Ellingsen, L., Saltvedt, S., Gissler, M., Geirsson, R. T., & Nyfløt, L. T. (2017). Maternal deaths in Nordic countries. *Acta Obstetricia et Gynecologica Scandinavica, 96,* 1112-1119. https://doi.org/10.1111/aogs.13172

Weston, K. (2018). Maternal death rates drop, maternal suicide remains high. *Kai Tiaki/Nursing New Zealand, 24*(6), 7.

Williams, J., Ryan, D., Thomas-Peter, K., Cadario, B., & Li, D. (2014). *Best practice guidelines for mental health disorders in the perinatal period*. BC Reproductive Mental Health Program & Perinatal Services BC.

Winter, D., Bradshaw, S., Bunn, F., & Wellsted, D. (2013). A systematic review of the literature on counselling and psychotherapy for the prevention of suicide: 2. Quantitative outcome and process studies. *Counselling & Psychotherapy Research, 13*(3), 164–183. https://doi.org/10.1080/14733145.2012.761717

Chapter 5. Manuscript II: "Feeling Like a Failure as a Mother": Stories of Perinatal Suicidality to Recovery

Abstract

This exploratory qualitative study involved eight Canadian mothers who shared their lived experiences of recovery from perinatal suicidality following counselling. Participants were interviewed for an interpretative phenomenological analysis (IPA) study focused upon therapeutic factors contributing to diminished suicidality. Analysis of the semi-structured interviews illuminated rich narratives of mothers' stories of perinatal suicidality and recovery that contribute to filling gaps in understanding of recovery following effective therapy. While not characteristic of an IPA manuscript, the stories of the mothers further highlight feeling like a failure as a mother through key challenges of "shame," "guilt," "pretending to be a happy mom," and "slipping through the healthcare cracks," which are associated with experiencing a perinatal mood disorder (PMAD) and suicidality.

Key words: Counselling, recovery, perinatal suicidality, shame, perinatal mood and anxiety disorders, life experiences

"Feeling Like a Failure as a Mother": Stories of Perinatal Suicidality to Recovery

In this study, eight mothers were interviewed for an IPA study guided by the following research question: *What are the lived experiences of mothers' recovery from perinatal suicidality following counselling?* When interviewing these mothers, they revealed the power in hearing other women's stories who had suffered from a perinatal mental health disorder (PMAD) and made it through to the other side (i.e., living and thriving), inspiring their own recovery. Further, the mothers shared that hearing other women's stories of recovery from a PMAD made them feel hopeful, connected, validated, and empowered. Mothers disclosed they found it difficult to find other women who experienced suicidal thoughts in the perinatal period, and it was also hard for them to share their stories because of shame and stigma attached to speaking about suicidality as a mother. Considering the impact of mothers' stories of PMADs and the silencing effect of shame, the purpose of this manuscript is to share stories of mothers experiencing suicidality.

As such, a collection of mothers' stories of PMADs and suicidality is important to share not only honour the mothers'(participants') stories, but also: (1) that when other women are searching to hear or see themselves in the words of another, they can find the stories that provide the connection they are looking for (which fosters hope); (2) broadly, the dissemination of stories about mothers experiencing suicidality minimizes stigma; (3) more specifically, mothers disclosed after the interview that sharing stories of themselves was healing; (4) the stories provide hope in knowing that mothers will make it through the darkness of a PMAD and suicidality; and (5) the stories provide detailed lived

experiences of mothers' recovery from perinatal suicidality which informs healthcare professionals.

Overview of PMADs

PMADS are the most common complication of pregnancy and childbirth (Howard & Khalifeh, 2020) affecting approximately 15% to 21% of women and childbearing individuals (Byrnes, 2018). PMADs include prenatal depression or anxiety, postpartum depression (PPD), postpartum anxiety (PPA) or panic disorder, perinatal obsessive-compulsive disorder (P-OCD), postpartum post-traumatic disorder (P-PTSD), bipolar mood disorder, and postpartum psychosis (PP; Byrnes, 2018; Williams et al., 2014). There is the potential that all women can develop a PMAD, regardless of culture, age, race, and socioeconomic status, (World Health Organization, 2018). Symptoms can appear anytime during pregnancy and the first 12 months after childbirth (Byrnes, 2018) However, recovery is possible and there are effective and well-researched treatment options (MacQueen et al., 2016). A devastating consequence to untreated PMADs is suicide.

Perinatal Suicide

Suicide is a leading cause of maternal death in high income countries (Goldman-Mellor & Margerison, 2019; Grigoriadis et al., 2017; Lega et al., 2020; Oates, 2009; Takeda et al., 2017; Vangen et al., 2017; Weston, 2018). Mothers experiencing perinatal suicidality reported a rapid onset of suicidal thoughts following feeling like a failure as a mother, self-identifying as a "bad mother", and becoming defeated and entrapped (Reid et al., 2022a). Furthermore, mothers who died by suicide during the perinatal period are more likely to use a violent method of suicide such as hanging, drowning, jumping, or a

firearm (Grigoriadis et al., 2017; Khalifeh et al., 2016; Knasmüller et al., 2019). Additionally, the loss of a mother to suicide has devastating consequences, to the woman's loss of life, and to that of her family, community, and society as a whole. Currently, the majority of research in the area focuses on risk factors for perinatal suicidality (Reid et al., 2022b) such as mothers history of ACES (adverse childhood experiences)(Ammerman et al., 2019; Muzik et al, 2016; Sit et al., 2015), exposure to IPV (Alhusen et al., 2015; Ammerman et al., 2019; Gavin et al., 2011; Gold et al., 2012; Onah et al., 2017), sleep disturbances (Sit et al., 2015), personal or family history of mental health disorders (Mangla et al., 2019) and experiencing a PMAD (Huang et al., 2012; Khalifeh et al., 2016; Sit et al., 2015). As such, there exists a paucity of formalized research of mothers' lived experiences of perinatal suicidality and recovery.

Power of Story

Indeed, research has shown that hope is important to recovery (Leamy et al., 2018). Hope ignited in people struggling with their mental illness when they were exposed to stories and experiences of others with similar mental health diagnosis (Honey et al., 2020; Yeung et al., 2020). The literature underscores the fact that exposure to lived experience of others with a similar mental health issue promotes increased knowledge; reflection concerning personal mental health healing journey; lessened loneliness; and helps people feel empowered to explain their situation to others (Yeung et al., 2020). Furthermore, mothers hearing other mothers' stories was a significant buffer to experiencing suicidal ideation (Praetorius et al., 2020). In this study, mothers felt relieved when they heard that other mothers experience PMADs and are, at the same time,

capable of raising children who thrive. In other words, knowing it is possible to be diagnosed with a PMAD and be considered a "good mom", gave hope.

Method

This study was informed by a feminist constructivist research paradigm. The data collection followed IPA methods (Smith et al., 2009). The following stories are narratives of each mothers' experiences gleaned from semi-structured interviews from the researcher's perspective. Approval was obtained from the Athabasca University Ethics Review Board. The procedures used in this study adhered to the tenets of the Tri-council policy statement: Ethical conduct for research involving humans (TCPS 2: core).

Demographics and Study Procedures

A detailed account of recruiting, sampling, and data collection can be found in the manuscript titled: Perinatal Suicidality: Mother's Experiences of Recovery Following Counselling (edit in process). Overall, eight Canadian mothers between the ages of 29 to 46 (m=35) provided insight into their stories of perinatal suicidality and recovery following counselling. Mothers' experiences of perinatal suicidality were from 6 months recovered up to 20 years ago. Seven mothers identified as heterosexual, and one identified as bisexual. In terms of cultural background, six mothers were white, one was Chinese, and another was a mix of Caucasian and Indigenous.

Data collection occurred over 5 months (August to December, 2021). Informed consent was obtained from participants for video and audio recording of the semi-structured interview which was conducted over Zoom inc. Zoom recordings were transcribed verbatim by the first author (V.V.). Member checks were completed at two different times; first, the mothers provided feedback and approval of the transcripts and

secondly, a draft version of their story. One mother provided minor clarification changes, one mother emailed their approval of the original transcript, and the other mothers indicated approval through non-reply to the email. Four mothers emailed their approval of their story, one mother provided minor clarification changes, and the other mothers indicated approval through non-reply to the email. Mothers expressed gratitude for receiving their story.

The following stories capture the experiences of eight Canadian mothers and their recovery of perinatal suicidality following counselling. Sophia[6], Grace, and Patricia's stories are longer in format given the complexity of their experiences. Sophia's story is longer due to capturing the detail of betrayal in the medical system and highlighting the difficulty in receiving adequate postpartum mental health support. For Grace and Patricia, the length of their stories was in order to document the multiple suicidal experiences with each subsequent child and multiple counselling experiences. Each story follows the mothers' experiences vis-a-vie her expectations versus the lived reality, which spiralled into enhancing PMAD, her fortitude in seeking help, and her path to recovery. While all the mothers experienced the following themes: "shame," "guilt," "the mask of motherhood," and "slipping through the healthcare system," certain stories illuminate each theme more powerfully. What follows is a description of these themes and the mothers' stories that bring them to life.

Shame

Throughout the stories from eight mothers involved in this study, shame resonated throughout their narratives from; not enjoying their baby, having thoughts of

[6] Pseudonyms were used to protect the anonymity of participants.

suicide, hating breastfeeding, feeling like a failure as a mother, self-harm, wishing the baby was never born, being angry, and missing the pre-mother-self. Shame was one of the most prominent themes within the context of perinatal suicidality for these mothers. The construct of shame has been defined as a psycho-social-cultural construct in which a woman experiences extremely painful feelings of believing they are flawed "therefore unworthy of acceptance and belonging" (Brown, 2006, p. 45). The real or perceived failure of meeting cultural expectations leads to shame (Brown, 2006).

When mothers believe they did not meet their ideal standard of a good mother, which was found to be influenced by patriarchal societal expectations, it fuels feelings of shame (Law et al., 2021; Liss et al., 2013). Women experiencing shame, as opposed to guilt, has serious psychological consequences, such as feeling trapped, powerless, isolated (Brown, 2006) and a stronger link to depression (Caldwell et al., 2021; Law et al., 2021; Rotkirch & Janhunen, 2010). Moreover, shame is intensified if the mother thinks she is going to be judged by others based on her mothering capabilities (Liss et al., 2013). For example, mothers who experience difficulties with breastfeeding felt shame because they perceived this as failing as a mother (Hanell, 2017; Jackson et al., 2022; McIntyre et al., 2018).

Shame had a circular effect in exacerbating suicidality. That is, a mother would have a negative self-evaluation (e.g., *I hate breastfeeding*[7]), feel shame, spiral to another negative self-evaluation (e.g., *I am a bad mom*), experience more shame, spiral to thoughts of suicide (e.g., *my children are better off without me*), feel shame for experiencing suicidal thoughts as a mother, and the cycle continues. Courtney described

[7] Quotes from mothers are represented by italicized writing

how her recovery from suicidality was possible when she started to address the shame. Kleiman (2017) asserted that in therapy, "if you do not address the shame, you only scratch the surface" (p. 53). Herein, I describe how Courtney and Grace's stories exemplify suicidality, shame, and the journey to recovery.

Courtney

Courtney is a mother of two children. In the interview, I find Courtney to have a calming presence about her that exudes motherly wisdom. She shares that during her pregnancy, she did not have other women's stories of PMADs to guide her or let her know PMADs are highly treatable. During her pregnancy she experienced crippling shame that prevented her from seeking help until it was almost too late. She passionately shares her story with me with the purpose to end stigma around PMADs in hopes that other women do not have to suffer alone in silence with their shame.

Expectations Versus Reality

Courtney expected that pregnancy and motherhood would come naturally to her because she is a woman. However, based on her own upbringing doubts and fears started to fill her mind, she pondered if she would be a *good* mom. To complicate matters, her husband was not overly supportive of the pregnancy. At that time, she did not have many close friends and was quite isolated. Courtney read everything she could get her hands on to prepare for motherhood, but found all the information prodigious, which added to the fear of motherhood. Overwhelmed by motherhood, Courtney started to question if she even had the skills to become a mother.

Spiraling Into Depression and Anxiety

At her first prenatal doctor's appointment, Courtney disclosed that she had a history of depression and if needed she was open to taking medication throughout the pregnancy. The doctor suggested staying off anti-depression medications. As a result, she struggled and described *white knuckling it* for 7 months of pregnancy. She experienced obsessive thoughts, anxiety, and fear and she coped by self-harm. She recounted her feelings of shame and how it prevented her from asking for help from her doctor. In fact, Courtney hoped and waited for her doctor to ask about her mental health during an appointment, but they never asked, and she never mentioned her struggles. Courtney confessed to me:

> *I didn't want to admit to it [self-harm] because I felt like that would mean I failed. This [motherhood] is the one thing that is supposed to come naturally. My body should know how to do this. I should know how to do this. That disconnect between the way I felt and what I thought society expected of me, made it even harder to get through the day.*

Seeking Help

Courtney's younger sister recognized that Courtney's mental health was suffering during her pregnancy and asked her to come live with their family so that they could provide support. Courtney moved to a different town, back into their family home, but she continued to self-harm. She reflects that in hindsight it was probably not helpful to move into her family home as the family dynamics were tumultuous. As the pregnancy progressed, she started questioning if the baby might also struggle with mental health issues. Given this fear of her baby one day being in emotional pain, she started to make a plan for suicide.

Courtney shared her plans for suicide with a family member and they decided it was time to ask for professional help; they called the local crisis response team. As a

result, she was admitted into the psychiatric ward at the local hospital, which, upon reflection, Courtney said she knew she needed, as it led to a turning point in her mental health. For the first time during her pregnancy, she started to take antidepressant medication and engaged in counselling at the hospital. Courtney realized she had a choice to move forward with the pregnancy and choose life over death.

> *Just by talking it out… it was kind of a hard reset, to be in the hospital, to realize that it had gotten this bad. I got two ways I can go…I am either going to finish off what I think I started with suicide or I am going to go forward and take care of this baby and do the best that I can.*

While Courtney was starting to shift towards wanting to live, shame was still prominent, and fears about being a bad mom lingered. Courtney reflected:

> *I had worries, that somehow because I had gotten myself into the [health] system that one day a social worker was going to land on my doorstep and tell me that I wasn't fit to be a mom. So, there's some fear in seeking out help that I think, that if it was easily explained up front, it might have been a bit better.*

Recovery

Courtney described her recovery in counselling began with addressing the shame attached to having thoughts of suicide while being pregnant. She explained that part of this process was accepting the reality that she was having suicidal thoughts. Courtney learned grounding techniques, wrote in a journal, and made it a priority to build her support network. Courtney felt quite isolated in her experience of suicidality while pregnant. Despite the enduring shame she felt, she started to identify people who were trustworthy, people who she could share her struggles with.

> *The biggest part of it that I struggled with was the shame around it [suicidality]. And so, just detaching that from who you are [I am] as a person… what kind of mother you are [I am] going to be… all of that. If you [I] can just separate that out. I would have loved to have found a group of mothers who were feeling the same way or have experienced it in some way. I would have loved to have had some stories to follow, to just make me feel so not alone. It's very isolating. It's so*

> *isolating. So, any way that you can possibly, gently, bring somebody out to talk about it, and even just listen [to] it, I think would be so helpful.*

Courtney found it helpful once the baby was born: he was here, concrete, a responsibility, and a focus for her attention. She described the initial postpartum period as a bit chaotic as she did not have much support. She did not establish a schedule and she just followed the needs of her baby. Her baby started sleeping through the night at two weeks old and that really helped her to sleep, which she thinks helped her cope. At around 6-8 months postpartum, Courtney celebrated the fact that she was mothering with perinatal depression; she felt proud to be a mom. She knew that having a PMAD did not make her a bad mother and overcoming the PMAD made her feel stronger. The experience of a PMAD increased her understanding and feeling of readiness to embrace whatever mental health issues her son may face in the future. She shares, *I feel lucky that he has had me as a mom… sounds like such an egotistical thing; but I'm glad he has a parent who is ready to accept mental health issues.*

When Courtney shares her story with me, she describes that there are still deep emotions that stirred within her chest as her body remembers the intensity of that stage in her life. She is surprised at the acuteness of negative emotions. Despite the passing of time, shame is a powerful emotion with lingering memories in her body. As she talks, the emotion shifts; and there is happiness and joy present because in the end, she overcame the suicidal thoughts. Approximately 15 years later, Courtney has not experienced any suicidal thoughts since her time spent in the hospital.

Grace

Grace, a mother of 4 children, was surprised at how each pregnancy, birth, and postpartum experience was unique with each child. She first experienced suicidality

during her second pregnancy. Grace took medication for depression and anxiety throughout her third and fourth pregnancies. The image that stuck in my mind from our interview was Grace taking her toddlers to a swimming lesson, visibly pregnant, surrounded by other moms and their toddlers, but Grace was wearing a bright pink long sleeve swim top to hide the scars of self-harm on her arms. Essentially, she was hiding the excruciating shame she felt for being suicidal while pregnant behind a mask, pretending to be a happy, not a self-injuring, mom.

Expectations Versus Reality

Grace observed pregnancy and motherhood as being comfortable, easy, and effortless for her mom. She witnessed her own mother giving birth to two of her siblings, so she figured she had a realistic expectation of what to expect for birth. Grace's first pregnancy was filled with excitement; however, the birth was a traumatic experience. Grace severely hemorrhaged after the baby was born and thought that she was going to die. After coming home from the hospital, Grace experienced anxiety about her baby's ability to thrive. She relayed that she would often check that the baby was breathing. She also talked about having an *intense feeling of doom* that lingered during that period in her life, that something bad was going to happen, that either her or her baby *was going to die*.

Spiraling Into Depression and Anxiety

At 10 months postpartum Grace found out she was pregnant with her second child; she was not planning for this baby and was quite emotional throughout the pregnancy. Adding to the stress, her *marriage was in a bad place*, she *felt trapped* in her marriage, and *the idea of divorce feels like the big sin.* Grace did not have continuous

care with a midwife throughout her pregnancy; she saw a different midwife at each appointment. She started experiencing thoughts of suicide but did not share this with a midwife as she did not feel comfortable disclosing such shameful thoughts to someone she just met. Luckily, the thoughts of suicide went away after the baby was born.

