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Bonnie Scarth

bonnie.scarth@monash.edu

Monash University https://orcid.org/0000-0002-5123-3520

Suzanne Wereta

Hiwa Navigation

Kaitlyn McVicar

Monash University

Kylie King

Monash University https://orcid.org/0000-0001-8500-4972

Anne Buist

University of Melbourne https://orcid.org/0000-0002-0512-3945

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Concealment, failed help-seeking, and the conditions of safe disclosure in perinatal suicidal behaviour

Bonnie Scarth[a,*], Suzi Wereta[b], Kaitlyn McVicar[a], Kylie King[a,†], Anne Buist[c,†]

[a] The Monash School of Psychological Sciences, Building 17, Monash University, Wellington Road, Clayton, Victoria 3800, Australia.

[b] Hiwa Navigation, 8 Huia Street, Saint Leonards, Dunedin, 9022, New Zealand.

[c] Department of Psychiatry, The University of Melbourne, Grattan Street, Parkville, Victoria 3010, Australia.

† Kylie King and Anne Buist contributed equally as co-senior authors.

* Corresponding author. Bonnie Scarth, The Monash School of Psychological Sciences, Building 17, Monash University, Wellington Road, Clayton, Victoria 3800, Australia. Email: Bonnie.Scarth@monash.edu

Abstract

Suicide is a leading cause of maternal death during the perinatal period. Current prevention strategies rely on screening, risk assessment, and “reach out” campaigns, all built on two untested assumptions: that a woman who is asked will answer honestly, and that an honest answer will be met with support. This study interrogated both premises through reflexive thematic analysis, within a critical realist orientation, of a participatory family qualitative study in Australia. The 43 participants comprised women with lived experience of perinatal suicidal behaviour, family members and carers, and perinatal health professionals.

Three themes were constructed. “I couldn’t tell anyone” describes how women concealed distress as a deliberate, self-protective response shaped largely by fear of child removal. “One step closer” captures what happened when they sought help. Participants reported being dismissed, minimised, disbelieved, or met with adverse responses, and each unsuccessful effort became, in their own reasoning, evidence that they were beyond help. “Safe to tell” identifies the conditions that made honest disclosure possible and ensured it was adequately answered.

We interpret concealment and dismissal as two expressions of the same underlying condition: an inadequate response environment, meaning how services and individuals react when a woman discloses distress. Based on these findings we argue that prevention policy should prioritise the safety of disclosure and the capacity of services to respond effectively.

Keywords: perinatal suicidal behaviour; disclosure; suicide prevention; iatrogenic harm; screening; child protection; lived experience

1. Introduction

Suicide prevention campaigns often place responsibility on the suicidal person, urging them to ask for help, disclose their distress, or call a service, with the expectation that support will follow (Pirkis et al., 2019; When Life Doesn’t Go as Planned, n.d.). The message reflects a basic truth: disclosure is central to most clinical interventions, and concealment is frequently noted in deaths (Hallford et al., 2023). Yet these campaigns rest on two assumptions that

have received little scrutiny. The first is that a distressed person will disclose. The second is that disclosure will lead to help rather than harm. This paper examines both premises in the context of perinatal suicidal behaviour, where the risks attached to an honest answer are high.

Suicide is a leading cause of maternal death during the perinatal period (Chin et al., 2022), and suicidal ideation and self-harm during pregnancy and after birth are far more common than maternal suicide itself (Peinado-Molina et al., 2025). The consequences extend across the family as the non-birthing parent's wellbeing is affected (Roxburgh et al., 2025), and perinatal adversity shapes children's outcomes over the long term (Paul et al., 2021). Despite this impact, evidence-based interventions for perinatal suicide remain scarce. A recent systematic review identified only five intervention studies worldwide (Scarth et al., 2026), which leaves services with little tested policy and practice guidance.

Current perinatal suicide prevention relies heavily on identification of those experiencing suicidal distress. In Australia, as in many other settings, universal screening with tools such as the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987), supported by clinical risk assessment, is the main mechanism through which services detect distress (AIHW, 2024). The perinatal period appears well suited to "reach out" logic because no other stage of life places women in such regular, scheduled contact with health professionals (Levis et al., 2020). Debate about screening instruments is active, particularly regarding their psychometric performance (Levis et al., 2020). Screening accuracy studies measure how well an instrument detects distress that is reported, but not the conditions surrounding disclosure of distress. They fail to support suicide prevention when distress is deliberately withheld, or when a woman's disclosure is met with refusal or disbelief (Dudeney, Coates, et al., 2024; Dudeney, Meades, et al., 2024). These gaps have direct implications for policy, as they shape how services can realistically detect and respond to suicidal distress.

Stigma and fear of judgement are recognised barriers to perinatal mental health disclosure and help-seeking (Dudeney, Coates, et al., 2024; Dudeney, Meades, et al., 2024). Fear of child-protection involvement is a specific deterrent to honest reporting at this time (Dudeney, Coates, et al., 2024; Dudeney, Meades, et al., 2024; Townsend, 2025). Among adolescent mothers involved with perinatal child protection, withholding suicidal feelings to avoid being seen as unfit was common enough that Dion et al. (2022) termed it "disclosure vulnerability." Refugee-background women in Norway described similar fears attached to any admission of need (Asbjornsen et al., 2025). The feared consequence is concrete: mothers whose children are taken into care show elevated rates of suicide attempt and suicide mortality (Kenny et al., 2026; Townsend, 2025). These patterns highlight a policy problem, which is that when disclosure carries material risk, concealment becomes a rational response. Despite this, concealment has rarely been examined as a deliberate, reasoned practice described by the women who used it, and even less attention has been paid to what followed disclosure. Research has seldom asked women who concealed perinatal suicidal behaviour why they did so and what might have changed it, and to our knowledge no study has examined concealment and disclosure across the family.

