

More Than a Walking Diagnosis: Identity and the Long Aftermath of Perinatal Suicidal Behaviour

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Abstract

Suicide ranks among the leading causes of maternal death in high income countries, and Australian population-based evidence shows that the risk persists for years after childbirth. Researchers have rarely examined the years after a perinatal suicidal crisis. We asked how women experienced diagnosis and misdiagnosis, what the crisis left behind, and how women and their families rebuilt afterwards. Forty-three people took part in interviews, a practitioner survey and five lived-experience co-design sessions; those sessions also shaped the study. With those groups, we defined perinatal suicidal behaviour as an umbrella term for suicidal ideation, planning, suicide attempts and self-harm during pregnancy or in the three years after birth. We used reflexive thematic analysis within a critical realist orientation. We constructed three themes: the long search for understanding; the long shadow of what the crisis left; and transformation rather than recovery. Many participants waited years for an explanation. When clinicians gave a diagnosis that fitted and offered validation with it, women could understand what had happened and enter a care pathway. An incorrect or dismissive label, most often borderline personality disorder, fragmented their self-understanding; participants said the label changed how clinicians engaged with them. One mother linked a refused assessment to her later suicide attempt. The second theme traced effects on parenting, relationships, healthcare engagement, employment and identity that persisted for years, while follow-up care lasted weeks. The third theme described participants' rejection of recovery language. They described instead a self they had built, with growth held alongside grief.

Introduction

Suicide ranks among the leading causes of maternal death in high income countries (Chin et al., 2022). An Australian population-based study followed maternal deaths from suicide, accidental poisoning and undetermined intent for five years after childbirth (Makarious et al., 2026). When perinatal suicide risk endures across years, some women may also carry distress across years. This paper examines the aftermath of perinatal suicidal behaviour.

In clinical practice, clinicians usually recognise perinatal suicidal behaviour through a mental health diagnosis, and women can struggle to obtain an appropriate diagnosis, particularly when they are ethnic minority, low-socioeconomic, adolescent, and Indigenous women (Prady et al., 2021). Presentations are heterogeneous (Howard & Khalifeh, 2020), yet Australian screening guidance centres on the Edinburgh Postnatal Depression Scale (Highet & the Expert Working Group and Expert Subcommittees, 2023). A diagnostic label carries consequences for treatment, identity and safety (Howard & Khalifeh, 2020; Petreca et al., 2026). Qualitative research also suggests that unmet expectations of motherhood and failures of recognition by services shape pathways into perinatal suicidality (Biggs et al., 2023).

Researchers have paid little attention to the aftermath of perinatal suicidal behaviour. The literature to date focuses on the crisis period or ends at what is understood as recovery (Biggs et al., 2023; Kobylski et al., 2026; Reid et al., 2022). A systematic review of interventions for perinatal suicidal behaviour, which defined the perinatal period as pregnancy and the first postpartum year, identified five eligible studies;

the one controlled trial followed women to 7 to 8 months postpartum (Scarth, Derakhshan, et al., 2026). Researchers have not qualitatively studied how the crisis affects identity, relationships, parenting, healthcare engagement, and families in the years afterwards. Where studies have examined the aftermath, they have focused on children (Mebrahtu et al., 2020). Researchers have not asked women who survived perinatal suicidal behaviour what the crisis did to them in the years that followed. Previous work with suicide attempt survivors outside the perinatal context found that survival was accompanied by deliberate meaning-making, and that people's relationship with their suicidal experience was ongoing (Scarth et al., 2021).

This qualitative study forms part of a larger co-designed programme on family support for perinatal suicidal behaviour. Four companion analyses examine adjacent questions: concealment of perinatal suicidal behaviour and the conditions of safe disclosure (Scarth, Wereta, et al., 2026); traumatic birth and its relationship to suicidal ideation and suicide attempts (Scarth, Dudeney, et al., 2026); the care, capability and unmet needs of partners, fathers and kin (Scarth, Vella, et al., 2026); and the whole-family model of care participants specified across the perinatal continuum (Scarth et al., in preparation). Each participant excerpt appears in one analysis only.

Here, we examined how women experienced diagnosis and misdiagnosis before, during and after perinatal suicidal behaviour, what the crisis left behind, and how women and families rebuilt and healed afterwards.