When Grace became pregnant with her third baby, she and her husband were attending marriage counselling. She felt trapped in the relationship and was physically isolated where she lived and shared a vehicle with her husband so she could not always leave the house. She did not have any friends in the community, which added to her feelings of loneliness. Grace experienced anxious thoughts that spiraled into self-hatred and thoughts of suicide.

Suicidal thoughts brought confusion and cognitive dissonance. On one hand it provided relief, like *seeing the end of a marathon*; however, on the other hand it created a reaction of being *horrified for thinking about suicide while pregnant*. These thoughts brought on feelings of intense guilt and destructive shame for thinking about suicide while she was pregnant. Grace stated:

> *Probably at the peak of my suicidality of wanting to take my life with my third and knowing that I couldn't while I was pregnant… There was so much self-hatred at that point. I think a lot of it came from the conflict of wanting to take my own life, wanting to escape from my life, and not feeling like I could.*

At the peak of suicidality, Grace disclosed to me that she self-harmed to cope with the suicidal thoughts and to punish herself for having suicidal thoughts. She recalled the anticipation of waiting for the curling iron to heat up, the feeling of relief in being able to act on the suicidal thoughts; not killing herself but being able to hurt herself. The burn marks on her arms served as painful reminders and filled her with guilt and shame. It was at this time that she took her kids to the indoor pool. Grace shared:

> *I remember I had to take my two little ones to swimming lessons, and I scrambled and bought a long sleeve swim top. Feeling so broken and like this horrible mother, because I was quite pregnant at that point, I was definitely in my third trimester, with my toddlers in swimming lessons, with all the other moms, feeling like I was hiding this hatred underneath this like bright pink long sleeve swim top.*

Seeking Help

One day, Grace's sister unexpectedly arrived for a visit and found Grace in a fetal position on the bathroom floor crying and screaming. Grace's sister facilitated a conversation between Grace and her husband. That was a turning point in realizing she needed professional support for her mental health. Grace went to their marriage counsellor, who directed her to public health addictions and mental health. Grace remembers sitting in the waiting room feeling embarrassed and shameful. She said:

> *There was shame around that, like I'm supposed to be glowing. You know, in this wonderful part of my life, or the worst thing that is supposed to be happening is my ankles are swelling...*

Recovery

Grace appreciated that her counsellor was articulate, smart, calm, and understanding. She felt comfortable discussing her suicidal thoughts with the counsellor right away. Initially the counsellor focused on building emotional regulation skills to manage the thoughts of suicide. Grace found it helpful to fill a bowl with ice and water and stick her face in it, use affirmations, prayer, and practice more self-care. Grace described recovery as a slow process that involved working through past trauma. For example:

> *I feel like it [recovery] is a lot of unlearning of things and that the suicidality, for me, is so connected to many other things. It [suicidality] is kind of the final turn of a lot of other thoughts, feelings, and anxieties that come before that. Working through all of those precursor kind of things has been really important.*

Grace found it helpful to learn about PMADs. This knowledge allowed her to have more self-compassion and empathy around experiencing suicidal thoughts. Grace remarked that she became better at noticing the suicidal thought, letting it be, and not latching onto the thought with guilt. Grace would have liked to continue to see her counsellor, but her counsellor had moved on to a new position.

When Grace became pregnant with her fourth baby, she had one midwife from start to finish and she candidly shared with her midwife about her mental health history. Towards the very end of her pregnancy, approximately 5 days before her due date, she could feel herself getting to a point of knowing the suicidal thoughts were coming. The midwife suggested they induce labour as in the past it seemed to help Grace's mental health once the baby was born. In the hospital, Grace met with a mental health liaison, two psychiatrists, was connected to a new counsellor, and the nurses checked in regularly with specific questions about her mental health. Reflecting on this past birth experience, Grace was content with how everything lined up. She shared that it felt good to be taken seriously by medical staff and to be proactive in preventing her mental health from declining. She still struggled with feelings of shame and feeling broken: *I was trying to disassociate myself from feeling like, oh my gosh, my baby is not even ready to be born yet and I am kicking them out because of this [suicidal thoughts].*

Today, Grace knows she is a good mom and enjoys being a mom. While reflecting on her past pregnancies and postpartum periods she feels grief and guilt around being an *emotional parent.* She acknowledges that her children witnessing her experience postpartum mental illness and recovery provides them with opportunities to learn empathy, understanding, and develop emotional intelligence. Nowadays, Grace notices

her children are well adjusted, loving, and compassionate. She is on her postpartum journey with her fourth child; and excitedly shared that this has been her best new-born experience. She had not had any suicidal thoughts since the baby was born.

Guilt

Guilt and shame seem to come hand in hand when experiencing suicidality in the perinatal period, but they are conceptually different. Brown (2006) defines guilt "as a feeling that results from *behaving* in a flawed or bad way" (p .45). Indeed, it is well documented that mothers reported feeling maternal guilt when they perceived that they did not live up to, or behave in accordance with societal expectations of motherhood– or the unattainable standards of *motherhood myths* (Constantinou et al., 2021; Liss et al., 2013; Rotkirch & Janhunen, 2010). These myths include: intensive mothering (Hays, 1993), the perfect mother, attachment mothering, or the bad mom (Wong, 2012).

Hays (1996) believed that motherhood myths led to intensive mothering. The *Intensive mothering* ideology describes the unattainable standard that a mother must achieve in order to be considered a *good* mother (Hays, 1996). Intensive mothering ideology concludes the mother is: solely responsible for her children; completely fulfilled by her children (i.e., self-sacrificing); provides consistent intellectual stimulation for her child (i.e., expert-guided); child-centred in that her life revolves around her child; gives copious amounts of time and energy to her children (i.e., labour-intensive; Hays, 1996). Guilt undoubtedly arises with these unattainable intensive mothering ideologies that mothers internalize and then are not able to meet (Constantinou et al., 2021).

In this study, mothers shared the following experiences of guilt: guilt for having suicidal thoughts while pregnant, guilt for not enjoying their newborn baby, guilt for not

wanting to cuddle or spend time with their newborn baby, and guilt for struggling with breastfeeding. While these experiences of guilt are, aside from having suicidal thoughts, quite common. The stories of Mel and Xena highlight the extreme guilt that mothers can experience and how suicidality intensifies guilt and guilt intensifies suicidality.

Mel

Mel, a mother of two children, captures my attention with her down-to-earth and pragmatic attitude. When we began the interview, she was quick to answer questions with a very candid expression on her face. Throughout our interview, she mentions the immense guilt and shame she felt during the postpartum period for not being happy or enjoying her baby. The incongruity between societal expectations of motherhood being a wonderful and joyful time and her lived experience of motherhood being challenging, added immensely to her guilt and shame. She talks about feeling isolated in her experience, which I know is not uncommon for mothers to feel alone. I admire the courage it takes to share her story of guilt with me.

Expectations Versus Reality

Mel describes her pregnancy as *fantastic; everything went smoothly* which led her to believe that once her baby was born it would be a fairy tale ending of *happily ever after that everybody was looking when they get their child*. Mel expected that she would love all aspects of having a newborn and felt pressure to *enjoy* her baby. But, shortly after her daughter was born, Mel started to struggle with day-to-day tasks, finding that taking care of her baby took substantial effort. This was not the beginning of the fairy tale ending she imagined. Mel shared:

> *I started to feel that guilt of why am I not enjoying this? I thought I was supposed to be happy… I started that whole guilt process that adds to my mindset. Because*

> *that [guilt] is what I kept feeling. I thought this was supposed to be fun. I thought this was supposed to be good. Why do I not want to spend time with my child? Cuddle her? I felt guilty. That is the last thing I should be feeling when I am depressed. It [guilt] just adds to it [depression].*

Spiralling Into Depression and Anxiety

Mel describes the postpartum period as going through the motions: *robotic, empty shell, hollow, drowning, not wanting to be around her baby, a negative downward spiral,* and *thoughts of suicide* into what would later be diagnosed, at 8 months postpartum, as PPD. Mel reflected to me that she felt tremendous amounts of guilt for not wanting to be around her baby. Despite how she felt, Mel sensed pressure from society to pretend to be a happy mom in public. Therefore, during Mel's regular postpartum check-ups, she presented herself as a happy mom. Mel suspected that because of her happy front she was not screened for PPD by her primary doctor.

Seeking Help

Mel did not recognize that she was suffering from PPD. She, quite literally thought she was just a bad mother, which filled her with guilt. I reflect to Mel how it was symbolic that she reached out for mental health help on Mother's Day at the urge and stern prompt from her own mother. She recounts,

> *…on Mother's Day my mom called because it was my first Mother's Day. I replied, 'I don't want to be with my child.' She said, 'Get to the hospital right now'… I just didn't want to get up every day. I didn't want to take care of my child. I didn't want to do anything. Right? I was checked out. So, I packed her [daughter] up and my husband took me to the ER."*

I am impressed with Mel's determination and willingness to make her mental health a priority and accept support in the face of her enduring guilt. Initially, after the emergency room visit, Mel and her baby moved to a different town to live with her parents for 6 weeks while the anti-depressant medication took its course. Mel was

grateful for help with childcare. When she moved back home, her mother and sister lived with her for a short period of time, but they did not have an adequate understanding of PPD and they felt frustrated with the lack of progress in Mel's mental health. She was trying to recover from PPD but was faced with barriers, lack of resources, and no direction about how to help herself. After Mel's family left, she appreciated when her mother-in-law would come watch the baby and do housework during the day. This helped relieve the pressure of getting tasks finished while simultaneously caring for her baby.

Mel lived in a small northern town where there was no access to counselling or support groups. As someone determined to get help, she attempted to start a support group herself so that she would not feel so alone. She was so wanting to connect with other moms who understood how she felt. However, as a result of liability issues surrounding the inherent risk with suicidality, she was unable to start the support group. While a group could not be formed, Mel remained resolved on getting better, so she picked up books on depression at the library even though she struggled to read them given the challenge of PPD symptoms such as difficulty focusing and *brain fog*.

Amidst it all, Mel and her husband moved to a new city to start a business. Mel's husband did not understand the PMAD symptoms, which added great struggle and strain in their marriage along with other marital problems. At 14 months postpartum, shortly after the move, Mel felt herself spiralling deeper into her depression. She felt very alone in a new city, which was compounded with the stress of owning a new store. Mel started experiencing thoughts of suicide. While she was driving, she thought, *I could just smash into that pole.* Or, if she saw scissors, she thought, *I could just slit my wrists…* She did

not dwell on these thoughts that popped into consciousness from time to time, nor did she actively make a suicide plan. But, one day, the intensity of the thoughts started to scare her, and she realized she wanted to be there for her baby. So, she asked her husband to drive her to the hospital.

The psychiatrist immediately saw her in the hospital. Mel was given the choice of going to the psychiatric ward or receiving support from her family. She decided it was best for her parents to look after her daughter for approximately 3 months so that she could focus on getting better. The psychiatrist diagnosed Mel with PPD, prescribed her medication, and set her up with a counsellor. The diagnosis provided Mel with relief and understanding of her PMAD symptoms. As Mel reveals her story to me, I am surprised that counselling was mandatory. I also could not help but wonder why Mel did not get to pick her counsellor and was astonished that despite Mel strongly disliking her counsellor, the experience was still effective for her journey to recovery. Mel stated, *she (the counsellor) struck every nerve, but she was effective.*

Recovery

Mel described her recovery as *taking enormous amounts of determination*, a slow process of pushing, and climbing herself out of a hole of depression. Medication was an important part of stabilizing her mood which allowed her to be a present mom for her child. She learned to separate herself from the suicidal thoughts, created small changes in her negative thought patterns by refocusing on the positive, and distracted herself from the suicidal thoughts.

> *I think the first step was recognizing that the suicidal thoughts were coming from the depression. That is not me, this [suicidal thoughts] is a separate identity that has a hold of me.*

As Mel put in the effort to better her mental health, there was no shortage of challenges in her life: she left her husband after an abusive incident. She moved in with her parents for 6 months and then transitioned to living on her own. Mel's parents kept her baby for another 3 months so that she could adjust to balancing work and single parenting. The support that Mel received from her parents allowed her to focus on her self-care and lessen the added pressure of parenting all the time. Mel described knowing she was recovered when she woke up one day and felt like *Mel was back.*

Successive Pregnancy

Fast forward a few years later, Mel was in a new relationship with a man she married. They wanted a baby but she was nervous about getting pregnant for fear that her mental health would decline as it did with her first child. Mel's mother had passed away which worried Mel, given her mother had been a great source of support. She greatly feared experiencing suicidal thoughts again. Nevertheless, Mel became pregnant faster than she expected. In this second pregnancy and postpartum period she did not experience PPD or thoughts of suicide. While pregnant, she was reluctant to stop taking her anti-depression medication; however, it was her psychiatrist's recommendation. Mel happily reports that through working closely with her psychiatrist, having a supportive husband, and benefiting from help from a local pregnancy outreach centre, she experienced no mental illness.

Throughout the years, Mel has openly shared her story of PPD with friends to help them through their postpartum periods. Today, she shares her experience in hopes of normalizing the difficulties of motherhood, bringing awareness about PPD symptoms,

and advocating for women to seek counselling when needed. Mel is passionate about honestly sharing her story so that other women can alleviate the guilt they feel when having a baby does not meet their expectations.

Xena

Xena is a mother to one child. Interviewing Xena feels like a conversation with an old friend; she is personable, funny, down-to-earth, and easy to connect with. She is very detailed in her descriptions, and it evokes a physical response within my body. For example, when she describes the frustration and exhaustion with late night feedings, I can empathise with her struggle and feel the tiredness in my bones.

Expectation Versus Reality

Xena spoke about having an *easy, happy, positive pregnancy* in which she felt very connected to her baby. Xena revelled in her friends' delight and celebration when they learned that she was pregnant. She admits to me that she did not have a lot of experience with babies or young children and she just assumed, similar to Grace and Mel, that the blissful feeling would continue into motherhood. Xena recalled coworkers and friends gently warning her that motherhood is not all bliss; that there are sleepless nights, exhaustion, and feeling of being *touched out from her baby*. She heard the warnings, but they did not really sink in. However, towards the end of her pregnancy, the *bliss* began shifting as she started to grieve how her life could change with the permanent responsibility of having a child.

This was just the beginning of her struggle. Xena described her birth experience as traumatic. After five days of extreme back labour pain, which got progressively worse, she felt her spirit breaking. By the last day, she was crying and recalled explicitly stating

to her husband that she *wanted to die*. It did not get easier at the hospital. The labour did not progress, so a C-section was performed. Certainly not the bliss she had envisioned. Xena felt that this was a bad start into the postpartum period because she was exhausted, in pain, and needed to heal from the c-section. Adding to her exhaustion, she struggled with breastfeeding which was compounded by her baby being jaundiced. This increased the pressure she felt to keep her baby alive. Xena shared:

> *It wasn't just hard. I know what doing hard things feels like, but it was beyond hard, I don't have a word for it… impossible, like everything was impossible. You still need to make it work or your baby would die.*

Spiralling Into Depression and Anxiety

Soon after giving birth, Xena was screened for PPD and PPA by community health nurses when checking the baby's weight. Xena described: *They [community health nurses] used a screening tool… like I will not get a diagnosis unless I see a psychiatrist, so they said I screened for having some concerns of postpartum mental illness.* A community health nurse called Xena to check in every two weeks and referred her to a postpartum counsellor, but she never got connected with the counsellor. Without counseling, she felt like time moved slowly in the first months with her newborn; *there were days where I spent… I would just try to get through the next 10 minutes, the next 15 minutes, the next hour. Lots and lots of days like that in the early months.* At 6 months postpartum, Xena felt like her symptoms of anxiety were abating, but that PPD was worsening.

On top of PPD symptoms worsening, Xena experienced intrusive thoughts of harming the baby. Afterwards, she would experience intense guilt and severe shame which would lead to suicidal thoughts. She also experienced underlying negative

thoughts which intensified feelings of guilt, shame, and confusion. Xena shared examples of her self-critical thoughts:

> *I regretted having a baby… I was frustrated by the lack of sleep… I was not doing the right things to control the baby…I grieved how my life had changed…I was angry at my husband,* [and] *I was resentful that my husband could go to work.*

Everything felt impossible. Suicidal thoughts provided a sense of relief and an escape from reality.

> *I remember one night he woke up and I was nursing him, and I started thinking about, "I really, I just really want to die." I sometimes would pray, but not to a specific god, but I would just pray and say, "end my life now, please just let me die." And so, a lot of those thoughts, "please just let me die" because I didn't want to take my own life. Then sometimes it would escalate, especially after I would nurse him, and he would be crying and screaming, and it would take a couple of hours to get him back to sleep at 2:00 am. If that happened then I would start out with wishing, praying, that I was dead, and then if it keeps escalating it really triggers my fight or flight then I start having pretty violent thoughts.*

Xena described suicidal thoughts of running her head into a wall or slashing her throat. She would punch or bite herself to stop the suicidal thoughts from continuing. Depression rippled into all aspects of Xena's life and this spiralled into questioning her ability as a helping professional in her own life. For example:

> *I don't think I'm cut out to be a parent, I was finding all these reasons that showed me that I'm not equipped to be a parent and then what does that mean about my job and my career? I work as a [helping professional]. Should I even be doing this?*

Seeking Help

Xena found it very helpful to call a postpartum support hotline and they encouraged her to take breaks from caring for her baby, to continue talking to friends, reaching out for help, and to access counselling. She realized self-harm was not a healthy

coping mechanism, which prompted her to invest in a counsellor that specialized in somatic therapy.