Qualitative research drawing on first-hand experience of suicidal behaviour can highlight how people reasoned and what they were responding to (Scarth et al., 2021). This study had three aims: to examine what prevents women from disclosing perinatal suicidal behaviour, to understand what happened when they did reach out, and to identify what would make

honest disclosure safe and adequately met. These aims speak directly to policy questions about how systems can improve the support of those experiencing suicidal distress by strengthening the conditions under which help can be safely sought and reliably provided.

2. Methods

2.1. Design

This qualitative study forms part of a larger co-designed research programme on family support for perinatal suicidal behaviour, conducted within a participatory action research orientation (Cornish et al., 2023). Five lived-experience co-design sessions (four with a group of five mothers, one with a group of five male family members) shaped recruitment, instruments, and analytic priorities. With members' consent, recordings of these sessions were also included as data in this study. Some members additionally took part in individual interviews, which had an entirely separate set of questions and a more personal, in-depth focus, so the two sources did not duplicate content. To protect members' identities, including those named in the acknowledgements, we do not report how many took part in both. The definition of perinatal suicidal behaviour used in this study was developed within the co-design sessions. Here, perinatal suicidal behaviour is defined as any suicidal thoughts, planning, feelings, attempts, or self-harm during pregnancy and/or up to three years after birth, regardless of the type or outcome of the pregnancy. Terminology follows contemporary nomenclature recommendations (De Leo et al., 2021). Excerpts from co-design sessions are attributed as "(co-design session)".

2.2. Participants and recruitment

Three participant groups were eligible to take part in this study, all aged 18 or over: women with lived experience of perinatal suicidal behaviour during pregnancy and/or within three years postpartum; family members or friends of women who experienced it; and perinatal health professionals or key stakeholders who had worked directly with these women. Sample size was guided by the Information Power approach (Malterud et al., 2016) which emphasises the richness and relevance of the data rather than saturation. Up to 15 participants were sought per group. Participants were recruited through the networks formed by the lived-experience co-design groups, snowball sampling, perinatal mental health and suicide prevention organisations, social media, and the study website. Co-design members who had agreed to be contacted were emailed once, reminded they were under no obligation to take part, and left to initiate contact. Snowballing invitations asked participants to pass information on only where comfortable. Interview participants received a $50 supermarket voucher. The anonymous practitioner survey carried no reimbursement.

2.3. Data generation

All interviews except one were conducted by the first author (BS), who also transcribed and de-identified the recordings. For the remaining interview BS worked with an interpreter so that the participant could be interviewed privately in their first language. Reflecting the co-design groups' emphasis on choice and safety, participants chose their interviewer from four experienced researchers (including registered psychologists) introduced by photo or video on the study website, with a preliminary chat available before deciding. All participants chose BS along with an interpreter as needed. Participants could elect to be interviewed with a

spouse or an important family member as support. Two participants took part in a joint couple interview. Most interviews were conducted by Zoom (two in person) between March and June 2026 and lasted approximately 60 to 180 minutes. All interviews began with a pre-brief to check participants' readiness and comfort to proceed and ended with a debrief that signposted available support resources. Prior to each interview, participants were also invited to complete a wellbeing plan, and each was offered a follow-up check-in afterwards.

The semi-structured interview guides were co-designed with the lived-experience groups and asked about experiences of disclosure and non-disclosure, encounters with screening and services, what helped and hindered, and a "magic wand" question inviting participants to design prevention without resource constraints. Perinatal health professionals could choose to take part in an anonymous online survey that mirrored the interview schedule, rather than doing an interview due to time constraints. Practitioners were not asked about their own lived experience; where they disclosed it spontaneously, attributions reflect this.

Co-design sessions were conducted via Zoom and recorded and transcribed with consent. The mothers' sessions were co-facilitated by BS and a lived-experience advocate and peer practitioner. The male family members' session was facilitated by a male researcher and an interpreter for a participant who required one. All other data generation was conducted by BS.

2.4. Ethics

The study was approved by the Monash University Human Research Ethics Committee (MUHREC; project ID 50913 for qualitative interviews and project ID 49134 for co-design workshops) and conducted in accordance with the Declaration of Helsinki. All participants, including co-design members, provided informed consent to participation and to publication of de-identified material. Practitioners who completed the survey gave electronic consent without providing their names, so their responses remained anonymous. Participation was voluntary, and participants could decline any question or withdraw at any time. A stepped distress protocol applied to all data collection: the interviewer could pause and offer support, contact a support person nominated in advance, refer on to services, or, where risk was acute, contact emergency services and stay with the participant until help arrived. Any use was documented for team review, and no acute risk incidents occurred. Consistent with safe reporting practice, no descriptions of suicide or self-harm methods were carried into the analytic corpus, and none appear in this paper; suicidal behaviour is reported by type only; excerpts are edited to remove identifying details, with edits indicated by (…). Because several participants hold singular characteristics, some details are deliberately generalised, and some sequences are reported without temporal details.

Participants are identified by participant number (e.g., P12) rather than by pseudonyms or real names, a decision reached with the lived-experience co-design groups. This study's subject matter carries too high a risk profile for the real-name attribution some bereaved participants have valued in earlier thanatology research (Scarth, 2016), and in a culturally diverse sample researcher-assigned pseudonyms either misrepresent participants' cultural heritage or risk re-identification within closely connected communities (Allen & Wiles, 2016). Numeric codes remain the most protective compromise available, and every code in this paper represents a real person and a real story, entrusted to this research on the understanding that safety came first.

2.5. Data analysis

BS conducted reflexive thematic analysis (Braun & Clarke, 2021, 2023) within a critical realist orientation, combining ontological realism with epistemological relativism (Bhaskar, 2009). We treat participants' accounts as fallible but genuinely informative evidence about real generative mechanisms, and we hold our themes as interpretive constructions rather than discoveries. This orientation matters in two ways here. We analyse concealment as a real generative mechanism that produces a systematic gap between the actual (what women were experiencing) and the empirical (what services and screening instruments were able to observe); and we analyse the dismissive encounter as a second mechanism, operating on those who breached the first. Interview, survey, and co-design data were pooled and analysed together, while staying alert to similarities, differences, and nuances across and between participant groups; the source of each excerpt is indicated after each quote.