Methods

Design and Orientation

We conducted our programme of research within a participatory action research orientation that positions people with lived experience as co-researchers who shape the research from design through to analysis (Cornish et al., 2023). Five lived-experience co-design sessions, four with mothers and one with male family members, shaped recruitment, instruments and analytic priorities; the sessions also generated data in their own right. One of the mothers' sessions focused on the aftermath of perinatal suicidal behaviour, and its material informs much of Themes 2 and 3. Some members also gave individual interviews, which covered their own histories in ways the group setting did not.

The co-design groups developed the definition of perinatal suicidal behaviour used here: an umbrella term for suicidal ideation, planning, suicide attempts and self-harm during pregnancy or in the three years after birth, regardless of the type or outcome of the pregnancy. Terminology follows the nomenclature recommendations of De Leo et al. (2021). We use "mother" for the birthing parent because all participants used it. Excerpts from the mothers' co-design sessions are attributed as "(mothers' co-design session)". Excerpts from the practitioner survey are attributed by participant number, role and source, for example "(P37, health professional, survey)".

We took a critical realist orientation (Bhaskar, 2009). We take the events participants described as real; their accounts, and our interpretations of them, are partial and fallible knowledge of those events. We treat a diagnosis as a real event with real consequences, and participants' accounts of its effects on identity as evidence about those consequences. We assembled the account from diagnosis to rebuilding the self as a co-construction, and where a claim rests on our inference rather than on participants' words, we say so.

Participants and Recruitment

Forty-three people took part: 38 interviewees across 37 semi-structured interviews (one a joint interview with a couple), three perinatal health professionals who completed a written survey, and two lived-experience co-design members who took part through a session only.

We recruited through the networks formed by the co-design groups, snowballing, perinatal mental health and suicide prevention organisations, social media and the study website. We assessed the size of the participant group using information power (Malterud et al., 2016). The aim was specific and the groups hard to reach, which reduces the number needed. We sought up to 15 participants per group and reviewed that target against the depth of what participants were telling us. Interview participants received a \$50 supermarket voucher; the anonymous practitioner survey carried no reimbursement.

We describe the participant group's demographics in prose rather than in a table because several participants are the only person in the group with a particular combination of cultural background, role and history, and a demographic table would identify them. Twenty-seven women had lived experience of their own perinatal suicidal behaviour, and two of the men who took part as kin made suicide attempts of their own after the period of caring (Scarth, Vella, et al., 2026). Nine participants took part primarily as family members or carers, and seven as perinatal health professionals, including two senior perinatal psychiatrists. Thirty-five participants were self-described women and eight were men, with recorded ages from late adolescence to over 70. Participants included Aboriginal and Torres Strait Islander people, Māori people, people from culturally and linguistically diverse backgrounds, and white Australian-born participants.

Self-reported diagnostic histories were extensive and often contested. Table 1 summarises them for the perinatal period. Sixteen participants held dual roles across lived experience and the perinatal workforce. Ten disclosed one or more suicide attempts. For eight, a family member's suicidal behaviour was the interview's main subject.

Table 1

Events During Pregnancy and the Three Years After Birth, and What Clinicians Recognised (n = 27)

Pattern in participants' accounts	n	Examples from the accounts
Described a traumatic birth or a serious obstetric or neonatal event	19	Haemorrhage, emergency caesarean, pelvic floor injury, neonatal resuscitation, neonatal intensive care
A clinician identified the birth as traumatic at the time	2	Premature birth, haemorrhage
The birth was recognised as trauma only later, by the participant, a peer or a clinician outside maternity care	9	Through peer work training, a news article, a physiotherapist or a neurologist
The physical injury was missed or not disclosed	3	Pelvic floor injury identified months later by a physiotherapist
Received a psychiatric diagnosis in this period	22	Postnatal depression, postpartum psychosis, PTSD, OCD, bipolar disorder, ADHD
Received a diagnosis in this period that they dispute or describe as a misdiagnosis	6	Borderline personality disorder, bipolar disorder, anxiety
Received no new diagnosis in this period despite suicidal behaviour	5	Pre-existing depression or anxiety left unchanged, or symptoms concealed
Identified in themselves a condition that no clinician had diagnosed	11	Autism, ADHD, OCD, complex PTSD, postnatal depression, birth trauma
Concealed symptoms because they expected their child to be removed	19	First Nations women, women who grew up in Out of Home Care systems, women with a history of complex trauma
Described harm caused by a service in this period	18	Refused assessments, dismissal, a child protection investigation after disclosing suicidal thoughts, racism in care
<p><i>Note.</i> Counts describe the corpus and do not measure how strongly a theme is supported. Participants are the 27 with lived experience of their own suicidal behaviour. PTSD = post-traumatic stress disorder; OCD = obsessive-compulsive disorder; ADHD = attention-deficit/hyperactivity disorder.</p>		