Recovery

Xena felt lucky to have a counsellor who was genuine, non-judgemental, displayed unconditional acceptance, and created a safe environment during the sessions. During the counselling sessions, Xena discovered that she experienced childhood traumas and started to process those traumatic experiences with Eye Movement Desensitization and Reprocessin and somatic therapy. She shared:

> *When I think about that [PMAD], one part of it is my heart and another part is my lungs which to me holds sadness, fear, heartbreak, abandonment, and neglect as a child, a lot of that stuff just comes up when I think about my postpartum mental illness.*

Xena's face lights up with happiness when she describes that one of the biggest moments of learning during counselling was understanding that she was not going to hurt her baby and that she was a good mom. It was useful for the counsellor to explain that Xena's behaviour was a triggered reaction into fight or flight mode because of adverse experiences from the past. In counselling, she learned how to ground herself when she felt triggered. She found the following grounding techniques helpful: 5-4-3-2-1, progressive body relaxation, deep breathing, or thinking of a word with each letter of her name. These skills were helpful because she could do these skills while in the presence of her child, without her child noticing that she was grounding herself.

Xena felt like she went through an identity crisis when becoming a mom. Listening to podcasts, *The Longest Shortest Time* and *Adult Conversations*, which are about other women's stories of navigating motherhood, helped formulate her identity as a mother. Talking with close friends about motherhood validated the struggles of

mothering, maternal guilt, and the importance of supporting each other. Xena appreciated that her husband's coworkers, who were a bit older than her, reached out and checked in on her mental health. Through counselling, she came to understand that she does not need to feel guilty about not loving all aspects of motherhood. Xena's self-care was to have guilt-free goals outside of motherhood, to go back to work, and to have time away from her child. She stated: *I know that my strength will come in all different stages of motherhood and I'm learning where my strengths are.*

Today, it is very rare that Xena experiences an intrusive or suicidal thought. Nowadays, if she does experience a fleeting suicidal thought, she compassionately catches herself, and implements guilt-free self-care.

Presenting as a Good Mom

As a way to protect themselves, mothers in this study presented themselves as looking *good*, even when it was detrimental for them to access help from professionals (e.g., doctors, nurses, counsellors, etc.). Law and colleagues (2021) found it was difficult for new mothers to share their negative thoughts, shame, and guilt related to motherhood with others. Looking good and presenting as a good happy mom is a facade to hide the parts that do not fit society's expectations of motherhood. Indeed, motherhood myths play a large role in setting the standards of how to present as a good mom. As well, looking good asserts some control over what can feel like a very out of control period of time in her life (Kleiman, 2017). Further, suppressing feelings and trying to live up to standards of female goodness (Friedan, 1963) are linked with increased mental health challenges. Marie's and Patricia's stories illustrate the pressures of motherhood and how

mothers can present as a *good* mom to convince themselves and others that they are doing *fine*.

Marie

Marie, a mother to 4 children, is tender-hearted and introspective. Throughout Marie's story I can see the *myths of motherhood* attacking her self-confidence. I relate to Marie as she softly shares that she felt overwhelmed with all the different advice on mothering. It is easy to get lost in the pressure to feel that we, as mothers, are doing it correctly. Marie's story serves as a reminder to have self-compassion while sorting out a mothering identity amongst the myths of motherhood. To some extent, these myths are so pervasive that it is common that we are all trying to present as a good mom.

Expectations Versus Reality

Marie expected motherhood to be a time of gathering with extended family to pass down generational knowledge of mothering. Indeed, after the baby was born, she experienced the baby shower, the gathering of friends and family, the excitement of a newborn, but then the shower ended, and the initial elation faded. Now that the baby had arrived, she thought to herself, *I should know what I am doing by this point*. Seeds of doubt started to grow. Marie found herself comparing her mothering abilities to other mothers. Marie presented herself as a good mom, which hindered her from fully connecting with her other mothers, further isolating her. There was contradicting advice given on feeding, sleeping techniques, how to settle the baby, whether to use a soother, and different parenting styles. All the options, opinions, advice, and decisions started to feel like a *pressure-cooker*. As the cold and dark northern Canadian winter blanketed the land so too did a PMAD settle onto Marie's life.

Spiraling Into Depression and Anxiety

Marie was apathetic towards her baby. She fed, clothed, and did the minimal care for her baby. She noticed her mood shifting to a dark place. It was her anger that started to scare her. The experience of anger added a new layer of doubt, confusion, self-judgement, shame, guilt, and self-criticism. Marie described her inner being as *all black snakes slithering around. My whole insides are just like this waste. Desolate. Destruction*. She needed to feel pain and would pound her kitchen floor until her hands hurt. Marie started to believe that other people could parent her child better than her and thought about ending her life. Marie stated: *I had no idea what to do and that confusion really spiraled to my misled conclusion that obviously everybody can do it [parent] better, so they don't need me.*

The suicidal thoughts scared Marie; however, they were also freeing. Suicidal thoughts provided a way to escape reality and to know that this phase of life could be over. When Marie contemplated suicide, she realized suicide was permanent and it would cause great sadness to those left behind. Despite this realization, Marie still did not want to be here. Marie reflected:

> *Lying in bed just trying to come up with the different ideas or options, well the bathtub, maybe I could drown myself, well let's see if I can just sleep and maybe tomorrow, I won't have those thoughts.*

Seeking Help

Marie wanted her husband to see her pain, to be heard, to be understood, and to be validated but she did not know how to share her suicidal thoughts with him. She would hint at her pain. Marie's husband encouraged her to go to counselling. The thick fog of depression made it difficult to think of a good place to get help. In the past at her

baby's vaccination appointments, Marie felt seen, heard, and cared for by the public health nurses; she decided to call them for help. At the appointment, Marie filled out the Edinburgh Postnatal Depression Scale (EPDS). Marie shared:

> *It was easier that it [admitting thoughts of suicide] was in writing. I was just doing the form by myself, then I could give it to her [the nurse] and when she drilled me on it, I just sat quietly and cried. I would not say it felt freeing to open up, but I think a little part inside me was like, "Okay now somebody is going to help me."*

A nurse set up a counselling appointment and promised to call in the next couple of weeks to check in.

Initially, Marie was resistant to attending counselling. At the first counselling appointment, she was adamant that the focus of counselling should be on anger management. When it came to talking to her counsellor, she alluded to thoughts of suicide but had a difficult time stating, *I am suicidal*. Marie shared: *So again, same with my husband, not actually wanting to say, what my darkest thoughts were but just trying to give enough hints, like here is how empty and hollow I am inside right now.* When Marie hinted at thoughts of suicide, she expected the counsellor to be more concerned for her safety. She was surprised at how calm the counsellor remained and that the counsellor did not push for more information.

Recovery

Despite the initial resistance to counselling, after the first session, Marie deeply valued her relationship with the counsellor and looked forward to the sessions. She felt confident in her counsellor's skills, which created safety and security during the sessions. The counsellor worked from a cognitive behavioural therapy (CBT) perspective. Marie found thought stopping and thought replacement to be very helpful. The counsellor

provided a handout with the tool NEST (nutrition, exercise, sleep, and time for self). Practicing *NEST* every day gave Marie something simple, achievable, and concrete to implement for self-care. Gradually this helped improve her mental health. Like Mel, one day Marie woke up and felt more like herself. Marie reflected:

> *Tomorrow is a new month. A new month… this is going to happen, and I woke up the next morning and all the black was gone and I was like "it's a new month!" I felt so free. It was a total answer to prayer, it felt like such a miracle, that overnight that I felt way more like myself again.*

Successive Pregnancies

Around the same time that Marie started counselling she found out she was pregnant again. Over the duration of her pregnancy her mental health improved. However, Marie experienced suicidal thoughts again when her second baby was nine months old. Marie noticed the intensity of the thoughts was less severe, but she decided to resume counselling. Due to scheduling restrictions, she opted to see another counsellor. Marie did not mention having thoughts of suicide to this counsellor. This counsellor helped Marie acknowledge and name the intense season of motherhood that she was experiencing. The counsellor suggested Marie be vulnerable and lower her mask of motherhood by sharing with her friends about the not so perfect aspects of mothering. Marie questioned why she would *dump* that on her friends:

> *She [the counsellor] was like "if you talk about all the things… the depression will be mitigated." Talking about all the normal things, like always being at home, never getting a rest, the kids always squabbling at each other, the diapers, or the endless feeling on edge, being in fight or flight mode… other moms can understand that. But their journeys all look easier, they look much more confident, or they just could do it because they knew what they were doing. So, I felt like why would I talk to my friends? They look like they knew what they were doing and I don't have it all together. That is the myth, nobody has it all together. But I still don't want to air [out] all of my not togetherness, I would rather at least try to pretend as much as possible that I am putting my best foot forward.*

In addition to counselling helping her, Marie shared that recovery was made possible by the passing of time, a supportive husband, self-care, religion, and hearing other women's stories of struggling with a PMAD. Marie also paid for a babysitter for one afternoon a week where she was free to do whatever she wanted, such as go to a local coffee shop, read a book, or visit a friend. Additionally, religion provided grounding through tradition, familiarity of scripture, songs, and prayer for Marie. Attending church weekly provided a time of reflection and meditation. Marie found that listening to worship songs shifted the focus from spiraling negative thoughts to focusing on the lyrics and allowing the fast-paced thoughts to slow down. Marie found it helpful to know that there was a church community of people supporting her through prayer. Marie said:

> *When I am in that challenging thought, I am able to remember that people are praying for me, people are praying for the challenges to be doable, so this is a challenging moment, and I will get through it because people are praying for me.*

Today, Marie is in another postpartum period and is committed to being mindful of her thoughts, focusing on getting enough sleep, and making her self-care a priority. She is well supported by a team of doctors and feels prepared for whatever the next year of life holds. Marie's past experiences of a PMAD inspires her to lower her mask of motherhood around other mothers to connect and support them in their mothering journey. She combats the myths of motherhood by normalizing taking time for yourself, that motherhood has difficult moments, that you do not have to take pleasure in the monotonous tasks (e.g., diaper changes, feeding, laundry) and acknowledging the feeling of overwhelm with all the decisions or conflicting advice.

Patricia

Patricia is a mom of three children, works in public health, and attended counselling during the postpartum period after each birth. Patricia's story brings forth the challenges of living in a Canadian rural town, with which I am very familiar with - everybody knows everything about everyone - it is all shared in passing at the local post office or grocery store. People usually mean well with their curiosity and concerns, but it can be difficult to remain anonymous when seeking mental health help. For example, issues in rural communities are the following: lack of specialized perinatal mental health professionals (e.g., psychiatrist, psychologist, nurses, counsellors, etc.), long waitlists, limited sessions per person, dual relationships, lack of funding for mental health, and lack of privacy (see Halverson & Brownlee, 2010; Helbok, 2010; Malone & Dyck, 2011; Schank, 1998). Patricia went through great lengths to present as a happy mom. I admire Patricia's boldness in eventually reaching out for help despite the barriers.

Expectation Versus Reality

Patricia enjoyed a healthy pregnancy with no complications so it led her to believe that she would *rock the newborn stage and parenting*. She had a preconceived idea of how she would deal with pain during birth because she was used to taking risks in extreme sports and managing the pain that followed. Unfortunately, the birth was not meant to be how she imagined it; she experienced a prolonged painful labour at her home birth. She was greatly discouraged at how she handled the pain. She described her birth as traumatic due to the intense pain and because her baby needed to be resuscitated and oxygenated immediately following birth. She also attributed what the midwives said to her as contributing to the traumatic birth. Following birth, they told her that her son was

healthy and that there would be no long-term consequences. But, what seared itself into her mind was when the midwives casually mentioned to monitor his breathing throughout the night. The midwife's words gave rise to extreme anxiety about her son thriving. Patricia explained how her anxiety lasted beyond the first few nights and fixated on questioning if her baby was just going to die one night; *from that birth, I was anxious right from the get-go … that was just the beginning of my anxiety of, 'will he just not be breathing?*

Spiralling Into Depression and Anxiety

In order to connect with other moms, Patricia immediately wanted to participate in a community mom's group. She packed up the baby while still bleeding from the birth, and in pain from birth. She was so happy when she arrived at the mom's group. Patricia was especially excited to meet other new moms, but the leaders announced that they were closing the program for the summer. She felt devastated as this news, which added to her growing feelings of isolation.

On top of feeling alone and anxious about her son's breathing, Patricia found that breastfeeding was extremely painful, so she asked the midwives and her mother for advice. The midwives responded that *the baby was not tongue tied* and her mother responded *that breastfeeding is painful*. These responses made Patricia downplay the severity of her experiences, lose confidence, and start to doubt her ability as a mother even beyond breastfeeding. In fact, the midwives were wrong: her baby was assessed by another professional and he was severely tongue tied. Nevertheless, the emotional damage to Patricia's confidence in her mothering ability was already done. Patricia recalled expecting her breastfeeding journey to be *warm, nurturing, natural* or

wonderful, but instead she started to resent feeding her baby which brought shame. Additionally, Patricia struggled with sleeping; she was getting up every one to two hours to feed her baby and because of anxiety about not knowing if her baby was still breathing, she would not fall asleep in-between feedings. She ruminated over a worst-case scenario of *my baby is probably going to just be dead in the bassinet*. By 4 months postpartum she was emotionally and mentally exhausted and experienced her first thoughts of suicide. For example:

> *We live on a really big ravine. I thought of throwing myself off the ravine. Like I said, my ideation was never a really solid concrete plan, like thinking about it, I probably would not actually die if I did that. I would have just got injured and have to crawl back up the hill… I was not at the point of, I need to die, and this is how, it was just like I need to be out of the picture.*

Seeking Help

Experiencing suicidal thoughts made Patricia realize that she needed to address her mental health. Patricia hesitated to reach out because of her professional role within the community. She wanted to present as a *good mom* and in public would pretend to *have it all together*. Patricia detailed:

> *I think a lot of it with my first was trying to prove to myself and to others that I was a good mom. A good mom always has the soother, has the baby dressed, properly swaddled and has all the things.*

Patricia was in a unique situation. Because she worked in public health, she knew what depression screening tools would be used to assess her mental health. She scored herself just below the cut off so that she would not receive a referral. Patricia remembered feeling sad that the nurse did not further question her and she was angry at herself for not being honest and asking for help. Patricia stated:

> *The barrier for me in answering that [Edinburgh Postnatal Depression Scale] honestly was that we work in public health and we have a very small town. I work*

> *with the people administering the screening. [For] my own sense of professional pride and competency, I didn't want them to actually know that I was struggling as much as I actually was… I know how it is scored, so I could score myself however I wanted to.*

Recovery

Patricia recalls at around 10 months postpartum she started to feed her baby a bottle. When he slept through the night then she started sleeping through the night. Patricia implemented practices that brought her joy in order to support her mental health such as the following: intense exercise, time away from the baby, visiting with friends, and time in nature. Patricia found it hopeful to hear about other moms' experiences with motherhood such as struggling with their baby constantly crying or painful breastfeeding. Subsequently, Patricia stated that her mood started to greatly improve and she was no longer experiencing suicidal thoughts. However, she decided to start counselling because she recognized her husband could no longer be her main support. The counsellor directly challenged the myths of motherhood *(e.g., trust your instincts, mother knows best, you will know what your baby needs)* that were influencing Patricia feeling like a failure as a mother. Directly dismantling myths of motherhood helped Patricia build confidence in her mothering ability.

When Patricia was pregnant with her second child, she deliberately chose a female nurse practitioner who specialized in women's mental health. She shared her history of PPD, PPA, and thoughts of suicide. The nurse practitioner prescribed Patricia medication for anxiety symptoms. Patricia found the second pregnancy and postpartum period to be fine whereas she described her third postpartum period as being very dark again. She requested a referral to the mental health team and worked with a mental health nurse on the *Coping with anxiety during pregnancy and following the birth: A cognitive*

behaviour therapy-based self-management guide for women and health care practitioners (Haring et al., 2013). Patricia remembers the workbook being helpful in identifying her anxiety triggers, noticing her body sensations, understanding at what point anxiety felt unmanageable, and how to prevent it from becoming unmanageable. Patricia also shared:

> *With my second and my third I told all my care providers my history, so my nurse practitioner, I told my midwives, I told my public health nurses, I said "you have to directly ask me how I am doing" because I know myself. I never ever presented as someone depressed, I was always showered, always on time, baby was in a clean outfit. No one could have ever guessed [I struggled with my mental health and suicidality] and even my closest friends were like, "What?! We did not know". I am pretty good at not showing how I am doing.*

Patricia was referred to the provincial reproductive mental health program where she was able to meet with a psychiatrist in conjunction with the mental health nurse that she was seeing. She received a diagnosis of generalized anxiety disorder (GAD) . Initially she had a difficult time accepting this diagnosis as she wanted the anxiety to be time limited around having a baby. Upon reflecting on her childhood experiences and struggles with sleep, Patricia shared: *I have actually come to accept that [GAD diagnosis], and it has been good to accept that in myself… I need to be very proactive about my mental health.* Today, Patricia is self-aware and pre-emptive with her mental health. She is passionate to have a conversation about ending the stigma attached to taking medications for mental health during pregnancy and postpartum. Her experience has motivated her to take Applied Suicide Intervention Skills Training so she could provide better care to her patients.

Slipping Through the Healthcare Cracks

The mothers presented in these stories went to multiple healthcare providers before being appropriately screened, diagnosed, or received proper help for a PMAD. Grigoriadis and colleagues (2017) found that perinatal women who died by suicide were less likely to have seen a psychiatrist and more likely to have seen a primary healthcare provider. Furthermore, perinatal women who died by suicide had contact with a health professional within the year before death (Grigoriadis et al., 2017) and were less likely to have received any active treatment (Khalifeh et al., 2016). Most mothers experiencing a PMAD are not adequately diagnosed by healthcare providers (Delatte et al., 2009). A prevalent *motherhood myth* in society is that pregnancy and becoming a mother are a woman's happiest time of her life, so it can be difficult for women to acknowledge and seek help if their experience deviates from the perceived societal norm (Patrick, 2013; Viveiros & Darling, 2018). In fact, mothers felt that the stigma attached to being a bad mother was worse than being labelled depressed, which resulted in women denying how bad they felt and deterred help-seeking behaviour (Bilszta et al., 2010; Dolman et al., 2016; McLeish & Redshaw, 2017; Sword et al., 2008). Joanne's and Sophia's stories represent how mothers slip through the healthcare cracks because shame, guilt, and how presenting as a *good* mom could prevent mothers from receiving the care that they need.