Coding was both inductive and deductive: the data drove the findings, while the questions co-designed with the lived-experience groups also framed the analysis. Theme development was interpretive and predominantly latent, attending to meanings and mechanisms beneath the surface content of participants' accounts. BS coded the entire dataset systematically and wrote the interpretive memos through which themes were constructed. There was no second coder. Consistent with a reflexive approach, we calculated no measure of intercoder agreement (Braun & Clarke, 2021). BS instead developed interpretations through sustained memo-writing and tested them against disconfirming cases within the corpus. Candidate themes and interpretations were brought to a sense-making session with the mothers' lived-experience co-design group and refined in response to the group's readings, and in discussion with co-authors. The final themes and subthemes, with summaries and illustrative excerpts, are presented in Supplementary Table S1.

2.6. Reflexivity and positionality

This analysis was conducted by BS, a mother and researcher-practitioner with twenty-five years’ experience in mental health, family violence, and suicide prevention and postvention.

3. Results

3.1. Sample characteristics

Participant characteristics are reported narratively because overlapping roles resist clean categorisation and several characteristics are singular enough that tabulation would risk identification. Forty-three participants took part: 38 interviewees across 37 semi-structured interviews (one a joint couple interview), three practitioner surveys, and two lived-experience co-design members who contributed through a co-design session only, with confirmed consent. Twenty-seven women had lived experience of their own perinatal suicidal behaviour, and two men had suicidal experience connected to the perinatal period. Eight participants took part primarily as family members or carers (including the two co-design-only members), and six as perinatal health professionals; 35 were women and eight were men, with recorded ages from late adolescence to over 70. Participants included Aboriginal and Torres Strait Islander people, Māori people, and people from culturally and linguistically diverse backgrounds, including migrants to Australia, alongside white Australian-born participants. Self-reported diagnostic histories were extensive and often contested, and prevalent trauma histories included traumatic birth, childhood adversity, suicide

bereavement, and intimate partner violence. Ten participants disclosed one or more suicide attempts; others described ideation with or without planning, including chronic, managed forms; several had engaged in self-harm; for eight, a family member's suicidal behaviour was the interview's primary subject.

Three main themes were constructed: ‘I couldn’t tell anyone’, ‘One step closer’, and ‘Safe to tell’ (Supplementary Table S1).

3.2. Theme 1. ‘I couldn’t tell anyone’: concealment as a rational strategy

Accounts of telling and not telling arose both in response to direct asking, most often in routine screening or clinical assessment, and in unprompted disclosure to clinicians, family members, or peers.

3.2.1. What telling could cost

Across the corpus, the fear of child removal was the most pervasive barrier to honest disclosure, described by mothers, family members, workers, and clinicians alike. Women described weighing up what an honest answer might set in motion and concluding that the risk was intolerable:

> *The hospital had a special care unit, which was where you went if you were suicidal, but of course, your baby would not go with you, so… So, I didn't tell anyone I was having those thoughts, because… I didn't want it. (P12, mother)*

For this mother, the feared separation required no child-protection involvement at all: mothers were aware that the hospital's own pathway routed suicidal mothers to a unit their babies could not enter.

Participants described the fear as a fixed feature of the perinatal position itself:

> *It's not safe to get help for your mental health or suicidal stuff. It's just not safe (…) definitely not safe as a pregnant woman or a woman who's a mother. (P24, mother)*

> *If I fucking tell anybody about how I really feel, then they'll take her away. (P19, mother)*

Child protection was not the only cost participants weighed. A father described avoiding any record of help-seeking because of its legal discoverability:

> *if there was any record of me with mental health problems then that would act against me in the [family] court. (P32, father)*

The fear sat alongside a deep need for help, and that combination made the bind acute. One mother described needing support while fearing the very system she might turn to:

> *I desperately want someone to take the baby… someone take this baby, but don't touch my baby! (P4, mother)*

Participants across all groups noted that fear of child removal weighs especially heavily on First Nations families, given its history and ongoing reality. They described the link between removal and maternal suicide as urgent and under-researched. They also emphasised that

disclosing distress to services with mandated reporting to child-protection systems carries a distinctly higher risk for Aboriginal and Torres Strait Islander mothers.

One participant stated the theme's conclusion plainly:

> *my kids and I survived because I didn't say anything. (P24, mother)*

These women chose not to tell because they had seen what disclosure had cost them or others.

3.2.2. The good mother cannot say it

Beneath the fear of institutions, participants described a fear that social judgement enforced. Disclosure was experienced as *"taboo"* (P6, mother). Suicidal ideation was tied to feeling like a failed or *"selfish"* mother (P11, mother), with being *"not a good enough mother"* (P25, mother), and with the conviction of being a burden (P30, lived experience and clinician). The weight of these judgements was gendered, as the mothers' co-design group observed, the guilt *"always seems to come back on mums".*

Participants described how willingness to disclose varied by symptom. Mood symptoms were hard to voice, and psychotic experiences could feel impossible: *"God forbid you would talk to anyone about that"* (P14, mother).

The taboo was cultural as well as gendered. One participant said she could not talk about her mental health with her parents *because "in their country, mental health is very taboo, and you don't talk about it at all,"* and language added another barrier: *"I can't really say what I'm saying in our home language, and that's all they understand"* (P14, mother).