Data Generation

The first author conducted all interviews except one, transcribed and de-identified the recordings, and checked the automated transcripts against the audio before analysis. An interpreter conducted the remaining interview in the participant's first language, with the first author present in support, so that he could speak privately. Interviews took place by Zoom, two of them in person, between March and June 2026, and lasted between about 60 and 180 minutes. Each interview opened with a readiness check and closed with a debrief; participants were offered a wellbeing plan beforehand and a check-in afterwards. Zoom produced automated transcripts of the online interviews, and the first author transcribed the two

in-person interviews by hand. Google Translate produced an English version of the interpreted interview, and the interpreter checked the quoted passages against the recording.

The co-design groups designed the semi-structured guides, which asked about the course of participants' experiences, disclosure, contact with services and what helped and what hindered, and recorded diagnoses in a screening section (the guides are available from the corresponding author). The guides did not ask directly how diagnoses were communicated or what life had been like since. Participants raised both matters, and the first author followed them up in interview; the mothers' aftermath session addressed the second directly. Perinatal health professionals could instead complete an anonymous online survey that mirrored the interview schedule. We did not ask practitioners about their own lived experience; where they disclosed it, attributions reflect that.

Ethics

The Monash University Human Research Ethics Committee approved the study (Project ID 50913, qualitative interviews; Project ID 49134, co-design workshops). The University of Melbourne first approved the co-design study in May 2025, and participants enrolled under that approval were re-consented under the Monash approval. All interview and co-design participants gave written informed consent to take part and to publication of de-identified material. The first author sent each interview participant the explanatory statement and consent form and received the signed form before the interview; co-design members gave written consent to the first author before their first session. Practitioner survey respondents gave consent by completing the anonymous survey, with the explanatory statement presented as its landing page. Participation was voluntary, and participants could decline any question or withdraw at any time.

A stepped distress protocol, running from pausing to offer support through to contacting emergency services, applied to all data generation. No acute risk incident occurred. We carried no descriptions of suicide or self-harm methods into the analytic corpus, and none appear here; we report suicidal behaviour by type only. We have edited excerpts to remove identifying details, marking omissions with (...), pauses in speech with ... and clarifications with square brackets. Several participants are the only people in the corpus with a particular characteristic, so we generalised some details and reported some sequences without dates.

One ethical feature is specific to this paper. Because participants were describing identity and its reconstruction, one participant asked to revise their own words for accuracy after the fact.

Data Analysis

The first author analysed the data using reflexive thematic analysis (Braun & Clarke, 2021) within the critical realist orientation described above (Fryer, 2022). We chose reflexive thematic analysis over codebook and coding-reliability variants because the question concerned how participants made sense of a diagnosis and of what followed. The participatory design also suits an approach that treats the

researcher's subjectivity as something to examine, and the method is compatible with critical realism (Braun & Clarke, 2021, 2025).

The first author developed codes from the data, so the coding was inductive; the co-designed questions and the aftermath session also framed what she looked for, so the coding was deductive as well. Coding moved from semantic description towards latent interpretation. She worked through Braun and Clarke's six phases recursively rather than in sequence (Braun & Clarke, 2021). Familiarisation began during data generation. She coded the entire dataset in MAXQDA (VERBI Software), without its automated coding functions, revised codes as her reading changed, and wrote the interpretive memos through which candidate themes were built. She reviewed each candidate against the whole dataset, asking whether it described a shared meaning organised around a central concept or only a topic that several participants had raised, and she kept dissenting accounts in view throughout. Two of the present themes were first constructed as separate analyses and merged when review showed that they shared a central concept and four excerpts. Writing formed part of the analysis, and the theme structure changed while she drafted. We pooled and analysed interview, survey and co-design data together, with attention to where participant groups agreed and where they did not.