Joanne

Joanne is a mother of 2 children. The interview with Joanne starts off a little unconventional as she is driving. I find it distracting and difficult to connect at first but once she is at her house, we were able to build rapport. Joanne reveals to me that she had recently experienced a significant loss in her life, the death of her ex-partner, and this

seems to pull the conversation into the present. Joanne is a resilient, strong, independent mother, willing to do the best for her children, and advocate for her mental health. Joanne's story emphasises the challenges mothers experience in seeking care during the perinatal period with the specific fear of having her children removed from her care. I appreciate that as a single mom and in the process of grieving, Joanne is willing to take the time to share her story. This makes me be adaptable in making the interview work.

Expectation Versus Reality

Joanne pictured parenting responsibilities to be shared with her partner and to have more help from extended family and friends. She expected motherhood to be filled with connection and community with other moms. She invested her time and energy into building up a village but felt like she could never fully rely on other people for support. Then the sense of community she had created ended with COVID-19 restrictions and mandates.

Joanne's partner struggled with addictions which resulted in a tumultuous relationship. When Joanne was pregnant in the second trimester with their second child, the relationship ended. Joanne moved out with her son and struggled to get child support. Towards the end of the pregnancy, the relationship with her ex-partner was slightly more amicable. He attended the birth and was going to take care of their son so Joanne could spend two weeks *lying in for postpartum rest*. Joanne described how on the second night after she gave birth, her ex-partner stopped responding to text messages, so she hastily went with her father-in-law to check on her son. She found her ex-partner intoxicated. Joanne took her son home and abruptly adjusted to mothering a toddler and a newborn on her own.

Spiralling Into Depression and Anxiety

Approximately two weeks postpartum Joanne started to feel the pressure of parenting alone. She was in physical pain, she had recently sprained her ankle, and everything started to feel overwhelming. Doubt started to grow, and she questioned if she was a good enough mother and if she was capable of parenting her children at all. Joanne compared her life to other people's and it seemed like other people had their lives together. She saw them having successful businesses or supportive partners, and she questioned why life was such a struggle for herself. She physically felt like she was having panic attacks and experienced spiralling negative thoughts, where at the bottom of the spiral was the thought of suicide. Like Marie and Xena, Joanne described a suicide thought as not actually wanting to kill herself but reflected that it was a way to escape her life: an option to end pain. For example, she shared: *the difference of wanting to die and not be alive– I would say [is] just the not wanting to be alive, more not wanting this to be my life*. Joanne shared that her children were her motivation to stop the suicidal thoughts. She shared: *Then I usually started thinking, 'Where would my kids go?' and that's, I mean, it put a bit of a stop to it.*

Seeking Help

In the past, Joanne has seen multiple counsellors for various reasons through different community resources and has found counselling to be helpful in getting past challenging life circumstances. Joanne has had to advocate for her mental health, and despite being familiar with navigating the healthcare system, she felt like it was arduous to get the counselling she needed to maintain good mental health during her postpartum. When it came to seeking help in her postpartum period, she was afraid of admitting

thoughts of suicide to the counsellor because she had a trepidation of what was going to happen to her. She shared:

> *When you start counselling, they [the counsellor] describe the confidentiality … [they will keep confidentiality] accept under the circumstance of hurting or harming yourself… I would say that fear is the biggest hinderance to getting help, like that fear of what is going to happen if I admit this [suicidal thoughts].*

As a single mother, she was nervous that child welfare services would get involved and her children would be taken away. She reflected: *It is very scary to think about what would happen if you actually said those words [I am suicidal], like what would happen to your kids?*

Recovery

Joanne prefers counsellors who are assertive and not afraid to challenge her point of view. She explained that she does not just want somebody to validate her feelings and experiences but to help direct her in creating appropriate changes. Joanne learned different techniques to help ground her thoughts such as listening to music, affirmations, or journaling. Counsellors encouraged Joanne to perform self-care. She stated it is difficult to make time for self-care as a single mom. Joanne realized that self-care does not need to be expensive or elaborate; some days her self-care looks like a hot cup of coffee or making sure the house is clean.

Outside of counselling, Joanne appreciated peer support and play groups offered by community resources. This created a space where she could connect with other moms. She found it less isolating to share and be uplifted by the common experiences in motherhood. She found it helpful to participate in *circle of security* programs and book clubs on parenting. This provided clarity in parenting, social support, and exploring her mothering identity.

Today Joanne is in counselling to help her navigate the grief from the loss of her ex-partner. She continues to make her mental health a priority so that she can be a present mom for her children. Joanne wanted to share her story so that other mothers experiencing a PMAD will be willing to reach out for help.

Sophia

Sophia, a mother of two children, is bubbly, optimistic, joyful, and radiates life. Sophia's story highlights the need for PMAD trained professionals. Sophia had to advocate for her mental health every step of the way. I am impressed with Sophie's strength and resilience, but I would come to realize that she would not take my perspective of her resilience as a compliment.

Expectations Versus Reality

Sophia was hopeful that the postpartum period would be a chance to bond with her baby and looked forward to going for walks while wearing matching cute outfits with her baby. But this idyllic postpartum image was not to be as in so many of the stories in my research. After a planned c-section, which Sophie recalled as a great experience, she started passing blood clots. She went back to the hospital and was assessed as having a retained placenta. She was sent home and after taking medication that would push the placenta out, she began hemorrhaging. Sophia's mother was the one who found her passed out in the bathroom surrounded by blood. This near-death experience terrified Sophia and she was hospitalized after they found an infection caused by the retained placenta. Sophia spent six days in the hospital on antibiotics and received iron transfusions.

Sophie's hoped-for vision of early motherhood was quickly dashed as she was not able to go for relaxing walks with her newborn. Instead, early motherhood became the

stage when she learned how much she really had to advocate for herself and her boundaries. That is, despite feeling triggered because of a sexual trauma history, she still underwent 11 pelvic exams. Initially the doctors wanted to perform a transvaginal ultrasound, but Sophia declined. Further, when Sophia was admitted into the hospital, they were not going to let her keep her baby with her because the baby was not assigned as a patient to the nurses. Sophia ruthlessly argued to keep her baby with her so that she could continue to breastfeed, and she was permitted to do so.

Spiralling Into Postpartum Depression, Anxiety, and Obsessive Compulsive Disorder

At six weeks postpartum, upon being released from the hospital following the hemorrhaging experience, Sophia noticed that she was not feeling like her normal self but wrote it off as a result of coping from the birth complications. She observed herself becoming paranoid, *super sad, full of rage, and missing her maternal instincts to keep her baby safe*. Sophia started having intrusive thoughts of harm towards her children. Sophia found the intrusive thoughts very distressing.

Seeking Help

At approximately five months postpartum, Sophia reached out to the obstetrician who delivered her baby and shared the symptoms she was experiencing. The obstetrician initially tried treating Sophia while consulting with a psychiatrist given the waitlist to see a psychiatrist was 2 years. Sophia was very distressed by the intrusive thoughts and at ten months postpartum she started to self-harm to cope with them. Without seeing consistent improvements over five months in Sophia's mental health, the obstetrician referred her to the province's mental health and addictions services. Sophia was ten months postpartum when a mental health nurse phoned her to complete an intake form for counselling and

determine the triage level. Sophia described her intrusive thoughts to the nurse as honestly as she could, despite the crippling shame she felt. The nurse told her that the intrusive thoughts were *not good but that she could see a counsellor the following Monday*. The nurse inquired if she would be able to remain safe over the weekend until her first appointment. Sophia agreed she would be okay and was hopeful to start therapy.

After the phone call, Sophia went to run errands with the baby. She was surprised when she came home to her very concerned and confused husband. The intake nurse had called Sophia's husband and told him everything that Sophia had said on the phone. This was alarming as she had not previously discussed any of her mental health symptoms with her husband. The nurse told Sophia's husband that she was a risk to herself and the children; therefore, she needed to be brought to the hospital immediately. Furthermore, if she failed to comply, they would send the police. The nurse also reported her concerns to child welfare services which opened an investigation with a social worker. Sophia felt betrayed by the nurse and her confidence and trust in mental health services were broken.

Feeling disappointed and beyond frustrated with how the nurse handled the situation behind her back, she reflected to me that she would have gone straight to the hospital if she herself felt that it was in her best interest. And without a choice, Sophia went to the hospital where she saw a psychiatrist and was assessed that she was not going to act on the intrusive thoughts.

> *I'm super thankful for the way he [the psychiatrist] explained them [intrusive thoughts] to me because they were so distressing. I think that is what caused me the most distress because my intrusive thoughts came out in the form of harming my kids. It made me sick. I was like, I can't control these thoughts. It's not something I want to do… why am I thinking like this? And he, the psychiatrist, explained to me that, with OCD it's like the parts of the brain [knows to go for what] you care for*

> *the most, it's like OCD attacks what you value the most, so it's like, I could take what my thoughts were saying and then rationally say, no it's a complete 180 of how I actually feel. He spoke to me for about an hour, and he said, "I don't think you are a risk to anybody; this is your brain working against you".*

After a night in the hospital Sophia was allowed to go home. She accessed therapy through the provincial mental health services but once she was past the initial crisis, she was unable to continue because of the limited counselling sessions allotted per person. Sophia was prescribed multiple medications but *never felt stable*. She described feeling good for a month or two, then she would *crash and burn*, the psychiatrist would adjust her medications or add more frequent therapy sessions.

Amidst it all, one day, a social worker unexpectedly showed up at Sophia's house while she was trying to get out the door for a counselling session. Being involved with social services added to her daily stress and complicated her self-image as a mother. Sophia was defensive when the social worker first met her because there was some confusion between the intake nurse's report to the social worker and the statements Sophia had shared with the intake nurse. To the intake nurse, Sophia had stated she hated breastfeeding, that she did not enjoy it, and she did not want to do it. The social workers case file indicated that she said she did not feed her baby. The social worker was expecting a malnourished baby, when in reality, the baby was exceeding her milestones, and Sophia was still breastfeeding her baby despite not enjoying it. Sophia shared:

> *The child welfare [person] was really, I mean, really, really hard on me. I just felt attacked as a mother, and I was already in a place, especially given the intrusive thoughts, and I had low motivation… I was in a really bad place as far as feeling worthy as a mother. I felt consistently like I was failing my children and having child welfare involved just kind of confirmed it.*

The experience of having child welfare services involved in their lives confirmed Sophia's feeling like a failure as a mother. This intensified her experience of suicidality and she started to think that maybe her children would be better off without her.

Breaking Point

For Sophia, seeking counselling was a convoluted path, but she was committed to her mental health, despite the barriers she continually faced. She recognized that she needed continued therapy and decided to pay for private counselling. She found a counsellor she connected with and she wanted to address some past traumas. The counsellor felt that Sophie was too emotionally dysregulated to do trauma work and referred her to a dialectical behavior therapy (DBT) counsellor. The DBT counsellor suspected that Sophia had an eating disorder and referred her to an eating disorder clinic. Sophia agreed with this diagnosis and started going to the eating disorder clinic. She was getting frustrated with the lack of continued care for her mental health. She was not necessarily falling through healthcare cracks but was bounced around. Given this, she felt like a bad mother, and started to make suicide plans. Sophia recalls:

> *… I reached my breaking point, I was like, I don't know, I felt like I was trying so hard to get to a healthy place and I just felt like there were obstacles in my place every which way.*

Sophia had reached a point where she felt like she was a complete failure as a mother. One afternoon she attempted to end her life by overdosing on prescription medication. Sophia was found by her husband and brought to the emergency room at a local hospital where she met with a different psychiatrist.

Recovery

After the suicide attempt, Sophia started to meet with her eating disorder counsellor for weekly sessions for several consecutive weeks where they shifted the focus from eating disorder to the thoughts of suicide. Near the end of the intensive counselling, Sophia started to realize how the PMAD had taken over her mental health. She wanted to make sure that her mental health never reached a point of suicidality again. However, Sophia described how it was difficult to be fully honest and transparent with the therapist as she was worried about child welfare services getting involved. She recalled:

> *I was open enough for her [the counsellor] to know that I was not in a good place but not open enough for her [the counsellor] to know that I might still have been at risk.*

Sophie's faith in the healthcare system was fading, she was not fully trusting of health professionals. However, after recognizing how seriously ill she was, she made changes at home and started to play a more active role in therapy. Sophia described the process of counselling to be hard work, emotionally difficult, exhausting, and arduous to self-reflect on her actions of suicide. She was taught emotional regulation skills to manage thoughts of suicide. She found cold temperature to be very helpful in distracting her thoughts and bringing herself back into her body. Sophia described standing in the cold, splashing her face with cold water, or putting ice on her wrist as very helpful. Other techniques that were helpful were listening to music loudly or jumping up and down. Sophia explained that it was not easy to integrate these techniques while mothering:

> *Just having to remember all these things and practice them, and simultaneously trying to raise children. I couldn't always just say to my kids, "okay, sit here while mommy is going to go splash water on her face" like it's just not, I don't know, so it's hard, and it's exhausting.*

Similar to what Mel had described, one day Sophia woke up and the intrusive thoughts and suicidal thoughts were gone. Sophia described:

> *It's weird because it is like, it feels like forever, and I mean it is forever, like, it is a long time, and then it's just like one day you wake up and you don't even realize that it is over. Like, it's like you wake up one day and you're like oh I have been feeling good for a little while now. But it was not without hard work and it's not without active participation.*

Sophia noticed that as her mental health improved so did her relationships with her children. Sophia observed that she was more present, able to play, enjoyed time spent with her children, celebrated her children, and openly engaged in conversations. Sophia's motivation to recover was the hope that one day life would be better. She was determined to make up that time to her children, and to show her children how wonderful life can be.

What strikes me in Sophia's story is how she was constantly reaching out for help despite the egregious breach of trust with the nurse and frustration in navigating the medical system to get help. I was deeply moved when Sophia stated she did not want to be thought of as resilient, that it was not a compliment to be strong. Instead, she wanted to *feel* better and to get healthy. Instead of the praise of words, she was determined to embody and process feelings rather than be labelled with admiration. Sophia shared,

> *I had pharmacists question the doctor's prescriptions because I didn't present the way my symptoms were being described. I was told that I cope very well. Which I hated. I was like, I cope well because I don't have a choice. It's not a compliment. It's survive or die.*

It is Sophia's wish to see a future where women are educated about PMADs early on in their pregnancy, so that they will not reach a point where they are experiencing thoughts of suicide as she did. Sophia wants women to know that no matter how horrible

the things are that you are experiencing, you can get through it, and how important it is to ask for help. Sophia stated:

> *Especially these intrusive thoughts… the suicidal thoughts, like, while they might not be common, they are normal. There is nothing inherently wrong with you as a person and a mother. And that it is absolutely, it is curable… it is treatable.*

Perinatal Mental Health: Shortcomings in the Canadian Healthcare System

These stories provide detailed lived experiences of mothers' recovery from perinatal suicidality following counselling, despite the barriers of shame, guilt, pretending to be a good/happy mom, and slipping through the healthcare cracks. These mothers courageously shared their stories to provide hope to other mothers experiencing suicidality in the perinatal period, to reduce stigma, and to inform healthcare professionals. In these stories, the mothers saw many different healthcare professionals (e.g., doctors, obstetricians, nurses, midwives, and counsellors) before being properly assessed or diagnosed. For some of the mothers they did not even receive an official diagnosis but self-identified with having a PMAD. The stories highlight the following shortcomings in our healthcare system, that are also well recognized in the literature and among perinatal mental health specialists: lack of trained PMAD clinicians (Bayrampour et al., 2018; Puspitasari et al., 2021); lack of information about medication while pregnant or postpartum; long waitlists to see a psychiatrist or psychologist/counsellor; hasty referrals to social services; limited number of counselling sessions; lack of continued care for the mother during the pregnancy and postpartum period; dismissive attitudes towards checking mental health in regular prenatal appointments; and mothers' lack of PMAD awareness prior to pregnancy or receiving a diagnosis. Indeed, a recent environmental scan of perinatal mental health infrastructure across Canada revealed that

less than half of the provinces and territories have provincial guidelines, strategies, or policies in place (Hippman et al., 2022). The significant gaps in the healthcare system mean that mothers are slipping through the cracks.

Recommendations Healthcare Professionals

Ideally all healthcare professionals who encounter a mother during the perinatal period would have specialized training in PMADS. Specialized training in PMADs would address some of the aforementioned shortcomings. PMAD trained healthcare professionals would be better equipped to deal with the high levels of distress, sensitive to risk assessment, and understand the urgency in providing appropriate treatment. Further, a mother presenting with suicidal ideation should not necessitate immediate contact of social services but such measures should take place as a result of thorough risk assessment by a trained PMAD clinician. A lack of respectful, direct, caring, and non-judgemental communication can further exacerbate mental health issues for the mother and intensify suicidality in the perinatal period. Mothers experiencing suicidality in this study illuminated that barriers to help-seeking are a result of shame, guilt, and pretending to be a happy mom. Healthcare professionals reading this manuscript are provided with lived experiences for effective and life-giving interventions with mothers suffering from suicidality. The arguments presented in this manuscript can offer a training toolkit for perinatal mental health practice for working with mothers experiencing suicidality in the perinatal period. Thus, a primary recommendation emerging from this study is universal screening for PMADs, which can prevent mothers from slipping through cracks in the healthcare system.