One mother, who felt that she had to hide her grief after a mid-pregnancy loss, described the pressure on her to do so, the effort that silence required, and what speaking might have changed:

> *If I could have spoken about it freely, instead of having to pretend that I was okay, and pretend that I was… a good mum, like, I think that would have made everything feel a lot better, but it was just that I had to really… like, shut that shit down. Nobody wants your grief. (P17, mother)*

Participants described how shame was experienced as a judgement on their whole selves, and noted that it could begin to ease once a mother understood her experience with self-acceptance:

> *this wasn't my fault… it's something that happened to me. (P1, mother)*

3.2.3. Taught not to tell: concealment as learned competence

Participants had learned the fear of disclosure, and they described the process by which they were taught it. For example, one mother's disclosure of suicidal ideation was followed by a child-protection investigation rather than by care. After that experience she said that she stopped answering honestly. Her account of what her child meant to her describes how removal would have resulted in increased suicidality:

> *he is my protective factor. You take him away, and I will die. (P4, mother)*

In her account, her child was her reason to stay alive, so whoever held the power to remove him held, in effect, power over her survival.

For one mother, her fear was confirmed by an official record. After she disclosed her own history of out-of-home care, Child Protection Services placed an alert in relation to her unborn baby, confirming for her that disclosure could indeed cost her custody of her children:

> *if I am anything less than perfect, they will take my babies away from me, so I never told anyone. (P7, mother)*

Another participant described how the one time she broke her usual silence, it had brought the exact response she had feared: she told a clinician about her suicidal distress and was then investigated by Child Protection Services. For others, learned silence started long before motherhood. One participant described how growing up where speaking was unsafe had taught her not to talk, and in the perinatal period that silence returned as fear that her child might be removed (P19, mother).

Concealment took skill and effort and was often collaborative rather than passive. Mothers described the Edinburgh Postnatal Depression Scale (EPDS) as routinely answered dishonestly, and the strategy as explicit:

> *We're just gonna lie and tell them what they want to [hear]. (P6, mother)*

Masking could be learned and practised, and competence itself could hide distress. One mother kept her house immaculate so that services would read it as evidence that she was coping; the tidy home was part of the performance (P19, mother). Concealment could also be coordinated, with couples working together to manage what services were allowed to see. In one family this meant a serious illness went unnoticed by health services (P26). It crossed gender: one father maintained a year-long, entirely silent plan, with no external signal sought or offered (P33, father). Women also coached each other in how to describe intrusive thoughts in clinical language so they could get help without triggering Child Protection involvement (P7, mother). Consistent with the corpus more broadly, such intrusive experiences were described as unwanted and distressing rather than reflecting intent, and we report them only at that pattern level. Participant mothers explained how a mother had to seem unwell enough to receive support, but not so unwell that her disclosure might be taken as grounds for removal. She had to decide how much to say and how to say it while she was already distressed, and the line shifted depending on who heard her. They were managing the response their words would bring.

3.3. Theme 2. One step closer: when reaching out deepened the danger

Despite fears of the response, most participants did attempt to seek help. They presented to services, phoned, disclosed, and returned. This second theme follows what they said they encountered.

3.3.1. 'Turned away at the door'

The clearest accounts were refusals of help at the moment of asking. One mother, acutely unwell in the days before her suicide attempt, made what she described as her first-ever urgent request for help, calling the private hospital where she was known, and was told her doctor was unavailable and to present elsewhere.

> *And she [nurse] said no. And then that was my full stop. (P9, mother)*

Another mother presented to hospital three times during a postpartum psychotic episode and was turned away to ineffective supports:

> *they just turned me away and just said, go and get some sleeping tablets, or (…) your husband needs to step up. (P8, mother)*

A young mother who worked up the courage to tell her GP about escalating suicidal thoughts was given a phone number: *"just reach out to them (…) okay, bye"* (P15, mother). A suicide attempt followed shortly afterwards. In some accounts, services answered acute distress with another phone number (P15; P20), so that a woman who had already reached out was instructed to reach out again elsewhere.

3.3.2. 'Minimised, mislabelled, disbelieved'

The experience of being seen but not believed was the most common encounter. For example, one mother later read her clinical notes and felt anger and betrayal.

> *The clinician said I was seeking attention in my notes. (…) I wasn't seeking attention. This was just such a cry for help. (P8, mother)*

A practitioner survey respondent described the same pattern from the professional side, where acute perinatal mental illness was misdiagnosed by an admitting psychiatrist as *"just sleep deprivation,"* and the mother and newborn were sent home with antihistamines (P37, perinatal professional). Others described different kinds of dismissal, such as a mother who was dismissed by her psychiatrist with the line, *"If it were postnatal depression, you'd be so much worse"* (P23, mother), and never asked about suicidal distress.

One nurse dismissed a mother by shaming her, telling her she was *"disappointed"* in her, *"like such a… a child that had disappointed a parent"* (P9, mother). Another mother was offered antidepressants instead of receiving support for distress she knew was rooted in an untreated physical birth injury:

> *“There’s no amount of antidepressants that will fix how I feel when I walk around (…) my problem is mental due to a physical injury” (P16, mother).*

One mother, committed to breastfeeding while acutely suicidal, was repeatedly told to stop when she neither wanted nor needed to. Her attempts to seek help were turned back on her, and she described not feeling heard and instead being blamed: *“Nobody could hear me. They were just like, ‘You’re doing this to yourself’”* (P40, mother).

The screening process produced its own version of this failure, with flags raised and never acted upon. *“On all of those [screens] you indicate mental health issues already (…) but no one talks to you about that”* (P1, mother).

A clinician with lived experience of suicide described a time when a score on a screening test failed to identify her distress:

> *I didn't actually cry, so I was like, no… the test was like, oh yeah, you're alright.* (P36, clinician with lived experience)

The same participant described how the score was allowed to outweigh her stated distress, so the instrument overruled the person (P36, clinician with lived experience). Because these tools are tuned to specific presentations, distress that appeared as anxiety, agitation, frozenness, or masking rather than tears went unidentified in these accounts.