Reflexivity and Quality

We calculated no measure of intercoder agreement, because a reflexive approach does not treat agreement between coders as a marker of quality (Braun & Clarke, 2021).

The first author is a mother and a researcher-practitioner with an extensive background in mental health, family violence, suicide prevention and postvention.

The co-authors on this paper engaged in and challenged the analysis, and include clinicians, academics, peer workers, and lived-experience researchers engaged in co-design. All authors are mothers.

Two features of the programme bear on Themes 2 and 3. The five members of the mothers' co-design group are co-authors and also participants. The first author took candidate themes to a sense-making session with this group and refined them in response to members' readings; we did not seek consensus, and we do not treat the group's reading as corroboration. The critique of recovery language that anchors Theme 3 also began with a member of that group. We therefore report the transformation framing as one that lived-experience partners developed, and in Theme 3 we say where a participant was responding to it.

Overview of Themes

We constructed three themes. Together, the three themes form one sequence in participants' accounts. A diagnosis or understanding supplied the material for an account of what had happened; that account made meaning-making possible; and meaning-making constituted living well afterwards.

Theme 1. The Long Search for Understanding

Many participants described the absence of a diagnosis as a lengthy and frightening experience, because they did not understand what was happening to them.

Years Adrift Before Anything Was Explained

Some participants moved from service to service across months or years before anyone explained why they were experiencing suicidal distress. One senior perinatal clinician located part of the delay in women's concealment, and located the concealment in fear:

You're really good at hiding it (...) if you look at the (...) root cause there is society's attitudes, and fear of the baby being taken away. (P34, senior perinatal clinician)

Some participants received no diagnosis at the time; understanding came in retrospect:

I've never been diagnosed with it, but I think I'm a classic case of it. I just didn't have time to reach out for help (...) And my doctor has now said, looking back (...) you definitely did have it. (P20, mother)

Caring work consumed the time these participants needed to seek help. Confirmation arrived years later: useful for understanding, too late for treatment.

For some participants, the diagnosis that made sense of their perinatal suicidal distress arrived only through their child's diagnosis, which then required them to review their own history:

It's only after having both my girls that I've realised that I'm neurodivergent (...) since my eldest daughter has been diagnosed with autism and ADHD, that I'm clearly autistic as well, as having ADHD. And just the fact that you have to keep going and reviewing your life with these different lenses is so much work in itself while you're trying to raise the next generation. (mothers' co-design session)

Postpartum psychosis recurred across the corpus as the condition most easily missed or misdiagnosed, in part because women concealed it: *"Women with psychosis will present as being really well (...) you mask it because you're so scared, because your brain's really playing tricks on you"* (mothers' co-design session). One survey respondent proposed recognising postpartum psychosis in the Diagnostic and Statistical Manual of Mental Disorders, which she said, *"would make a big difference"* (P37, health professional, survey).

For a second group, clinicians offered conflicting diagnoses in sequence over years, each superseding the last, and the sequence itself became the problem. One participant's history ran from severe postnatal depression, through depression with psychotic features, to a query that did not fit:

originally, diagnosed with a severe, postnatal depression (...) And then, yeah, further down the track, a depression with psychotic features, or (...) postpartum psychosis, so it comes under that umbrella. And then

a (...) sort of a query around bipolar type 2, which (...) it fits and doesn't fit, I think. I'm not completely convinced or wedded to that. (P3, mother)

Another participant described the moment when a late diagnosis reorganised everything that preceded it:

we should have booked you in for an autism assessment. And it was then that I kind of went away and started looking up (...) late diagnosis women, autism, how much I realised, hello, I don't have just anxiety and depression. Like, this is (...) full body dysregulation, this is sensory difficulties, cognitive issues. (P22, mother)

Her earlier diagnoses, which included depression and anxiety, had “*stuck with me (...) pretty much my whole life*”, and a borderline personality disorder (BPD) label had been “*floated with the idea of (...) by an emergency room psychiatrist, who I'd never saw again*” (P22, mother).

Participants described the wait for an explanation, and the run of conflicting diagnoses, as frightening in itself. Several participants dated the deepening of their distress to that period, or to treatment that did not help.

When the Diagnosis Fits: Relief, Sense-Making and Validation

Participants often described the right diagnosis as a turning point:

It was life-changing, for good, for once, because everything actually made sense (...) the best thing to have ever happened. (P1, mother, of an ADHD diagnosis)

Another participant described a similar, more understated relief: “The panic disorder, I didn't realise it had a name. But it made sense” (P23, mother).