While universal screening has its shortcomings (Puspitasari et al., 2021), it is better than nothing. Currently, universal screening is only recommended in half of Canada's provinces or territories (Hippman et al., 2022). Universal screening with a standardized questionnaire (e.g., The Edinburgh Postnatal Depression Scale) for pregnant and postpartum women indicates the possibility of a mental illness (Gibson et al., 2009); therefore, setting into motion the process of getting help. Xena, Marie, and Patricia were screened for PPD by nurses at their child's immunization appointments. For Xena and Marie, being screened started the process of getting assessed, diagnosed, and treated (i.e., medication and counselling). Despite how a mother may be presenting herself, universal screening provides mothers the opportunity to have a conversation around mental health. In these stories, mothers shared it was easier to self-disclose thoughts of suicide through screening, when directly asked "are you suicidal" as opposed to having to just tell the nurse they were having thoughts of suicide. While an in-depth discussion of universal screening is beyond the scope of this paper, provisions for federal support of universal screening through a national strategy on perinatal mental health is yet to be realized. Several lobby groups in Canada have approached federal ministers of health (including the supervisor of this thesis) over the years. Current discussions are being organized and there is some hope in changes being made.

Mothers Closing Gratitude

Concluding the interviews, I thanked the mothers for their time, and for their willingness to share their story. The mothers responded with gratitude in being part of research that shared experiences of recovery from perinatal suicidality.

Mel: *I think the only way we can get better at it [helping mothers] is for people to share their stories and talk about it.*

Sophia: *It is a battle that shouldn't be lost, it [perinatal suicidality] is a treatable, preventable illness. There is no reason anybody should succumb to it [perinatal suicidality] anymore.*

Courtney: *I want to share my story as much as possible, because I don't hear stories about wanting to commit suicide while you are pregnant, I don't hear it a lot, I think there is a lot of shame around it, so I am happy to share the story, I almost look for opportunities.*

Xena: *Anything to help more women and more moms.*

Marie: *By me identifying with my PPD then I can be open to other mothers and they can connect with that. I think that has helped me through as well. The more I can talk about it [PPD] with other people the more common it [PPD] feels, the more it [PPD] feels normal, it [PPD] feels okay, or it [PPD] feels supported.* Grace: *I feel like there is a hole in our medical system and research around this [perinatal suicidality]. I think it is such an important thing and I think that experiencing it [suicidality] and then finding out that so many other women are experiencing it has been such an important part of my journey.* Joanne: *I think about how privileged I am and how difficult it has been for me getting help and how difficult it must be for other people.*

Patricia: *Had I recognized that earlier with my first, then maybe I wouldn't have got to that place [of suicidality… I was not asked a lot about my mood in pregnancy and postpartum until that 6-week EPDS [Edinburgh Postnatal Depression Scale… Those*

care providers who assume because they have a relationship with their clients that they don't need to do a screening question can be really harmful.

It was an honour for me to put these mothers' experiences down in words and tell their stories of recovery following counselling. I am inspired by the courage and bravery these mothers had in sharing their stories regardless of the intense shame they endured. I was intrigued by the power of storytelling in these mothers' journey to healing. These mothers shared how hearing other women's stories of overcoming a PMAD inspired their own recovery. What struck me was that the women who shared their story in passing, for example, a nurse honestly sharing her experience with a PMAD while doing her morning rounds, brought so much hope. The nurse will probably never know how inspiring her seemingly small moment of sharing her story was to the mother suffering with a PMAD. It struck me, that we never know the power that our words hold. A little kindness, empathy, and sharing of your story can connect with another person and have a rippling effect of healing. My hope in writing and sharing these stories is that mothers know that they are not alone in their experiences of suicidality, that they are not failing as a mother, that they are not to blame for their experiences of a PMAD, that there is treatment, and hope in recovery.

References

Alhusen, J. L., Frohman, N., & Purcell, G. (2015). Intimate partner violence and suicidal ideation in pregnant women. *Archives of Women's Mental Health, 18*(4), 573-578. https://doi.org/10.1007/s00737-015-0515-2

Ammerman, R. T., Scheiber, F. A., Peugh, J. L., Messer, E. P., Van Ginkel, & J. B., Putnam, F. W. (2019). Interpersonal trauma and suicide attempts in low-income depressed mothers in home visiting. *Child Abuse and Neglect, 97,* 104126. https://doi.org/10.1016/j.chiabu.2019.104126

Bayrampour H., Hapsari A.P., & Pavlovic, J. (2018). Barriers to addressing perinatal mental health issues in midwifery settings. *Midwifery*, *59*, 47-58. https://doi.org/10.1016/j.midw.2017.12.020

Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). Women's experience of postnatal depression -beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing*, *27*(3), 44-54. https://www.ajan.com.au/archive/Vol27/27-3_Bilszta.pdf

Brown, B. (2006). Shame resilience theory: a grounded theory study on women and shame. *Families and Society: The Journal of Contemporary Social Services*, *87*(1), 43-52. https://doi.org/10.1606/1044-3894.3483

Byrnes, L., (2018). Perinatal mood and anxiety disorders. *The Journal for Nurse Practitioners*, *14*(7), 507-513. https://doi.org/10.1016/j.nurpra.2018.03.010

Caldwell, J., Meredith, P., Whittingham, K., & Ziviani, J. (2021). Shame and guilt in the postnatal period: A systematic review. *Journal of Reproductive and Infant Psychology*, *39*(1), 67-85. https://doi.org/10.1080/02646838.2020.1754372

Constantinou, G., Varela, S., & Buckby, B. (2021). Reviewing the experiences of maternal guilt the "motherhood myth" influence. *Health Care for Women International*, *42*(4–6), 852–876. https://doi.org/10.1080/07399332.2020.1835917

Delatte, R., Cao, H., Meltzer-Brody, S., & Menard M. K. (2009). Universal screening for postpartum depression: an inquiry into provider attitudes and practice. *American Journal of Obstetrics and Gynecology*, *200*(5), 63-64. https://doi/org/10.1016/j.ajog.2008.12.002

Dolman, C., Jones, I. R., & Howard, M. (2016). Women with bipolar disorder and pregnancy factors influencing their decision-making. *British Journal of Psychology Open*, *2*(5), 294-300. https://doi.org/10.1192/bjpo.bp.116.003079

Friedan, B. (1963). *The feminine mystique*. Norton.

Gavin, A. R., Tabb, K. M., Melville, J. L., Guo, Y., & Katon, W. (2011). Prevalence and correlates of suicide ideation during pregnancy. *Archives Women's Mental Health, 14*(3), 239-246. https://doi.org/10.1007/s00737-011-0207-5

Gibson, J., McKenzie-McHarg, K., Shakespeare, J., Price, J., & Gray, R. (2009). A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. *Acta psychiatrica Scandinavica*, *119*(5), 350–364. https://doi.org/10.1111/j.1600-0447.2009.01363.x

Gold, K. J., Singh, V., Marcus, S. M., & Palladino, C. L. (2012). Mental health, substance use and intimate partner problems among pregnant and postpartum suicide victims in the National Violent Death Reporting System. *General Hospital Psychiatry, 34*(2), 139-145. https://doi.org/10.1016/j.genhosppsych.2011.09.017

Goldman-Mellor, S., & Margerison, C. E. (2019). Maternal drug-related death and suicide are leading causes of postpartum death in California. *Journal of Obstetrics and Gynecology, 221*(489), 1-9. https://doi.org/10.1016/j.ajog.2019.05.045

Grigoriadis, S., Wilton, A. S., Kurdyak, P. A., Rhodes, A. E., VonderPorten, E. H., Levitt, A., Cheungm A., & Vigod, S. N. (2017). Perinatal suicide in Ontario, Canada: a 15-year population-based study. *Canadian Medical Association Journal, 189*(34), 1085-1092. https://doi.org/10.1503/cmaj.170088

Halverson, G., Brownlee, K. (2010) Managing ethical considerations around dual relationships in small rural and remote Canadian communities. *International Social Work, 53*(2), 247-260. https://doi.org/10.1177/0020872809355386

Hanell, L. (2017). The failing body: narratives of breastfeeding troubles and shame. *Linguistic Anthropology*, *27*(2). https://doi.org/10.1111/jola.12158

Haring, M., Smith, J. E., Bodnar, D., Misri, S., Little, R. M., & Ryan, D. (2013). *Coping with anxiety during pregnancy and following the birth: A cognitive behaviour therapy-based self-management guide for women and health care practitioners.* BC Reproductive Mental Health Program, BC Mental Health & Addiction Services, Provincial Health Services Authority. http://www.bcmhsus.ca/Documents/coping-with-anxiety-during-pregnancy-and-following-the-birth.pdf

Hays, S. (1996). *The cultural contradictions of motherhood*. Yale University Press.

Helbok, C. M. (2010). The practice of psychology in rural communities: Potential ethical dilemmas. *Ethics & Behavior, 13*(4), 367-384. https://doi.org/10.1207/S15327019EB1304_5

Hippman, C. L., Adham, M., Zlobin, C., & Wong, G. (2022). An environmental scan of perinatal mental health infrastructure across Canada. *Journal of Obstetrics and Gynecology Canada, 44*(7), 745-746. https://doi.org/10.1016/j.jogc.2022.02.003

Honey, A., Boydell, K. M., Coniglio, F., Thuy Do, T., Dunn, L., Gill, K., Glover, H., Hines, M., Scanlan, J. N., & Tooth, B. (2020). Lived experience research as a resource for recovery: a mixed methods study. *BMC Psychiatry*, *20*(456), 1-13. https://doi.org/10.1186/s12888-020-02861-0

Howard, L. M. & Khalifeh, H. (2020). Perinatal mental health: a review of progress and challenges. *World Psychiatry, 19*(3), 313-327. https://doi.org/10.1002/wps.20769

Huang, H., Faisal-Cury, A., Chan, Y., Tabb, K., Katon, W., & Menezes, P. R. (2012). Suicidal ideation during pregnancy: prevalence and associated factors among low-income women in Sao Paula, Brazil. *Archives of Women's Mental Health, 15*(2), 135-138. https://doi.org/10.1007/s00737-012-0263-5

Jackson, L., Fallon, V., Harrold, J., & De Pascalis, L. (2022). Maternal guilt and shame in the postpartum infant feeding context: a concept analysis. *Midwifery, 105*, 103205. https://doi.org/10.1016/j.midw.2021.103205

Khalifeh H., Hunt, I. M., Appleby, L., & Howard, L. M. (2016). Suicide in perinatal and non-perinatal women in contact with psychiatric services: 15-year findings from a UK national inquiry. *Lancet Psychiatry, 3(*3), 233-42. https://doi.org/10.1016/S2215-0366(16)00003-1

Kleiman, K. (2017). *The art of holding in therapy: An essential intervention for postpartum depression and anxiety* (1st ed.). Routledge.

Knasmüller, P., Kotal, A., König, D., Vyssoki, B., Kapusta, N., & Blüml, V. (2019). Maternal suicide during pregnancy and the first postpartum year in Austria: Findings from 2004 to 2017. *Psychiatry Research, 281*, 1112530, 1-3. https://doi.org/10.1016/j.psychres.2019.112530

Law, N. K., Hall, P. L., & Cheshire, A. (2021). Common negative thoughts in early motherhood and their relationship to guilt, shame and depression. *Journal of Child & Family Studies, 30*(8), 1831–1845. https://doi.org/10.1007/s10826-021-01968-6

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry, 1996*(6), 445-452. https://doi.org/10.1192/bjp.bp.110.083733

Lega, I., Maraschini, A., D'Aloja, P., Andreozzi, S., Spettoli, D., Giangreco, M., Vichi, M., Loghi, M., Donati, S., & the Regional Maternal Mortality Working Group. (2020). Maternal suicide in Italy. *Archives of Women's Mental Health, 23*, 199-206. https://doi.org/10.1007/s00737-019-00977-1

Liss, M., Schiffrin, H. H., and Rizzo, K. M. (2013). Maternal guilt and shame: The role of self-discrepancy and negative evaluation. *Journal of Child & Family Studies, 22*(8), 1112–1119. https://doi.org/10.1007/s10826-012-9673-2

Malone, J. L., & Dyck, K. G. (2011). Professional ethics in rural and northern Canadian psychology. *Canadian Psychology / Psychologie canadienne, 52*(3), 206–214. https://doi.org/10.1037/a0024505

Mangla, K., Hoffman, M. C., Trumpff, C., O'Grady, S., & Monk, C. (2019). Maternal self-harm deaths: An unrecognized and preventable outcome. *American Journal of*

Obstetrics & Gynecology, *221*(4), 295-303. https://doi.org/10.1016/j.ajog.2019.02.056

McIntyre, L. M., Griffen, A. M., BrintzenhofeSzoc, K. (2018). Breast is best…except when it's not. *Journal of Human Lactation*, *34*(3), 575-580. https://doi.org/10.1177/0890334418774011

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organized peer support in pregnancy and early parenthood: a qualitative study. *BioMed Central, 17*(28), 1-14. https://doi.org/10.1186/s12884-017-1220-0

Muzik, M., Brier, Z., Menke, R. A., Davis, M. T., & Sexton, M. B. (2016). Longitudinal suicidal ideation across 18-months postpartum in mothers with childhood maltreatment histories. *Journal of Affective Disorders, 204,* 138–145. https://doi.org/10.1016/j.jad.2016.06.037

Oates, M. (2009). The confidential enquiry into maternal deaths 1997-2005: Implications for practice. *Psychiatry*, *8*(1), 13-16. https://doi.org/10.1016/j.mppsy.2008.10.013

Onah, M. N., Field, S., Bantjes, J., & Honikman, S. (2017). Perinatal suicidal ideation and behaviour: psychiatry and adversity. *Archives of Women's Mental Health, 20*(2), 321-331. https://doi.org/10.1007/s00737-016-0706-5

Patrick, K. (2013). It's time to put maternal suicide under the microscope. *Canadian Medical Association Journal*, *185*(13), 1115. https://doi.org/10.1503/cmaj.131248

Praetorius, R., Maxwell, D., Alam, K. (2020). Wearing a happy mask: mother's expressions of suicidality with postpartum depression. *Social Work in Mental Health*, *18*(4), 429-459. https://doi.org/10.1080/15332985.2020.1769003

Puspitasari, A.J. Heredia, D., Weber, E., Betcher, H. K., Coombes, B. J., Brodrick, E. M., Skinner, S. M., Tomlinson, A. L., Salik, S. S., Allen, S. V., O'Grady, J. S., Johnson, E. K., L'amoureux, T. M., & Moore, K. M. (2021). Perinatal mood and anxiety disorder management in multicentre community practices: clinicians' training, current practices and perceived strategies to improve future implementation. *Journal of Primary Care and Community Health*, *12*, 1-10. https://doi.org/10.1177/21501327219968888

Reid, H. E., Pratt, D., Edge, D., Wittkowski, A. (2022a). What makes a perinatal woman suicidal? A grounded theory study. *BMC Psychiatry 22*(386). https://doi.org/10.1186/s12888-022-04015-w

Reid, H. E., Pratt, D., Edge, D., Wittkowski, A. (2022b). Maternal suicide ideation and behaviour during pregnancy and the first postpartum year: a systematic review of psychological and psychosocial risk factors. *Frontiers in Psychiatry*, *13,* 765118. https://doi.org/10.3389/fpsyt.2022.765118

Rotkirch, A., & Janhunen, K. (2010). Maternal guilt. *Evolutionary Psychology*, *8*(1), 90-106. https://doi.org10.1177/147470491000800108

Schank, J. A. (2009). Ethical issues in rural counselling practice. *Canadian Journal of Counselling and Psychotherapy*, *32*(4). https://cjc-rcc.ucalgary.ca/article/view/59087

Sit, D., Luther, J., Buysse, D., Dills, J. L., Eng, H., Okun, M., Wisniewski, S., & Wisner, K. L. (2015). Suicidal ideation in depressed postpartum women: Associations with childhood trauma, sleep disturbance and anxiety. *Journal of Psychiatric Research, 66-67*, 95-104. https://doi.org/10.1016/j.jpsychires.2015.04.021

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research.* Sage.

Sword, W., Busser, D., Ganann, R., McMillan, T., & Swinton, M. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qualitative Health Research, 18*(9), 1161-1173. https://doi.org/10.1177/1049732308321736

Takeda, S., Takeda, J., Murakami, K., Kubo, T., Hamada, H., Murakami, M., Makino, S., Itoh, H., Ohba, T., Naruse, K., Tanaka, H., K, Kanayama, N., Matsubara, S., Sameshima, H., & Ikeda, T. (2017). Annual Report of the Perinatology Committee, Japan Society of Obstetrics and Gynecology, 2015: Proposal of urgent measures to reduce maternal deaths. *Journal of Obstetrics Gynaecology, 68*(6), 5-7. https://doi.org/10.1111/jog.13184

Vangen, S., Bødker, B., Ellingsen, L., Saltvedt, S., Gissler, M., Geirsson, R. T., & Nyfløt, L. T. (2017). Maternal deaths in Nordic countries. *Acta Obstetricia et Gynecologica Scandinavica, 96*, 1112-1119. https://doi.org/10.1111/aogs.13172

Viveiros, C. J., & Darling, E. K. (2018). Barriers and facilitators of accessing perinatal mental health services: The perspectives of women receiving continuity of care midwifery. *Midwifery 65*, 8-15. https://doi.org/10.1016/j.midw.2018.06.018

Weston, K. (2018). Maternal death rate drops, maternal suicide remains high. *Kai Tiaki Nursing New Zealand, 24*(6).

Williams, J., Ryan, D., Thomas-Peter, K., Cadario, B., & Li, D. (2014). *Best practice guidelines for mental health disorders in the perinatal period*. BC Reproductive Mental Health Program & Perinatal Services BC.

Wong, G. (Ed.). (2012). *Moms gone mad: Motherhood and madness, oppression and resistance*. Demeter Press.