Another mother described the same failure from inside a mother-baby unit, where staff assessed recovery task by task: “*you look after your mental health, you're no longer suicidal, great. Tick that box, you can look after your baby so we can send you home”* (P5, mother). What the checklist never asked, she volunteered to a nurse at discharge: *“I still don't love my baby. Like, I still don't love her”* (P5, mother). She had not raised this earlier partly *“because no one had ever asked”* (P5, mother).

For migrant mothers, the system could fail in a further way as services assumed a shared culture and language they did not check. One migrant mother answered screening honestly precisely because she did not know what an honest answer could set in motion:

> *I did not lie on my screening process, and I did not think about, oh, will my baby be taken away? But I guess this is, again, the cultural thing, you know? I don't know the system, so I don't know what can and cannot be done* (P16, mother).

The distance cut both ways in her communication with services: *“we are not the culture that knows how to read between the lines (…) I speak English, but I don't speak your language”* (P16, mother). Her honest asking then met the same absence documented above: *“Even if you can afford the help, and you are willing to take it, and you are craving it. You cannot get it. Now, I cannot imagine if due to (…) financial or cultural reasons, you cannot get the help”* (P16, mother). The assumption of shared language ran through care itself. A family member who attended weekly care meetings through an interpreter described the vocabulary gap, *“I didn't know mental-health vocabulary at all”*, and interpreting whose accuracy was *“sometimes good, sometimes ‘no, that's not quite right’”* (P28, family member). Care decisions in these meetings therefore rested on interpretation the family could not fully verify.

3.3.3. ‘Evidence that you’re screwed’: the iatrogenic loop

Participants described a cumulative process of reasoning in which each dismissed reach-out became proof that they themselves were beyond help, rather than that the service was inadequate. One mother articulated the mechanism with precision:

> *the more you seek help and then that service can't help you, the more evidence you have that you're screwed (…) well, they can't help me, and that person's not hearing me (…) then it's like, well, I'm not gonna bother anymore. (P9, mother)*

A mother whose admissions had involved prolonged separation from her child described the same inference, where she began to believe that she was unable to care for her child:

> *it just sort of gave me evidence that he [baby] was better off without me, because even the hospital doesn't work (…) everything you try, it just makes things worse. (P4, mother)*

The endpoint of this process was that participants stopped asking altogether: *"no one's listening to me, so might as well not talk to anybody"* (P15, mother). In two accounts the sequence ran, in the participant's own telling, directly to a suicide attempt as one mother described pressure from her treating team and infantilisation as the thing that *"just kind of tipped me over the edge (…) a day or so later, I did"* (P10, mother, describing the period preceding her suicide attempt). P9's refused crisis call, above, was *"the full stop."*

3.3.4. 'Help that punished'

Where the previous subthemes describe help refused, inadequate, or eroding, for another group reaching out was actively turned into harm. One mother disclosed suicidal thoughts to a mental-health support and was subsequently investigated by child protection: *"then you can't trust anyone",* she concluded; *"you're damned if you do, and you're damned if you don't"* (P4, mother). Another had organised her life around not asking for help. The one time she broke her own rule, seeking practical support during unrelated medical treatment, the supporting organisation reported her to child protection:

> *more proof that you do not go for help. (P24, mother)*

Her instruction to the workers who receive such disclosures, stated later in the same interview, was:

> *Go to support, not report. (P24, mother)*

A third mother made a safety plan with a friend, help-seeking of the most textbook kind, and saw it produced against her in family-court proceedings while seeking custody in the context of intimate partner violence: *"I was actively seeking help",* yet the help was held against her

(P18, mother). What the system's watching had amounted to, in one mother's words, was *“more surveillance rather than support”* (P6, mother).

These realised cases return to Theme 1: the fears that maintained concealment were not misplaced. Where disclosure produces investigation and court evidence, non-disclosure works as an accurate risk assessment rather than a failure of help-seeking literacy. That some infants do, at times, need protection is not in question, and nothing in these accounts licenses services to set aside their obligations to the child. What the accounts document is the shape of the response. When these women disclosed, services responded with immediate intervention that carried a high threat to the mother-child relationship itself, and this was the one consequence these women feared above all others. Support for the mother was not what met the disclosure. The clinical question the corpus poses is how concern for the baby is enacted, and whether its first expression is care or investigation.

3.3.5. ‘The burden returned to sender’

Participants described how, when the system failed to help, responsibility was routed back to the person it had failed. Participants pointed to the language services used: *“non-compliant is the exact term for the too-hard basket”,* observed P24, of people who disengage after being failed, *“[they] are the people that your service is actually there for”.*

Another mother traced the same displacement inside families mobilised to *“fix”* her: *“You've tried everything and nothing's worked, so therefore it must be you”* (P9, mother).

A third heard clinicians coach her own partner into the phrase *“you're not helping yourself”,* so that *“I just felt even less supported by, like, my main supporter”* (P40, mother). A clinician with lived experience located the failure at the level participants kept pointing to*: “it's not a failure of self that you're not coping. It's the whole systemic failure”* (P36, clinician with lived experience).

3.4. Theme 3. Safe to tell: the conditions of honest disclosure and an adequate answer

This theme gathers the conditions under which participants said honest disclosure became possible and was adequately answered: safety built before the asking, a receiver the mother could trust, skilled asking, and a response that made telling safe.

3.4.1. Safety precedes disclosure

Participants consistently said that safety and trust needs to be built in order to disclose: *“You're not just going to open up to the first person who asks you the question”* (P3). A clinician with lived experience described the same principle clinically: a course of sessions establishing safety before disclosure became possible.

Disclosure was also state-dependent as what a woman could say depended on when she was asked, so a single asking sampled how she felt at that moment, and not her experience as a whole (P12, mother). Intake-only screening, on this evidence, is structurally mistimed, given that it asks before safety has been established.