Often, a diagnosis worked by validating an experience that someone had dismissed. One mother contrasted a hospital where staff did not believe what she was going through with a service that explained her experience as postpartum psychosis:

They actually believed me (...) they validated how I was feeling. (P15, mother)

In these accounts, the explanation and the validation had to arrive together. Participants who received one without the other did not describe the same resolution.

One participant listed what the combination requires:

The right doctor, the right diagnosis, the right medication, and the right kind of relationship and rapport then, helped things. (P3, mother)

Participants who had a diagnosis that fitted but no safe therapeutic relationship did not describe that as enough, and neither did those who had the relationship without the diagnosis.

The explanation that finally made sense did not always come from a clinician. Several participants described peers, and in one case a stranger's account read online, as the source of the language that fitted. For birth trauma, recognition sometimes took more than a decade (Table 1), and a companion analysis reports that pathway (Scarth, Dudeney, et al., 2026).

Another participant found a diagnosis of BPD helpful. A psychiatrist gave it after a single session, overturning her GP's suspicion of ADHD, and she reclaimed the label:

instead of being like, oh, shit, I've got borderline, I was like, oh, yes, I've got borderline, right! How does a borderline brain work? (...) so when I have these emotions, my brain's actually better at making these than other people's brains (...) [and] worse at dealing with them. Right, okay, what can I do to combat that? (P17, mother)

She described the label as delivering a correction: *"having the diagnosis of borderline taught me (...) that as much as this is how my brain works and how I'm thinking, perhaps this is not actually the reality of every situation that I'm in"*. She reframed the construct itself: *"to me, borderline is more a trauma response of how my brain forms"* (P17, mother).

Her experience suggests that whether a diagnosis helped or harmed depended less on the label than on what surrounded it: whether the woman had a framework for the diagnosis, whether the clinician stayed engaged afterwards, and whether the diagnosis was offered as an explanation or delivered as an irrefutable fact about her as a person. Where those conditions were absent, participants experienced the diagnosis as harmful and stigmatising.

An explanation was not always welcome. The participant whose diagnoses had moved from postnatal depression to a query of bipolar type 2 felt she had been labelled too quickly: *"he was quite quick after one and a half sessions to label it, you know, to say, I think you've got bipolar type 2, which I wasn't ready to hear at that point either"* (P3, mother). Timing mattered as much as accuracy.

Another participant, who had survived extensive complex trauma, described resisting a BPD diagnosis:

my old doctor was trying to gently push me down that path when my son was 5, and I said, have you looked at complex (...) PTSD with autism? (...) I feel like that suits me a lot more than (...) a BPD diagnosis, because half of it isn't relevant. I don't experience that. (P20, mother)

As a very young mother with little support, she had to disclose traumatic experiences, research her own condition and contradict a clinician to resist it, because she understood that a BPD label would diminish the care she received.

One mother was offered ADHD screening by a peer for whom it had reframed her own depression, and declined:

I don't want to collect any, any more labels at the moment. (P23, mother)

She already had two diagnoses and had acquired more during a hospital admission. The capacity to take on further labels has a limit; someone with several diagnoses may receive additions as burdensome rather than clarifying.

When the Diagnosis Wounds: Misdiagnosis, Dismissal and the Wrong Label

The wrong diagnosis, or a dismissive one, can do real harm. Participants described misdiagnosis eroding their self-understanding:

You try and make it fit just so you can make sense of yourself, and then you end up more dissociated and disillusioned from yourself. (P1, mother)

Participants in the lived experience, professional and dual groups described a BPD diagnosis as changing how clinicians responded. One perinatal professional with lived experience summarised the harmful reading clinicians applied to women with the label: *"They're attention-seeking, they're just wanting attention"* (P25, perinatal professional with lived experience).