World Health Organization. (2018). *Maternal mental health*. http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

Yeung, W.S., Hancock, N., Honey, A., Wells, K., & Scanlan, J. N. (2020). Igniting and maintaining hope: the voices of people living with mental illness. *Community Mental Health Journal, 56*, 1044-1052. http://doi.org/10.1007/s10597-020-00557-z

Chapter 6. Conclusion

"Dear mother, No they would not be better off without you" (Laditan, 2019)[8]

The purpose of this thesis was to better understand mothers' experiences of perinatal suicidality and recovery following counselling. Eight Canadian mothers participated in semi-structured Zoom interviews, which were analysed using IPA to identify how their recovery from perinatal suicidality following counselling was experienced. Two manuscripts were prepared for publication in academic journals (*Canadian Psychology* and *The Qualitative Report)*. Manuscript I, Perinatal Suicidality: Mother's Experiences of Recovery Following Counselling, described the key finding: *Feeling like a failure as a mother* directly contributed to suicidality for all participants. The personal experiential themes included: (1) Connection with Counsellor as a Catalyst for Change; (2) Connection with Self Minimized Suicidality; and (3) Connection with Extra-Therapeutic Factors Important in Recovery. Manuscript II, "Feeling like a Failure as a Mother": Stories of Perinatal Suicidality to Recovery, was inspired by the results from the IPA study and contains summarized mothers' stories of perinatal suicidality and recovery. These stories further explore the key finding of *feeling like a failure as a mother*. More specifically, the stories highlight key challenges of "shame," "guilt," "pretending to be a happy mom," and "slipping through the healthcare cracks," associated with experiencing a PMAD and suicidality.

Emerging Theories of Perinatal Suicide

While this research was in progress two new theories emerged to explain why mothers die by suicide in the perinatal period. Praetorius and colleagues (2020) asserted

[8] Poem reproduced with permission from Laditan (2019); copyright 2019 Mira Books.

the Interpersonal Theory of Suicide (IPTS) (Joiner et al., 2009) was the best explanation of why women experiencing PPD would consider and attempt suicide. Second, Reid and colleagues (2022) developed a grounded theory model of suicide ideation and behaviour development during the perinatal period. The following paragraphs briefly summarize the theories.

Interpersonal Theory of Suicide

The original, IPTS has the following three constructs required for a person to die by suicide: thwarted belonginess, perceived burdensomeness, and acquired capability (Joiner et al., 2009). Praetorius and colleagues (2020) added *thwarted motherhood* under thwarted belonginess. Thwarted motherhood included the loss of identity, lack of confidence in mothering ability, and not meeting cultural expectations. Under the perceived burdensomeness construct, the *baby burden* was added which included: unexpected challenges with baby's health, baby temperament, challenges with breastfeeding, childbearing attitudes, struggles with fertility or unwanted pregnancy. Lack of maternal self-esteem and the influence of idealized motherhood and birth expectations lead to the mother feeling like a failure. Under acquired capability the following were added: *mothers elevated pain through PMAD symptoms, sleep disturbances, C-section, biological changes,* and *IPV*.

In essence, further constructs of the burden of a newborn baby, daily challenges during the perinatal period, and unique expectations of the perinatal period were added to the original IPTS. Relative to the findings from this study, the constructs that Praetorius and colleagues (2020) added to IPTS are in agreement with the eight mothers' lived experiences of suicidality in the perinatal period. Indeed, from this study, the eight

mothers' descriptions of suicidality, self-harm, shame, isolation, loneliness, exhaustion, self-comparison to other moms, showing a façade of a happy mom, struggle to parent, difficulty breastfeeding, struggle to complete household tasks, identity transition, and incongruence between expectations versus reality of motherhood during pregnancy or postpartum could fit within the constructs that Praetorius and colleagues (2020) added to IPTS.

Grounded Study of Perinatal Suicide

Reid and colleagues (2022) conducted a grounded theory study involving 12 mothers from the United Kingdom who experienced suicidality when pregnant or in the postpartum period. They identified that mothers felt attacked by motherhood (e.g., mothers' expectations did not meet reality, experienced isolation, uncomfortable feelings towards the baby, and feeling a loss of control) which led to feeling like a failure as a mother and self-identifying as a bad mother. When mothers felt defeated and entrapped (i.e., could not see any other way to resolve their distress) the option for suicide became viable. Mothers might make a suicide attempt if they are triggered, suicide seems like a viable option for escape, and if the means for suicide were available. Further, mothers wanted to ensure their children were safely looked after and that the means were lethal (i.e., more violent than overdosing).

Reid and colleagues (2022) provided a theory to conceptualize and understand how mothers in the perinatal period may consider suicide. However, it has a limitation in that they do not approach it from a feminist perspective. Reid and colleagues (2022) suggested "…a malfunction of the transition to motherhood may contribute to the development of suicidal ideation. An unwillingness or inability to engage in the

transition to motherhood" (p. 17). I find the wording problematic; in that it insinuates it is the mother's fault for not transitioning to a mother smoothly. This fails to recognize unattainable societal expectations placed on mothers and how these expectations negatively impact the transition of becoming a mother.

Personal Reflections

Working on this thesis has been both rewarding and challenging. Adding to the challenge was purchasing our own company, building a house, my oldest son starting kindergarten, and having another baby. A couple weeks after I gave birth to my second child, Ayla, my research ethics was approved. I eagerly posted my recruitment posters online and anticipated hearing from potential participants. I was busy soaking up Ayla's sweet newborn scent, relearning how to breastfeed, trying to sleep when my baby was sleeping, and checking my emails daily for messages from potential participants. Fast forward to August 2021, I interviewed my first participant. I transcribed the interview while Ayla was contently swinging in a baby swing, having tummy time, or napping. As Ayla developed and became more mobile, my focus was less on writing and more on her. Working on my thesis was getting pushed into nap times and nights when my children were sleeping. I asked my husband, Brad, to solo parent more often on the weekends so that I could have uninterrupted time to write. As the year progressed, I became more aware of the disproportionate division of domestic labour, the invisible load of motherhood, and motherhood myths present in my life.

I questioned my own feelings of failure as a mother and oscillated back to the question of whether it was selfish to continue my schooling with a newborn. Late at night, I questioned if I made the correct choices… should I be writing my thesis while

Ayla is a baby? Am I providing her with enough attention, stimulation, or cuddles? Is Grayson getting the best version of a mother from me… or is he getting a tired, anxious, stretched-thin version? Is this going to push my marriage to the edge? Can I actually balance it all successfully? Feelings of failure snuck in at unexpected moments; for example, at a routine check-up appointment for Ayla, the doctor inquired about the types of solid food she had eaten so far. I could only name a few because it was easier and more convenient for me to breastfeed. In the mere seconds it took me to stutter an answer, perfectionism reared its head, telling me I should have been more on top of feeding her a variety of solid foods. I felt intense guilt, a little bit of shame, and a lot like a failure as a mother. However, those moments pass; and I am thankful. I know I am doing everything to the best to my abilities. I think about the mothers in this study and how easy it is to get pulled into the spiral of *feeling like a failure as a mother* and how difficult it is to get out of the tornado of suicidal thoughts.

Brad and I have had more arguments this past year than I would like to admit, mostly around domestic duties. I wanted to believe we had created an egalitarian relationship, that we were enlightened to the discourses that were prevalent in our society, and we had risen above it all. Since having children, something shifted and I found myself completing most of the domestic labour (e.g., cooking, dishes, laundry, cleaning, grocery shopping, errands, etc.) while Brad went to work and did the chores like mowing the lawn and taking out the garbage and recycling. Brad not being impartial to the patriarchal influence of our society, would strongly take on the role of financial provider for the family and with a new baby, new house, and running a new company, he felt immensely the pressure to succeed. When Ayla was napping, I would be confronted

with a choice: work on my thesis or do the dishes. In those moments, I never chose to complete household chores. I would write… weeks of laundry piled up, dirty dishes filled the sink, the floors needed vacuuming and mopping. I would feel mentally stuck on some part of my thesis, but Ayla did not sleep through the night… it felt overwhelming. Just when I thought it could not get any worse, we would all get sick.

Each family member was sick, with a nasty head cold, for three weeks overlapping each other from November to December 2021. This meant two months of even more interrupted sleep (I was still breastfeeding Ayla twice throughout the night). My oldest child, Grayson, did not attend school for three weeks. While we had lots of cuddles, I enjoyed our time reading books, playing playdough, and Lego; I struggled with the pressure to get work done on my thesis. In early January each family member got COVID-19. I spent nights sleeping in the rocking chair so that Ayla could sleep sitting up and breathe better. I was exhausted on a whole different cellular level. I still needed to parent my children and take care of the household responsibilities. I could just see days slip by tending to my sick children and my deadlines creeping closer and closer. I was stressed by the approaching deadlines.

I thought to myself: this must be what they mean when they say women cannot have it all. At times, I found myself questioning how I was actually going to get my thesis written. The solution to this dilemma was that I had to ask for help. I had to schedule time to write. I needed to have conversations with Brad and find a way to split domestic duties. I also realized I took on certain parts of *invisible load of motherhood* and motherhood myths.

Motherhood myths had a sneaky way of showing up in my life and then I would also fall into maternal guilt. One of those motherhood myths I struggled with was having a perfectly cleaned house. Another was feeling like a bad mom if Grayson watched Netflix so I could be on a zoom meeting. These situations filled me with guilt. I took Ayla to a conference on suicide in Montreal. I felt guilty for leaving Grayson and guilty (and judged by other conference goers) for having Ayla with me at the conference. At the same time, I was so proud to present my research and happy to explore Montreal with Ayla. I have realized mom guilt is a rather useless self-induced feeling that does not actually help me parent better or get my work finished. It has taken effort to become conscious of mom guilt in my life and effort to consciously let the mom guilt go.

A Note About Suicide

While completing this research, suicide has become a closer topic in my life than I would have wanted. This past year, I have had people close to me struggle with suicide, a close maternal figure attempted suicide, and a distant relative died by suicide. From this study, the participants sharing their stories gave me hope because I knew they had recovered. Some of the participants clarified that they did not actually want to die but to *escape* their reality or escape the enduring pain that they suffered from daily. Knowing that participants did not want to die brought me clarity, perspective, and understanding that I could apply to the experiences of others in my life who struggled with suicidal ideation. I reflected that perhaps the people in my life struggling with suicidality could also be experiencing some similar feelings. Feelings such as pain, loneliness, suffering, a darkness of the soul, and feeling empty inside. Having participants describe their lived

experience with suicidality helped me understand the extremely distressing place that suicidality can bring you mentally and emotionally.

I realized that a shift in perspective, from understanding the action of a suicide attempt comes from a place of wanting to escape suffering and not that they necessarily want to die- opens dialogue so that people can move towards healing, move towards the desire to live. One participant shared that their family did not know how to talk about the attempt, that she was embarrassed by it, and glad that the family members did not bring it up. I thought about this particular participant quite often in the days that followed the news of the close maternal figure's attempt. I witnessed the family struggle. I witnessed confusion, anger, frustration, blame, guilt, a desire for needing to understand the "why" behind the person who attempted. There was a hesitation to engage in conversation with the maternal figure who attempted suicide. All these conversations and release of feelings happened without the person who attempted. Not including the person who attempted was not because of malice but more out of not knowing how to talk about suicide with the person who attempted. There was a temporary loss for words. I realized, based on this research, that I did not need to have the correct words, in the preliminary analysis it was becoming apparent that healing came in holding safe space, in not being judgemental, and in listening. In doing this research and the personal experience with a close maternal figure attempting suicide, I realized, to hold a safe space requires that I am self-reflective and implementing self-care.

Self-Care

The research participants all talked about how self-care was part of their recovery. I was quick to reflect on my own self-care and how it was the first thing to

disappear when my schedule gets full, especially in the postpartum period. In doing this research, there were times when my heart would hurt. Sitting in the experiences of these participants and saturating myself within these mothers' words, really trying to fully understand their embodied experience of suicidality when pregnant or postpartum, it could get dark and heavy within my own thoughts. Suicidality is a dark place to be mentally, emotionally, and physically. Considering I was walking my own postpartum journey it was not difficult for me to immerse myself into the words of another mother.

If a participant recalled sleepless nights being frustrating or triggering of suicidal thoughts, I could undoubtedly understand, as just the night before I would have been up multiple times to feed Ayla. I could see how they get there, but also see the differences. While I sigh and moan as I get out of bed for the third time in the past two hours to go feed Ayla, my brain does not jump to suicide, as frustrated and tired as I am, I still appreciated the weight of her body against mine as I feed her, the fluff of her hair, and the way her hand searches for my face in the dark. Sitting in the dark (or moonlight), breastfeeding my child at 1:00 am, I would often think of my thesis and the emerging themes. I would crawl into bed utterly exhausted and make note to myself that tomorrow I need to do something for me. Self-care was essential in completing this work. Yoga, spin biking, skiing, and walking (really, I was pushing the stroller trying to get Ayla to sleep) all helped me move through the thoughts, feelings, emotions and gave me the energy to do it all (i.e., mothering while writing a thesis).

Specifically, yoga was the way in which I would literally lay down heaviness of other people's suicidality experiences. While I can appreciate that my body can make certain yoga postures, perfection in the posture is not the goal of my practice. Yoga is a

practice that grounds me, it is space for me to move from being stuck in my thoughts to being in my body. Focusing on my breath allows me to connect to myself. When I got stuck on constructs, ideas, or emerging themes for the thesis, I would bring it all to my yoga mat. When I felt heavy from holding on to the mothers' stories of trying to understand the embodiment of a PMAD and suicidality, journaling was not enough, I surrendered it to my mat.

While the practice takes place on a mat, with me doing certain postures, the effects of the practice ripple out into many parts of my life. My self-compassion is fostered through my yoga practice. Failing on my mat, falling out of a difficult balancing posture, knowing I can try again, and seeing the results of trying the posture again; allows me to move past feeling like a failure. How can I surrender more to the discomfort of the pose with grace, ease, and softening? How can I apply this to mothering? Mom guilt, shame, feeling like a failure as a mother, do not serve me in being the best mom I can be to my children, and these are the things I leave on my yoga mat. The beauty of this practice is that there is no perfection and continually meeting myself where I am in that moment on any given day. I have found strength, perseverance, the knowledge that emotions will not last forever, creativity, joy, laughter, and connection to something greater than myself. My yoga practice helps me to show up with integrity to do my research and practice self-care as a counsellor.

Figure 3

Leaving it on the Yoga Mat

Note. I created the image from paint being placed on my hands and feet which then depicted the flow and movement during a hatha flow yoga practice.

This research has influenced me as a counsellor in many positive ways. As a result of interviewing the 8 mothers, I have become more keenly aware of the language to listen for that may indicate the mother is feeling suicidal, such as “feeling like a failure as a mother”, “my children would be better off without me”, or “someone else could parent my children better”. Next, the importance to further inquire about how the mother is feeling as she may be presenting a façade of a happy mom. In this study, mothers explained their experience of a PMAD and suicidality with descriptive words like, desolate, destruction, robotic, hollow, empty, etc. I am now more aware of the high levels

of distress that mothers embody when experiencing a PMAD. As a counsellor, I am now that much more conscious of the unique and urgent distress a mother with a PMAD could be feeling in the postpartum period. The high levels of distress a mother with a PMAD experiences highlight the importance of creating a safe space and practicing therapeutic holding of the mother. As a counsellor, I aspire to provide a space of therapeutic holding where such healing can occur.

Completing this research was a great honour. I thoroughly enjoyed the process of interviewing each mother. There are parts of each mother's story that I connect with on a personal level, as a mother, and as a woman. For me, as a researcher and a counsellor in training, in writing the second manuscript with each mother's story from the inception of a PMAD to the process of getting help, going to counselling, and recovery, was very powerful and impactful. More specifically, I hope that other mothers suffering from perinatal suicidality can read the stories and connect to these mothers who have been where they are, understand the intensity of feeling like a failure as a mother, and feel the possibility of hope that others have been there too, and have recovered.

References

Ajdacic-Gross, V., Hepp, U., Seifritz, E., & Bopp, M. (2019). Rethinking suicides as mental accidents: Towards a new paradigm. *Journal of Affective Disorders, 252,* 141-151. https://doi.org/10.1016/j.jad.2019.04.022

Alhusen, J. L., Frohman, N., & Purcell, G. (2015). Intimate partner violence and suicidal ideation in pregnant women. *Archives of Women's Mental Health, 18*(4), 573-578. http://doi.org/10.1007/s00737-015-0515-2

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th Ed.) Washington, DC: Publisher.