3.4.2. Who could be told

What could be said depended on who was receiving it. A participant with long experience on the receiving side of peer support stated the difference plainly:

they're not going to say the same thing to you that they will say to the child health nurse or the… social worker, they just don't. (P25)

Within families, particular people could still be told when no one else could: one woman, at the point of greatest danger, could still tell her mother (P29, mother). Where a woman understood the system well enough to predict what a disclosure would set in motion, honesty became possible as an informed choice. One mother named the condition that made her disclosure possible as she did not carry the fear that silenced others: *"It's really hard to get your baby taken away from you (…) And I was never worried that that would happen (…) So, I think that's what also helped me be honest"* (P5, mother). Her confidence followed from her position as she was white and professionally established, and she knew the relevant services from the inside.

Her position shaped what she could expect, but it did not govern what services would actually do. A similarly placed mother's disclosure of suicidal thoughts brought a child-protection investigation (Theme 1). The mothers from whom the system removes children most readily (First Nations mothers above all, and women marked by histories of out-of-home care, by youth, or by poverty) could not hold that expectation. A second negative case ran in the opposite direction: P16 (Theme 2) answered honestly because she was new to the system and had not yet learned what disclosure could cost. Honest answering, in this corpus, belonged to the two positions outside the fear: the woman the system would read generously, and the woman who did not yet know how it read anyone.

3.4.3. How the asking is done, and what answering takes

Participants were specific about what good asking and good answering involve. One mother's long-standing GP recognised her distress and arranged admission, and she described her helpline contact as steadying (P1, mother). Another disclosed honestly, without fear, and was helped (P5, mother). A third had been dismissed elsewhere and what kept her alive, in her own account, was a community nurse who *"is good at sitting with that level of risk"*, within a service built on continuity: *"the biggest thing is, like, trust"* (P15, mother). For P16, the turning point was a single validating practitioner and, later, a GP who took her suicidal behaviour seriously enough to treat its cause (P16, mother).

Participants named validation as a low-cost repair: *"it's so understandable that you feel the way that you feel (…) that's… that's what I needed to hear"* (P2). Language that neither minimised nor falsely normalised was appreciated.

One mother, for example, wished someone had asked directly, and asked again: *"I wish someone had said that to me"*. A senior perinatal clinician reframed disclosure itself as an act of trust to be resourced rather than a risk to be managed, urging services to provide *"a pair of ears attached to an actual heart"* (P35, senior perinatal clinician).

The co-design group also specified technique as rather than *"coming straight on with a question"*, asking could begin with *"what did you imagine motherhood was going to look like"* and proceed gently, *"circling around to empower the mum to then say, actually, what's really going on for me?"* (co-design session). On these accounts, asking works when a known

person does it, asks more than once, and treats what the woman discloses as pain to be heard with compassion. Participants set this against *"tick-box"* asking, and against responses that treated a disclosure as a threat to be targeted.

3.4.4. Making it safe to tell

Participants stated that making disclosure safe is the responsibility of services, and not a courage problem for mothers. A participant who now works in mental health drew the conclusion as policy:

> *mums need to be able to say it without having the baby taken off them, because that will probably guarantee suicide. (P18, mother)*

Participants' specifications for disclosure-safe identification were concrete and meant transparency about exactly what a disclosure does and does not trigger, so a mother can weigh facts rather than fears. Participants explained how the first response should be guaranteed care, then continuity, so the asker is someone with whom the mother feels safe, and asking more than once, because readiness is state-dependent.

Finally, participants emphasised that there should be a visible separation between support and surveillance *("go to support, not report"),* so that accepting help is not experienced as opening a child protection file. The mothers' co-design group specified the stance that the possibility of child removal should be openly discussed to remove fear and this makes honest answers possible: *"what we want is to encourage disclosure rather than if you tell me this, I will punish you by taking steps"* (co-design session). Open discussion of this threat makes its operation predictable, and a mother who can predict what telling will set in motion has less reason to fear it. For some mothers the feared consequence is real rather than imagined; transparency lets her weigh actual risk instead of unbounded fear.

4. Discussion

This study asked what stops women disclosing perinatal suicidal behaviour, what happened when they did reach out, and what would make honest disclosure safe and adequately answered (Supplementary Table S1). We emphasise four findings.

First, concealment and dismissal are produced by the same underlying condition, which we call the response environment, which is how services and people respond when a woman discloses perinatal suicidal behaviour. Women in this corpus concealed deliberately. Their accounts do not support reading concealment as a symptom or a failure of insight. They weighed what honesty might set in motion, above all child removal, and judged silence as safer on the evidence they held. The punished disclosures in this corpus (disclosure producing investigation, a safety plan produced in court) confirmed to the participants that they were reading their environment correctly. Mothers' concealment kept distress out of the empirical record, so what services observe (screening scores, disclosure rates, presentations) under-represents what is actually occurring where the fear is greatest. The dismissive encounter is the second mechanism, and it operates on those who disclosed.

Dismissal of distress functioned in participants' own reasoning as an active input to suicidal behaviour.

On participants' accounts, a refused or minimised presentation harmed the woman who made it. These are retrospective, first-person causal attestations, interpreted through reflexive analysis; they do not demonstrate causation. At the same time, the pattern arose independently across participants, is corroborated from the practitioner side, and is mechanistically coherent with what is known about defeat, entrapment and burdensomeness in suicidal process (O'Connor & Kirtley, 2018; Van Orden et al., 2005). The pattern is consistent with reports from adolescent mothers involved with child protection in Canada (Dion et al., 2022), refugee-background women in Norway (Asbjornsen et al., 2025), and pregnant and postnatal women in the UK who withheld suicidal thoughts from maternity practitioners for fear their baby would be removed (Dudeney, Meades, et al., 2024). In epistemic terms, both mechanisms operate as testimonial injustice (Fricker, 2007). Women anticipated it when they concealed; practitioners enacted it when they dismissed her, minimising her credibility ("seeking attention", "doing this to yourself") at precisely the moment her testimony mattered most. Together these findings reframe the screening-accuracy literature (Levis et al., 2020) as psychometric evaluation quantifies performance on the answers given and cannot see the answers withheld, or what the handling of given answers does to the next asking.

Second, women learned the fear, and how services responded decided what followed. They were well aware that the perinatal period is the one point in life at which a woman's honest account of her own suicidal thoughts is routinely heard primarily as evidence about risk to another person. Participants described fear of the response being taught in three ways: when women disclosed and were punished for it, when women saw the feared consequence come true for others, and, for some, through a silence learned long before motherhood. Only two women had not learned the fear, and both answered honestly, one because her position let her expect a generous reading, the other because she was new to the system and did not yet know what telling could cost. Their disclosures met mixed responses: one was helped, and the other met the service absences described in Theme 2.

Participants also described responsibility being routed back to them, in phrases like "non-compliant" and "not helping yourself", a displacement they connected explicitly to campaign messaging that places the whole burden of action on the mother, who has the fewest resources of anyone involved. Stated plainly, the current arrangement requires an acutely distressed mother to judge how unwell to appear, which is unwell enough that services will help her, and not so unwell that her baby is removed. She must make that judgement alone, and correctly, every time she is asked. UK maternity practitioners have described the same gap from the receiving side as they reported feeling untrained and unsafe holding disclosed risk, that lack of continuity prevented the trust honest answers require, and that asking without onward services could leave a woman worse off than not asking (Dudeney et al., 2025).

Third, disclosure-safe identification is an equity intervention. For mothers, the instruction to reach out is entangled with a statutory system that can convert disclosure into investigation, separation, and court evidence. This impact is compounded for Aboriginal and Torres Strait Islander mothers, and for mothers from other racialised and culturally diverse communities, because the health and statutory systems that receive their disclosures often lack cultural

safety (Curtis et al., 2019). The institutions have not examined how their own practices, assumptions, and power bear on the communities they serve (Curtis et al., 2019). Culturally and linguistically diverse participants in this corpus described that lack concretely as screening and services assumed a culture, a language, and a knowledge of the system that they did not hold (Theme 3). The practitioner and the institution decide what a disclosure means and what it sets in motion, and the mother cannot appeal their reading. The fear of removal is greatest where removal has been, and remains, a lived and historical state practice, and participants across groups identified this burden for First Nations families in particular. Mothers whose children are removed then show elevated rates of suicide attempt and mortality (Kenny et al., 2026). Mothers are thus placed in a dilemma whereby what disclosing costs them depends on the quality of whoever answers. A screening programme can be universal in its coverage and still fail to reach the women least able to answer it honestly.

The mother who answered screening honestly had never feared removal and could expect a generous response. Mothers who already face the heaviest removal practice cannot hold that expectation, and their testimony is also the testimony institutions discount most readily (Fricker, 2007). The contingency does not end with the mother, as the same disclosure meets practitioners who differ in how much risk they are prepared to hold, from the community nurse in this corpus who could sit with it to the clinicians who minimised, refused, or reported it. Maternity practitioners elsewhere attribute this capacity to training, support, and how safe they themselves feel holding disclosed risk (Dudeney et al., 2025). The response a disclosing mother receives is therefore doubly contingent on how the system classifies her and on how much risk the practitioner is prepared to hold, and she must run this complex safety assessment in every encounter.

Fourth, the reasoning behind concealment is not confined to mothers as couples ran it jointly, and fathers ran versions of it because of the legal consequences they feared. Families were also drawn in, with partners coached into the system's own accusatory phrases.

4.1. Implications for practice

Based on these findings, we propose that the onus belongs with services to create safe environments for disclosure, to receive the disclosure, to sit with the risk it describes, and to weigh openly what response serves the interests of the mother, the baby, and the family together, and to do so transparently. Health services and the bodies that fund them should treat the safety of telling, and the capacity to answer, as primary prevention targets, alongside and prior to detection via screening.

Participants specified the components of disclosure-safe identification, which involves transparency about exactly what a disclosure does and does not trigger, so a mother weighs facts rather than fears, a guaranteed caring first response, continuity, so the asker is someone the mother knows, asking more than once, because readiness is state-dependent, and a visible separation of support from surveillance.

Resourcing this shift requires three specific things: training and supervision that make practitioners safe to hold disclosed risk; staffing models that allow continuity; and appropriate services to refer women to. These are the same three absences in services that practitioners themselves have reported elsewhere (Dudeney et al., 2025). Family psychosocial care that

is sustained and relational shows the greatest promise for suicide prevention elsewhere (Scarth et al., 2026).

Identification needs to move beyond administration of scales. Participants described how scores on scales had been used to discount the person. Distress that presented as anxiety, agitation, frozenness, or masking went undetected by instruments tuned to other presentations. Instruments can fail on interpretation. For example, most perinatal women in one UK study read EPDS item-10's "harming myself" as non-suicidal self-harm rather than suicidal ideation (Dudeney, Coates, et al., 2024).

Our findings also highlight how services cannot become safe to tell without becoming culturally safe, with risk of harm borne unequally by some groups. Cultural safety is institutional work that involves services examining their own practices, biases, and power, and the communities receiving care judge whether that work has succeeded (Curtis et al., 2019).

Family-inclusive identification is promising, but family involvement must be assessed for safety and properly consented to by mothers, because intimate partner violence is present in this corpus (Theme 2), and mothers themselves need to identify who their supporters are. Services that enlist families in detection must not thereby enlist them in surveillance of the mother.

Finally, we are aware that a paper critiquing "reach out" messaging must itself follow safe messaging guidance. Nothing in these findings counsels against reaching out. A single adequate answer can be lifesaving, and participants who eventually met one described it as exactly that. Campaigns that solicit disclosure incur a duty to the moment of reception, meaning a duty to ensure that whoever receives the disclosure answers it well. Services can train and resource that response, and researchers can test whether it works.