American Psychological Assciation. (n.d.) APA dictionary of psychology. Retrieved December 4, 2020 from https://dictionary.apa.org/suicidality

American Psychiatric Association's Task Force on Research Ethics (2006). *Ethical principles and practices for research involving human participants with mental illness, 57*(4), 552-557. http://doi.org/10.1176/ps.2006.57.4.552

Ammerman, R. T., Scheiber, F. A., Peugh, J. L., Messer, E. P., Van Ginkel, & J. B., Putnam, F. W. (2019). Interpersonal trauma and suicide attempts in low-income depressed mothers in home visiting. *Child Abuse and Neglect, 97,* 104126. https://doi.org/10.1016/j.chiabu.2019.104126

Bambridge, G. A. Shaw, E. J., Ishak, M., Clarke, S. D., & Baker, C. (2017). Perinatal mental health: how to ask and how to help. *The Obstetrician & Gynaecologist, 19,* 147-153. https://doi.org/10.1111/tog.12376

Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review, 97,* 90–113. https://doi.org/10.1037/0033-295x.97.1.90

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *The American Journal of Psychiatry, 147*, 190–195. https://doi.org/10.1176/ajp.147.2.190

Berens, P. (2017). Overview of postpartum care. https://enjoypregnancyclub.com/wp-content/uploads/2017/06/Overview%20of%20postpartum%20care.pdf

Cha, C. B., & Nock, M. K. (2009). Emotional intelligence is a protective factor for suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(4), 422-430. https://doi.org/10.1097/CHI.0b013e3181984f44

Clandinin, D. J. (2006). Narrative Inquiry: A methodology for studying lived experience. *Research Studies in Music Education, 27*, 44-54. https://doi.org/10.1177/1321103X060270010301

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational Researcher*, (5). https://doi.org/10.3102/0013189X019005002

Cook, J. L., Majid, M., Blake, J., Scott, H., Tough, S., & Wong, T. (2017). Measuring maternal mortality and morbidity in Canada. *Journal of Obstetrics and Gynecology Canada, 39*(11), 1028-1037, https://doi.org/10.1016/j.jogc.2017.06.021

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine, 44*, 3361-3363. https://doi.org/10.1017/S0033291714001299

DeBeurs, D., Fried, E. I., Wetherall, K., Cleare, S., O'Connor, D. B., Ferguson, E., O'Carroll, R. E., & O'Connor, R. C. (2019). Exploring the psychology of suicidal ideation: A theory driven network analysis. *Behaviour Research and Therapy,*

120(103419), https://doi.org/10.1016/j.brat.2019.103419

Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin*, *51*(4), 327-358. https://doi.org//10.1037/h0061470

Freedenthal, S. (2017, September 21). Language matters: committed suicide vs. completed suicide vs. died by suicide. *Speaking of Suicide*. https://www.speakingofsuicide.com/2017/09/21/suicide-language/

Gallo, L. L., Moro, R. R., & Moore, L. (2019). Suicide content published in counseling journals: A 21-year content analysis to inform research and practice. *Journal of Mental Health Counselling*, *4*(2), 158-172. https//doi.org/10.17744/mehc.41.2.05

Gausia, K., Fisher, C., Ali, M., & Oosthuizen, J. (2009). Antenatal depression and suicidal ideation among rural Bangladeshi women: A community-based study. *Archives of Women's Mental Health, 12*, 351-358. https://doi.org/10.1007/s00737-009-0080-7

Gavin, A. R., Tabb, K. M., Melville, J. L., Guo, Y., & Katon, W. (2011). Prevalence and correlates of suicide ideation during pregnancy. *Archives Women's Mental Health, 14*(3), 239-246. https://doi.org/10.1007/s00737-011-0207-5

Glasser, S., Levinson, D., Gordon, E. S., Braun, T., Haklai, Z., & Goldberger, N. (2018). The tip of the iceberg: postpartum suicidality in Israel. *Israel Journal of Health Policy Research, 7*(34). https://doi.org/10.1186/s13584-018-0228-x

Gold, K. J., Singh, V., Marcus, S. M., & Palladino, C. L. (2012). Mental health, substance use and intimate partner problems among pregnant and postpartum suicide victims in the National Violent Death Reporting System. *General Hospital Psychiatry, 34*(2), 139-145. https://doi.org/10.1016/j.genhosppsych.2011.09.017

Goldman-Mellor, S., & Margerison, C. E. (2019). Maternal drug-related death and suicide are leading causes of postpartum death in California. *Journal of Obstetrics and Gynecology, 221*(489), 1-9. https://doi.org/10.1016/j.ajog.2019.05.045

Gressier, F., Guillard, V., Cazas, O., Falissard, B., Glangeaud-Freudenthal, N. M. C., & Sutter-Dallay, A. (2017). Risk factors for suicide attempt in pregnancy and the postpartum period in women with serious mental illnesses. *Journal of Psychiatric Research, 84*, 284-291. https://doi.org/10.1016/j.jpsychires.2016.10.009

Grigoriadis, S., Wilton, A. S., Kurdyak, P. A., Rhodes, A. E., VonderPorten, E. H., Levitt, A., Cheung, A., & Vigod, S. N. (2017). Perinatal suicide in Ontario, Canada: a 15-year population-based study. *Canadian Medical Association Journal, 189*(34), 1085-1092. https://doi.org/10.1503/cmaj.170088

Hardy, L. T., Reichenbacker, O. L. (2019). A practical guide to the use of psychotropics during pregnancy and lactation. *Archives of Psychiatric Nursing 33*(3), https://doi.org/10.1016/j.apnu.2019.04.001

Hasegawa, J., Katsuragi, S., Tanaka, H., Kubo, T., Sekizawa, A., Ishiwata, I., & Ikeda, T. (2020). How should maternal death due to suicide be classified? Discrepancy between ICD-10 and ICD-MM. *BJOG An International Journal of Obstetrics and Gynecology. 127*, 665-667. https://doi.org/10.1111/1471-0528.16087

Healey, C., Morriss, R., Henshaw, C., Wadoo, O., Sajjad, A., Scholefield, H., & Kinderman, P. (2013). Self-harm in postpartum depression and referrals to a perinatal mental health team: an audit study. *Archives of Women's Mental Health, 16*(3), 237–45. https://doi.org/10.1007/s00737-013-0335-1

Hjelmeland, H., & Knizek, B. L. (2020). The emperor's new clothes? A critical look at

the interpersonal theory of suicide. *Death Studies*, *44*(3), 168-178. https://doi.org/10.1080/07481187.2018.1527796

Huang, H., Faisal-Cury, A., Chan, Y., Tabb, K., Katon, W., & Menezes, P. R. (2012). Suicidal ideation during pregnancy: prevalence and associated factors among low-income women in Sao Paula, Brazil. *Archives of Women's Mental Health, 15*(2), 135-138. https://doi.org/10.1007/s00737-012-0263-5

Hwang, W. Y., Choi, S. Y., Jeong An, H. (2021). Concept analysis of transition to motherhood: a methodological study. *Korean Journal of Women Health Nursing, 28*(1), 8-17. https://doi.org/10.4069/kjwhn.2022.01.04

Ishida, K., Stupp, P., Serbanescu, F., & Tullo, E. (2010). Perinatal risk for common mental disorders and suicidal ideation among women in Paraguay. *International Journal of Gynecology and Obstetrics, 110,* 235-240. https://doi.org/10.1016/j.ijgo.2010.03.027

Johannsen, B. M., Larsen, J. T., Laursen, T. M., Bergink, V., Meltzer-Brody, S., & Munk-Olsen, T. (2016). All-cause mortality in women with severe postpartum psychiatric disorders. *The American Journal of Psychiatry*, *173*(6), 635–42. https://doi.org/10.1176/appi.ajp.2015.14121510

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients.* American Psychological Association.

Khalifeh H., Hunt, I. M., Appleby, L., & Howard, L. M. (2016). Suicide in perinatal and non-perinatal women in contact with psychiatric services: 15-year findings from a UK national inquiry. *Lancet Psychiatry*, *3*(3), 233-42.

https://doi.org/10.1016/S2215-0366(16)00003-1

Kim, J. J., La Porte, L. M., Saleh, M. P., Allweiss, S., Adams, M. G., Zhou, Y., & Silver, R. K. (2015). Suicide risk among perinatal women who report thoughts of self-harm on depression screens. *Obstetrics and Gynecology*, *125*(4), 885-893. https://doi.org/ 10.1097/AOG.0000000000000718

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory rooted in the "idea to action" framework. *International Journal of Cognitive Therapy*, *8*(2), 114-129.

Knasmüller, P., Kotal, A., König, D., Vyssoki, B., Kapusta, N., & Blüml, V. (2019). Maternal suicide during pregnancy and the first postpartum year in Austria: Findings from 2004 to 2017. *Psychiatry Research, 281*, 1112530, https://doi.org/10.1016/j.psychres.2019.112530

Kubota, C., Inada, T., Shiino, T., Ando, M., Sato, M., Nakamura, Y., Yamauchi, A., Morikawa., M., Okada, T., Ohara, M., Aleksic, B., Murase, S., Goto, S., Kanai, A., & Ozaki, N. (2020). The risk factors predicting suicidal ideation among perinatal women. *Frontiers in Psychiatry*, *11*(441), 1-7. https://doi.org/10.3389/fpsyt.2020.00441

Laditan, B. (2019). *Dear mother: Poems on the hot mess of motherhood.* Harlequin Enterprises Limited.

Lega, I., Maraschini, A., D'Aloja, P., Andreozzi, S., Spettoli, D., Giangreco, M., Vichi, M., Loghi, M., Donati, S., the Regional Maternal Mortality Working Group, Alberico, S., Antonelli, A., Asole, S., Basevi, V.,Borsari, S., Cetin, I., Dardanoni, G., Di Lallo, D., Dubini, V., & Germinario, C. (2020). Maternal suicide in Italy.

Archives of Women's Mental Health, *23*(2), 199–206. https://doi.org/10.1007/s00737-019-00977-1

Li, S., Yaseen, Z.S., Kim, H., Briggs, J., Duffy, M., Frechette-Hagan, A., Cohen, L. J., & Galynker, I. I. (2018). Entrapment as a mediator of suicide crises. *BMC Psychiatry 18*(4) https://doi.org/10.1186/s12888-018-1587-0

Lindahl, V., Pearson, J. L., & Colpe, L. (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archives of Women's Mental Health, 8*(2), 77-87. https://doi.org/10.1007/s00737-005-0080-1

Locher, B., & Prügl, E., (2001). Feminism and constructivism: Worlds apart or sharing the middle ground? *International Studies Quarterly*, *45*(1), 111 -129. https://www.jstor.org/stable/3096103

Lysell, H., Dahlin, M., Viktorin, A., Ljungberg, E., D'Onofrio, BM., Dickman, P., & Runeson, B. (2018). Maternal suicide: register based study of all suicides occurring after delivery in Sweden 1974-2009. *PLoS ONE*, *13*(1), 1-8. https://doi.org/10.1371/journal.pone.0190133

MacQueen, G. M., Frey, B. N., Ismail, Z., Jaworska, N., Steiner, M., Van Lieshout, R. J., Kennedy, S. H., Lam, R. W., Milev, R., Parikh, S. V., Ravindran, A .V., & the CANMAT Depression Work Group. (2016). Canadian network for mood and anxiety treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: Section 6. Special populations: youth, women and the elderly. *The Canadian Journal of Psychiatry, 6*(19), 588-603. https://doi.org/10.1177/0706743716659418

McAlpine, L. (2016). Why might you use narrative methodology? A story about

narrative. *Estonian Journal of Education, 4*(1), 32-57. https://doi.org/10.12697/eha.2016.4.1.02b

McGowan, I., Sinclair, M., & Owens, M. (2007). Maternal suicide: rates and trends. *RCM Midwives: the official Journal of the Royal College of Midwives 10*(4): 167-169. http://www.rcm.org.uk/midwives/features/maternal-suicide-rates-and-trends/?locale=en

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organized peer support in pregnancy and early parenthood: a qualitative study. *BioMed Central, 17*(28), 1-14. https://doi.org/10.1186/s12884-017-1220-0

Michel, K., Valach, L., & Gysin-Maillart, A. (2017). A novel therapy for people who attempt suicide and why we need new models of suicide. *International Journal of Environmental Research and Public Health, 14,* 243-258. https://doi.org/10.3390/ijerph14030243

Minaker, J. (2012). The space between. In G. Wong, (Ed.), *Moms gone mad: Motherhood and madness, oppression and resistance,* (pp. 124-140). Demeter Press.

Mota, N. P., Chartier, M., Ekuma, O., Nie, Y., Hensel, J. M., MacWilliam, L., McDougall, C., Vigod, S., & Bolton, J. M. (2019). Mental disorders and suicide attempts in the pregnancy and postpartum periods compared with non-pregnancy: A population-based study. *The Canadian Journal of Psychiatry, 64*(7), 482-491. https://doi.org/10.1177/0706743719838784

Muzik, M., Brier, Z., Menke, R. A., Davis, M. T., & Sexton, M. B. (2016). Longitudinal

suicidal ideation across 18-months postpartum in mothers with childhood maltreatment histories. *Journal of Affective Disorders, 204,* 138–145. https://doi.org/10.1016/j.jad.2016.06.037

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee S. (2008). Suicide and suicidal behaviour. *Epidemiologic Reviews, 30*(1), 133-154. https://doi.org/10.1093/epirev/mxn002

Nugent, A. C., Ballard, E. D., Park, L. T., & Zarate, C. A. (2019). Research on the pathophysiology, treatment, and prevention of suicide: practical and ethical issues. *BMC Psychiatry, 19,* 332-334. https://doi.org/10.1186/s12888-019-2301-6

Oates, M. (2009). The confidential enquiry into maternal deaths 1997-2005: Implications for practice. *Psychiatry, 8*(1), 13-16. https://doi.org/10.1016/j.mppsy.2008.10.013

O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences, 373(1754), 20170268.* https://doi.org/10.1098/rstb.2017.0268

Onah, M. N., Field, S., Bantjes, J., & Honikman, S. (2017). Perinatal suicidal ideation and beahaviour: psychiatry and adversity. *Archives of Women's Mental Health, 20*(2), 321-331. https://doi.org/10.1007/s00737-016-0706-5

Palladino, E., Varin, M., Lary, T., & Baker, M. M. (2020). Thoughts of self-harm and associated risk factors among postpartum women in Canada. *Journal of Affective Disorders, 270,* 69-74. https://doi/org/10.1016/j.jad.2020.03.054

Patrick, K. (2013). It's time to put maternal suicide under the microscope. *Canadian Medical Association Journal, 185*(13), 1115. https://doi.org/10.1503/cmaj.131248

Perlman, C. M., Neufeld, E., Martin, L., Goy, M., & Hirdes, J. P. (2011). *Suicide risk*

assessment inventory: A resource guide for Canadian health care organizations. Ontario Hospital Association and Canadian Patient Safety Institute.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Praetorius, R., Maxwell, D., Alam, K. (2020). Wearing a happy mask: mother's expressions of suicidality with postpartum depression. *Social Work in Mental Health, 18*(4), 429-459. https://doi.org/10.1080/15332985.2020.1769003

Rai, S., Pathak, A., & Sharma, I. (2015). Postpartum psychiatric disorders: Early diagnosis and management. *Indian Journal of Psychiatry, 57*(2), 216-221. https://doi.org/10.4103/0019-5545.161481

Rodrigues Farias, D., de Jesus Pereira Pinto, T., Teofilo M. M. A., Freitas Vilela, A. A., dos Santos Vaz, J., Egidio Nardi, A., & Kac, G. (2013). Prevalence of psychiatric disorders in the first trimester of pregnancy and factors associated with current suicide risk. *Psychiatry Research, 210*(3), 962-968. https://doi.org/10.1016/j.psychres.2013.08.053

Schotte, D. E., & Clum, G. A. (1987). Problem-solving skills in suicidal psychiatric patients. *Journal of Consulting and Clinical Psychology, 55,* 49–54. https://doi.org/10.1037//0022-006x.55.1.49

Shi, P., Ren, H., Li, H., & Dai, Q. (2018). Maternal depression and suicide at immediate prenatal and early postpartum periods and psychosocial risk factors. *Psychiatry Research, 261,* 298-306. https://doi.org/10.1016/j.psychres.2017.12.085

Shneidman, E. S. (1993). Suicide as psychache. *The Journal of Nervous and Mental*

Disease, 181, 145–147. https://doi.org/10.1097/00005053-199303000-00001

Sit, D., Luther, J., Buysse, D., Dills, J. L., Eng, H., Okun, M., Wisniewski, S., & Wisner, K. L. (2015). Suicidal ideation in depressed postpartum women: Associations with childhood trauma, sleep disturbance and anxiety. *Journal of Psychiatric Research, 66-67*, 95-104. https://doi.org/10.1016/j.jpsychires.2015.04.021

Smith, J. A. (1999). Toward a relational self: Social engagement during pregnancy and psychological preparation for motherhood. *British Journal of Social Psychology, 38*, 409-426. https://doi.org/10.1348/014466699164248

Smith J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54. https://doi.org/10.1191/1478088704qp004o

Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well Being, 2*, 3-11. https://doi.org/10.1080/17482620601016120

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9–27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research.* Sage.

Socholotiuk, K. D., Domene, J. F., & Trenholm, A. L. (2016). Understanding counselling and psychotherapy research: a primer for practitioners. In N. Gazzola, M. Buchanan, O. Sutherland, & S. Nuttgens, (Eds.), *Handbook of Counselling and Psychotherapy in Canada* (pp. 247-263). Canadian Counselling Psychotherapy

Association.

Statistics Canada. (2013). *Maternal Mortality in Canada*, Catalogue number HP32-7/2011E-PDF. https://publications.gc.ca/site/eng/403762/publication.html

Statistics Canada. (2018). *Deaths, 2018,* Catalogue number 11-001-X. https://www150.statcan.gc.ca/n1/en/daily-quotidien/191126/dq191126c-eng.pdf?st=3KMUgJx-

Statistics Canada. (2019). *Survey on Maternal Mental Health 2018/2019* [Infographics], Catalogue number 11-627-M. https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2019041-eng.htm

Suicide Prevention Resource Center, & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide.* Education Development Center, Inc. https://www.sprc.org/sites/default/files/migrate/library/RiskProtectiveFactorsPrimer.pdf

Surgenor, P. W. G. (2015). Promoting recovery from suicidal ideation through the development of protective factors. *Counselling and Psychotherapy Research, 15*(3), 207-216. https://doi.org/10.1002/capr.12035

Tabb, K. M., Gavin, A. R., Faisal-Cury, A., Nidey, N., Chan, Y., Malinga, T., Meline, B., & Huang, H. (2019). Prevalence of antenatal suicidal ideation among racially and ethnically diverse WIC enrolled women receiving care in a Midwestern public health clinic. *Journal of Affective Disorders, 256,* 278-281. https://doi.org/10.1016/j.jad.2019.06.012

Tabb, K. M., Gavin, A. R., Guo, Y., Huang, H., Debiec, K., & Katon, W. (2013). Views

and experiences of suicidal ideation during pregnancy and the postpartum: Findings from interview with maternal care clinic patients. *Women's Health, 53*(5), 519-535. https://doi.org/10.1080/03630242.2013.804024

Takeda, S., Takeda, J., Murakami, K., Kubo, T., Hamada, H., Murakami, M., Makino, S., Itoh, H., Ohba, T., Naruse, K., Tanaka, H., K, Kanayama, N., Matsubara, S., Sameshima, H., & Ikeda, T. (2017). Annual Report of the Perinatology Committee, Japan Society of Obstetrics and Gynecology, 2015: Proposal of urgent measures to reduce maternal deaths. *Journal of Obstetrics Gynaecology*, *68*(6), https://doi.org/10.1111/jog.13184

Tavares, D., Quevedo, L., Jansen, K., Souza, L., Pinheiro, R., & Silva, R. (2012). Prevalence of suicide risk and comorbidities in postpartum women in Pelotas. *Journal of the Brazilian Psychiatric Association*, *34*(3), 270-276. https://doi.org/10.1016/j.rbp.2011.12.001

Taylor, C. L., van Ravesteyn, L. M., Lambregtse van denBerg, M. P., Stewart, R. J., & Howard, L. M. (2016). The prevalence and correlates of self-harm in pregnant women with psychotic disorder and bipolar disorder. *Archives of Women's Mental Health*, *19*(5), 909-915. https://doi.org/10.1007/s00737-016-0636-2

Urlichs, J. (2020). *All I see is you: Poetry and proses on motherhood*. Jessica Urlichs

Valach, L. (2020). A non-cartesian view of suicide and suicide prevention intervention. *Journal of Psychosocial Rehabilitation Mental Health, 7*, 189-196. https://doi.org/10.1007/s40737-020-00161-0

Vangen, S., Bødker, B., Ellingsen, L., Saltvedt, S., Gissler, M., Geirsson, R. T., & Nyfløt, L. T. (2017). Maternal deaths in Nordic countries. *Acta Obstetricia et Gynecologica Scandinavica*, *96*, 1112-1119. https://doi.org/10.1111/aogs.13172

van Manen, M. (2007). Phenomenology of Practice. *Phenomenology & Practice*, *1*(1), 11-30. https://www.maxvanmanen.com/files/2014/03/Max-Phenomenology-of-Practice1.pdf

Viergever, R. F. (2019). The critical incident technique: method or methodology? *Qualitative Health Research*, *29*(7), 1065-1079. https://doi.org/10.1177/1049732318813112

Viswasam, K., Eslick, G. D., & Starcevic, V. (2019). Prevalence, onset and course of anxiety disorders during pregnancy: A systematic review and meta analysis. *Journal of Affective Disorders*, *255*, 27–40. https://doi.org/10.1016/j.jad.2019.05.016

Watkins, K. E., Ellinger, A. D., Suh, B., Brenes-Dawsey, J. C., & Oliver, L. C. (2022). Further Evolving the critical incident technique (CIT) buy applying different contemporary approaches for analyzing qualitative data in CIT studies. *European Journal of Training and Development*, *46* (7), 709-726. https://doi.org/10.1108/EJTD-07-2021-0107

Weston, K. (2018). Maternal death rates drop, maternal suicide remains high. *Kai Tiaki/Nursing New Zealand*, *24*(6), 7.

Williams, J., Ryan, D., Thomas-Peter, K., Cadario, B., & Li, D. (2014). *Best practice guidelines for mental health disorders in the perinatal period*. BC Reproductive Mental Health Program & Perinatal Services BC.

Winter, D., Bradshaw, S., Bunn, F., & Wellsted, D. (2014). A systematic review of the literature on counselling and psychotherapy for the prevention of suicide: 2. Qualitative studies. *Counselling & Psychotherapy Research*, *14*(1), 64–79. https://doi.org/10.1080/14733145.2012.737004

Wong, G. (Ed.). (2012). *Moms gone mad: Motherhood and madness, oppression and resistance*. Demeter Press.

World Health Organization. (2018). *Maternal mental health*. https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

Appendix A: Ethics Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **24341**

Principal Investigator:
Vanessa Vandergaag, Graduate Student
Faculty of Health Disciplines\Master of Counselling

Supervisor:
Dr. Gina Wong (Supervisor)

Project Title:
Perinatal Suicidality: Mothers' Experiences of Recovery Following Counselling

Effective Date: July 06, 2021 **Expiry Date**: July 05, 2022

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: July 06, 2021**

Jeff Chang, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL - RENEWAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

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Approved by: **Date: June 27, 2022**

Carolyn Greene, Chair
Athabasca University Research Ethics Board

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Appendix B: Demographic Information Sheet

DEMOGRAPHIC INFORMATION SHEET

Study Title: Perinatal Suicidality: Mother's Experiences of Recovery Following Counselling

Researcher: Vanessa Vandergaag, Master of Counselling Student, Athabasca University, Faculty of Health Disciplines, Graduate Centre for Applied Psychology

Contact: vvandergaag1@athabasca.edu

Supervisor: Dr. Gina Wong, Professor, Registered Psychologist, Athabasca University, Faculty of Health Disciplines, Graduate Centre for Applied Psychology

Contact: ginaw@athabascau.ca or 1-866-442-3089

Name:

Age:

Gender:

Current Location of Residence:

Country of Origin:

Cultural Background:

Marital Status:

Highest Level of Education Obtained:

Employment and Current Occupation:

How many pregnancies have you had?

Please list pregnancies that have ended in fetal loss (still birth), miscarriages, or abortion.

How many full term births have you had?

Have you had any issues with fertility?

How many biological children do you have?

How many non-biological children do you have?

What are the ages of your living child(ren)?

Were you diagnosed with a maternal mental health illness? If yes, what was the diagnosis? At what time? (e.g., 22 weeks pregnant, 12 weeks postpartum, etc.)

Appendix C: Semi-Structured Interview Schedule

SEMI-STRUCTURED INTERVIEW SCHEDULE

The following are examples of questions and prompts to be used during the interview with the participant to guide the conversation towards answering the research question.

1. Please tell me about your experience of pregnancy and postpartum.
2. In the past, did you attempt suicide? (How many times?)
3. Have you experienced suicidal thoughts before pregnancy?
4. Is there a family history with suicide (attempts or deaths)?
5. Is there a family history (mother, grandmother) with perinatal mood disorders (did they seek counselling or treatment)?
6. Which child(ren) did you experience suicidal ideation (e.g., 1st born, 2nd born, etc)?

   On a scale of 0-10, with 10 being the strongest almost to the extent of an active suicide attempt, how would you rate your level of suicidality when it was at its peak in the postpartum period. How old was your baby at that time?
7. Has experiencing suicidal thoughts changed the way you think or feel about yourself as a mother? About others (partner, child)? *Possible prompt*: Did it affect your relationship with your infant? Partner? Family? Friends?
8. If you feel comfortable, can you share an example of suicidal thoughts? Did you have a plan at any time? How close did you get to carrying out the plan?
9. Did you tell anyone about the suicidal thoughts?
10. *Possible prompt:* What were their reactions? Did you feel supported?
11. How did you decide to seek counselling?

12. Possible prompt: How did you decide where to go? How did you select your provider?
13. Can you describe your counselling relationship? How long did you see your counsellor?
14. *Possible prompt*: How did it feel to make the first visit? What was your experience of the counselling relationship? How soon was it in the counselling process that you discussed your suicidal thoughts? Concerning the suicidal thoughts what helped you in counselling?
15. Can you tell me how you dealt with thoughts about wanting to die?

    Possible prompt: Did you have strategies for managing suicidal thoughts? Did you learn this from counselling?
16. Describe your recovery from suicidality. How would you describe the role of counselling in your recovery?
17. What questions haven't I asked that will contribute to understanding about your experience of suicide and recovery following counselling during the perinatal period?

Appendix D: Informed Consent Form

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Perinatal Suicidality: Mothers' Experiences of Recovery Following Counselling

Researcher: *Vanessa Vandergaag*

Master of Counselling Student, Athabasca University, Faculty of Health Disciplines, Graduate Centre for Applied Psychology
Contact: vvandergaag1@athabasca.edu

Supervisor: *Dr. Gina Wong*

Professor, Registered Psychologist, Athabasca University, Faculty of Health Disciplines, Graduate Centre for Applied Psychology
Contact: ginaw@athabascau.ca
1-780-220-8610

Informed Consent
This form is part of the process of informed consent. The information presented should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. In order to decide whether you wish to participate in this research project, you should understand enough about its risks, benefits, and what it requires of you to be able to make an informed decision.

Please take time to read this carefully as it is important that you understand the information given to you. Please contact the researcher, Vanessa Vandergaag if you have any questions about the project or would like more information before you consent to participate.

It is entirely up to you whether or not you take part in this research. If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future.

Introduction
My name is Vanessa Vandergaag, and I am a Master of Counselling Student at Athabasca University. As a requirement to complete my degree, I am conducting a thesis research project about mother's experiences of recovery of perinatal suicidality following counselling. Perinatal includes the time during pregnancy and postpartum. Suicidality includes thoughts and feeling of being at risk for taking one's life. Recovery is considered as moving towards the desire to live. Suicide is one of the leading causes of death in the perinatal period, however there is limited information regarding treatment and recovery. This study provides an opportunity to understand how counselling aids in supporting mothers who struggle with suicidality in the perinatal period. I am conducting this project under the supervision of Dr. Gina Wong who is a registered psychologist specializing in perinatal mood and anxiety disorders.

Why are you being asked to take part in this research project?
You are being invited to participate in this project because you meet the inclusion criteria:

- You have indicated that you experienced and recovered from perinatal suicidality.
- You have also experienced counselling for perinatal suicidality and consider yourself recovered.
- It has been 6 months or longer since you have experienced and been distressed by suicidality.

What is the purpose of this research project?
The purpose of this research project is to learn about your experiences with suicidality during the perinatal period and share your story of recovering from suicidality. Women's perspectives and stories are missing in the current research literature on perinatal suicidality.
We want to know about your past counselling experiences and how they helped in your recovery. For example, what was it about counselling that helped? Who did you seek counselling from? What was unhelpful about counselling? What do you wish healthcare providers knew about perinatal suicidality? We are interested in what else helped your recovery besides counselling.

The results of this study will promote knowledge in awareness, prevention, and treatment of perinatal suicidality. The results of the study will assist counsellors to better understand how to help women experiencing perinatal suicidality. The study will hopefully reduce stigma around seeking help and encourage other women struggling with perinatal suicidality to seek help.

What will you be asked to do?
Your participation in this project would involve completing a brief demographic information sheet. The demographic information sheet will be emailed to you to complete any time that is convenient to you and return it prior to the interview. You will complete a 2-3 hour interview with the researcher. The interview is designed to hear your story and experiences with perinatal suicidality and counselling. The interview will include questions on your experiences of suicidality, expectations of a new mother, past counselling's experiences. The interview will be scheduled at a time that is convenient to you. The interview will be audio and video recorded over Zoom 5.0 video communications to ensure accuracy in transcribing information. The Zoom recordings will only be saved to the researcher's password protected computer. Prior to the interview a Zoom meeting link will be emailed to you.

After the interview, your interview transcript will be emailed to you within a month so that you can fill in possible gaps, clarify statements, and ensure that the researcher has accurately captured and interpreted your experiences. At that time, you will have the opportunity to ask any further questions and include any additional information to your interview transcript that you believe is relevant. The researcher may also ask you further questions to help her better understand your experiences.

A follow-up interview may be scheduled. During this second interview, you will be able to see what themes the researcher has identified and check these themes for accuracy. The researcher will take your feedback and incorporate it into the study. If you disagree with any interpretations the researcher has made, you will be able to work with her to revise it. You will be able to ask the researcher any questions you have about the study, which will be answered in this session. This follow-up interview will take a maximum of one hour and will be scheduled for a date and time that is most convenient to you.

The recordings, transcripts, and all other information collected about you for the purposes of this study will only be accessible to you, the researcher, and her supervisor, Dr. Gina Wong. All email communications will be kept private and confidential.

What are the risks and benefits?
There are some potential risks associated with participating in this research study. There are questions being posed to participants of a sensitive nature about the topic of perinatal suicidality. There is a possibility that the interview may be triggering for your and bring up unpleasant thoughts, feelings, or memories. However, we believe that the impact of people sharing their story of recovery and having their voice heard will be positive. If you decide to take part in this study and experience overwhelming or uncomfortable feelings or thoughts, you may choose to pause, have the interview rescheduled for another time, or withdraw from the study. Prior to the interview, resources will be provided for maternal mental health, general mental health (e.g., counselling services) and crisis support (e.g,. crisis telephone numbers).

You may or may not benefit directly from participating in this study. A potential benefit is that you may feel empowered when talking about their experiences of recovery. Talking about experiences of perinatal suicidality may reduce the stigma associated with perinatal mental health and may help other women experiencing perinatal suicidality to seek help. Potential benefits for counsellors are developing knowledge around effective treatment for perinatal suicidality, to normalize and raise awareness about perinatal mental health.

Do you have to take part in this project?
As stated earlier in this form, involvement in this project is entirely voluntary. You can choose to end your participation at any time without having to provide a reason. If you choose to withdraw your consent, there will be no negative consequences for doing so.

During data collection, you may choose to pause the interview, have the interview rescheduled for another time, or withdraw from the study. Data collected up until that point may be used for data analysis unless stated that you want the data removed from the project.

Data can be removed from the project after participation has ended, at your request, up to the start of data analysis.

How will your privacy and confidentiality be protected?

The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure. If you decide to participate in this study, the researcher will ask and collect only the information needed for this study.

Email or telephone correspondence with the researcher will be kept private and confidential. All confidential information will be accessible only to the researcher, Vanessa Vandergaag, and her supervisor, Dr. Gina Wong.

All information that you provide will be held strictly confidential, except when legislation or a professional code of conduct requires that it be reported (e.g. imminent risk of harm to yourself or someone else).

How will my anonymity be protected?
Anonymity refers to protecting participants' identifying characteristics, such as name or description of physical appearance.

During the interview transcription all participants identifying information will be removed and replaced with a pseudonym. You may choose a pseudonym, or one will be assigned to your data files that will be used to identify you. Every reasonable effort will be made to ensure your anonymity; you will not be identified in publications without your explicit permission.

How will the data collected be stored?

The data collected from this project will be uploaded and stored to Basecamp as encrypted data. Basecamp is a project management software with the latest web security, it will be password protected, and the files are encrypted. To protect confidential data the transcripts will use a pseudonym (a false name).

After 5 years, the data stored on basecamp will be erased using a software application that is designed to overwrite data files rendering them obsolete.

Secondary analysis would include analysis of the data, at a later date, with a different lens or the purpose of answering a different research question. Any proposed secondary analysis would go through a process of ethics approval with the Athabasca University Research Ethics Board.

Who will receive the results of the research project?

The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available.

When the results of this study are disseminated, your identity will not be disclosed.In the final research paper quotes from the interview may be used, but you will not be identified.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact Vanessa Vandergaag (vvandergaag1@athabasca.edu).

What are the rights of participants in a research study?

You have the right to receive all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction, before you make any decision. You have the right to ongoing consent throughout the research process and you also have the right to ask questions and to receive answers throughout this study.

If you have any questions or would like more information, please contact me, (the researcher) by e-mail vvandergaag1@athabasca.edu or my supervisor by ginaw@athabascau.ca *or 1-780-220-8610.* If you are ready to participate in this project, *please complete and sign the attached Consent Form and return it by* email to Vanessa prior to your scheduled interview.

Thank you.

Vanessa Vandergaag

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this project, please contact the Research Ethics Officer by e-mail at rebsec@athabascau.ca or by telephone at 780.213.2033.

DOCUMENTATION OF INFORMED CONSENT

You will be given a scanned copy of this informed consent form after it has been signed and dated by you and the researcher.

Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be retained by the researcher, unless you indicate otherwise.
- You understand that if you choose to withdraw **after** data collection has ended, your data can be removed from the project at your request, up to the start of data

analysis.

	YES	NO
I agree to be audio and video recorded	◯	◯
I agree to the use of direct quotations	◯	◯
I allow data collected from me to be archived in Basecamp	◯	◯
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.	◯	◯

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

_____ _____

Signature of Participant Date

_____

Pseudonym

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that he or she has freely chosen to participate.

_____ _____

Signature of Researcher Date

Appendix E: Recruitment Poster

PARTICIPANTS NEEDED FOR
RESEARCH IN PERINATAL SUICIDALITY: MOTHERS' EXPERIENCES OF RECOVERY FOLLOWING COUNSELLING

We are looking for participants to be involved in a study about mothers experiences of recovery from perinatal suicidality following counselling. Perinatal includes the time during pregnancy and postpartum. Suicidality includes thoughts and feeling of being at risk for taking one's life. Recovery is considered as moving towards the desire to live.

As a participant in this study, you would be asked to: Complete a brief demographic information sheet over email and a confidential interview over Zoom video communications 5.0.

Your participation is **entirely voluntary** and would take up approximately 2-3 hours of your time. The interview will be scheduled at your convenience. By participating in this study, you will help us reduce stigma associated with perinatal mental health, understand how counselling aids in supporting mothers who struggle with perinatal suicidality, and potentially aid counsellors in developing knowledge around effective treatment for perinatal suicidality.

To learn more about this study, or to participate in this study, please contact:

Principal Investigator:
Vanessa Vandergaag, Masters of Counselling student, Athabasca University
Contact: *vvandergaag1@athabasca.edu*

This study is supervised by Dr. Gina Wong
Contact: ginaw@athabascau.ca

This study has been reviewed by the Athabasca University Research Ethics Board.

Appendix F: Resources

Counselling & Suicide Resources

Pacific Postpartum Support Society
Call or Text: 1-604-255-7999
https://postpartum.org

Postpartum Support International
Call or Text: 1-800-944-4773
https://www.postpartum.net

Canada Suicide Prevention Services
Call: 833-456-4566
https://www.crisisservicescanada.ca/en/

Wellness Together Canada
Wellness Together Canada is a mental health and substance use website to support people across Canada and Canadians living abroad in both official languages. We provide the following resources for you at no cost:

- **Immediate text support**
- Information and videos on common mental health and substance use issues, such as **this session** from TAO on understanding depression and **this article** from Kids Help Phone on managing stress
- Wellness programs you can do on your own or with coaching, such as **this eCourse** by BreathingRoom, **this mindfulness program** by Mindwell, or **these substance use coping strategies** by Breaking Free: Wellness
- Community and peer support, such as **Togetherall** and **CAPSA** for mental health and substance use
- **Individual phone, video, and text counselling**

This online service was launched in response to growing mental health and substance use concerns related to the COVID-19 pandemic.

https://wellnesstogether.ca/en-CA

Athabasca University

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