4.2. Limitations

Participants were self-selecting and disposed towards disclosure and meaning-making. For a study of concealment and failed help-seeking, the selection problem is more acute as every participant here is, by definition, someone who eventually told someone, at minimum a researcher, and those most comprehensively failed by services are not represented. The corpus therefore likely understates the prevalence and depth of the phenomena described. Accounts were retrospective and may describe service contexts that have evolved, although the corpus’s most recent accounts suggest the central dynamics persist. The child-protection interface described here is Australian, and the transferability of specific policy implications will vary with jurisdiction, though analogues exist widely.

5. Conclusion

Perinatal suicide prevention has invested heavily in encouraging help-seeking and identifying mothers experiencing suicidal distress. The women in this corpus called, presented, disclosed, and returned to services, so they certainly “reached out”. Concealment was also common, because women judged that honesty risked the loss of their child. For those who reached out, much of what met them made them less safe, by their own precise account, as each dismissal was one more piece of evidence that nothing and no one could help. The repair that participants specified is a system that receives disclosure as care rather than as evidence, and a response that includes belief, validation, and someone willing to sit

with risk. Services that ask about suicidal ideation incur a duty to the moment of reception, which involves a practitioner who stays with the person, builds enough relationship for an honest conversation and is trained, supervised and supported (Huggett et al., 2022). A practitioner who feels safe in their own decision-making and referral pathways can hold a disclosure long enough to weigh it, and that safety reaches only as far as the system they work in as even a well-supported practitioner refers into a gap when the agencies around her are not working to a shared plan (Haeseler, 2013). That repair is owed most urgently where the danger of telling is greatest. Participants across all three groups named the fear of child removal as heaviest for Aboriginal and Torres Strait Islander families, for whom removal is a continuing state practice as well as a historical one, and mothers whose children are removed face elevated rates of suicide attempt and suicide death (Kenny et al., 2026). A mother who cannot expect a generous reading of her disclosure cannot afford to make one, so the women in greatest danger are the women the current system is least equipped to see.

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Consent: All participants provided informed consent to participate and for the use of de-identified excerpts in publications, including co-design members under the study's co-design consent provisions.

Data availability: Due to the identifying nature of these qualitative interviews, full transcripts cannot be shared for ethical and privacy reasons.

Supplementary material: Supplementary Table S1 (themes, subthemes, summaries, and illustrative excerpts) is provided at the end of this manuscript.

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Supplementary material

Supplementary Table S1. Themes, subthemes, summaries, and illustrative excerpts

Theme	Subtheme	Summary	Illustrative excerpt
Theme 1. 'I couldn't tell anyone': concealment as a rational strategy	3.2.1 What telling could cost	Women weighed what an honest answer might set in motion, above all child removal, and judged silence safer on the evidence they held.	*"my kids and I survived because I didn't say anything." (P24, mother)*
	3.2.2 The good mother cannot say it	Social judgement enforced silence. Suicidal ideation was tied to failing as a mother, and the taboo was gendered and, for some, cultural.	*"Nobody wants your grief." (P17, mother)*
	3.2.3 Taught not to tell: concealment as learned competence	Punished disclosures and observed consequences taught women to conceal. Concealment took skill and effort and was often collaborative, including coaching between mothers.	*"We're just gonna lie and tell them what they want to [hear]." (P6, mother)*
Theme 2. One step closer: when reaching out deepened the danger	3.3.1 'Turned away at the door'	Services refused help at the moment of asking, including during acute suicidal crisis.	*"And she [nurse] said no. And then that was my full stop." (P9, mother)*
	3.3.2 'Minimised, mislabelled, disbelieved'	Women were seen but not believed. Practitioners minimised, misdiagnosed, or shamed, and screening flags went unactioned.	*"The clinician said I was seeking attention in my notes." (P8, mother)*
	3.3.3 'Evidence that you're screwed': the iatrogenic loop	Each dismissed reach-out became, in participants' own reasoning, proof that they were beyond help rather than that the service was inadequate.	*"the more you seek help and then that service can't help you, the more evidence you have that you're screwed" (P9, mother)*
	3.3.4 'Help that punished'	Reaching out was turned into harm: disclosure produced child-protection investigation, and a safety plan was produced in court.	*"more proof that you do not go for help." (P24, mother)*
	3.3.5 'The burden returned to sender'	When the system failed to help, services and families routed responsibility back to the woman it had failed.	*"You've tried everything and nothing's worked, so therefore it must be you" (P9, mother)*
Theme 3. Safe to tell: the conditions of honest disclosure and an adequate answer	3.4.1 Safety precedes disclosure	Safety and trust had to be built before disclosure became possible, and readiness was state-dependent, so intake-only screening asked too early.	*"You're not just going to open up to the first person who asks you the question" (P3)*
	3.4.2 Who could be told	What could be said depended on who received it, and on whether a woman could predict what a disclosure would set in motion.	*"they're not going to say the same thing to you that they will say to the child health nurse or the… social worker, they just don't." (P25)*
	3.4.3 How the asking is done, and what answering takes	Good asking came from a known person, was repeated, and was met	*"a pair of ears attached to an actual heart" (P35, senior perinatal clinician)*

Theme	Subtheme	Summary	Illustrative excerpt
		with belief, validation, and willingness to sit with risk.	
	3.4.4 Making it safe to tell	Participants placed responsibility with services: transparency about what disclosure triggers, guaranteed care first, continuity, repeated asking, and visible separation of support from surveillance.	*“mums need to be able to say it without having the baby taken off them, because that will probably guarantee suicide.” (P18, mother)*

Note. Excerpts are edited to remove identifying details, with edits indicated by (…). Attributions give participant number and group; co-design session excerpts are attributed as “(co-design session)” in the main text. Consistent with safe reporting practice, no descriptions of suicide or self-harm methods appear.