One mother described the negative stance she had seen clinicians take towards BPD patients:

[They] don't want to take on a BPD patient, whereas if you've got bipolar disorder or something, it's like, oh yeah, [they] can do that, [they] can take that on. (P3, mother)

This participant also thought clinicians often missed and mislabelled neurodivergence, and that earlier recognition might have prevented some of the harm women experience:

there's a lot of neurodivergence and stuff happening in there, too, that's potentially being missed and mislabeled (...) as bipolar disorder, but potentially BPD as well (...) if they'd been diagnosed ADHD in their early 20s instead of being diagnosed with borderline personality disorder, a lot of this other stuff potentially wouldn't [have followed]. (P3, mother)

Participants also described harm from medication that clinicians misread or that did not suit their condition. One mother presented to hospital four times with akathisia, a reaction she developed after stopping medication in pregnancy: *"They had all said to me, no, you've got restless legs (...) [it was] akathisia (...) and they didn't recognise it"* (P13, mother). Another linked her suicidal period to psychiatric medication, prescribed on its own when she may have had a different condition that the medication was contraindicated for: *"potentially misdiagnosis, and, not being treated with the right medication, and yeah, I do think the medication certainly worsened things"* (P3, mother).

One participant's history of revised diagnoses spanned the same arc across decades, from a label that did not align with her experience to the relational care that helped:

they said that I had (...) chronic manic depression (...) which then went on to be bipolar, but I'm not bipolar (...) no medication ever worked (...) if I took medication, actually, I became worse (...) What worked was (...) going to see the social worker four times a week. (P19, mother)

The co-design sessions returned to the consequences of a missed diagnosis: *"for me my suicidality was around psychosis, and that was missed. So my diagnosis was depression. But the psychosis was causing the suicidality"* (mothers' co-design session). Another member described being dismissed: *"I was completely dismissed by my psychiatrist at the time, who put it all down to the fact that my baby doesn't sleep, so then it was, you know, solve the sleep problem, and then you'll be fine"* (mothers' co-design session).

Iatrogenic Harm

Where a label produced disengagement, minimisation, or what participants experienced as iatrogenic harm, participants described their suicidal behaviour deepening. The wrong explanation could also remove the support that might have interrupted their crises, because a label that explains a woman's distress as her character does not produce a treatment plan.

A mother admitted twice to a Mother and Baby Unit gave the most direct version of this claim. Her perinatal mental health clinician requested a specific assessment on her behalf at each admission. The unit refused both requests, and she wanted only to be listened to. Asked what would have prevented her suicide attempt, she said:

if the first place that I went to twice prior to it all happening; if they listened to my perinatal mental health lady. And just had done the diagnosis. Like, just done the ADHD test. Like, it really wouldn't have hurt anybody, to just do it. Like, and it just makes me angry...That would have stopped it. Yeah. If they'd figured it out, put me on medication, I would have felt amazing (...) The first time they put me on ADHD meds, it was only 5 milligrams, and I've never felt so happy in 14 years. (P10, mother)

What she needed from the service was basic: *"just listen to the people who are sending me there, because she knows me so much better than you do"* (P10, mother).

Another participant described how the diagnosis of a personality disorder had left her feeling invalidated and stigmatised during her admission:

They tried to diagnose me with like a personality disorder while I was in the unit, but this was before I was diagnosed with autism, which made more sense in the longer run, but they basically told me I had OCPD (...) that it was my sort of relentless need for control that was the problem, and I was the problem (...) it really kind of left me feeling like, am I the whole issue here? Like, in my brain, it's like, I'm doing everything I possibly can to like, to support my baby. (P40, mother)

Women experiencing perinatal suicidal behaviour often present well and mask, fearing the consequences of disclosure, as a companion analysis discusses (Scarth, Wereta, et al., 2026). Participants suggested that because of this, clinicians can most easily miss the presentations with the highest risk, so a clinician who stays curious is doing suicide prevention.

A curious clinician, an accurate explanation and being believed together reduced isolation and shame. One senior perinatal clinician offered a reframing intended to reduce shame: *“Suicidality is not a failure state (...) someone’s nervous system is daring to let us know how much pain they’re in”* (P35, senior perinatal clinician).

Having no explanation harmed differently: it left participants unable to distinguish the illness from their sense of self.

Theme 2. The Long Shadow: What the Crisis Left

This theme centres on a mismatch in time. Participants described effects that lasted years, reaching identity, family, parenting, work and relationships, while the services they had received measured their involvement in weeks.

A Rupture in Your Life

Mothers described their parenting as permanently marked. They were hypervigilant about their own states, guilt permeated their parenting, and for some, the crisis changed their plans for more children. Participants described relationships with partners that were rebuilt on new terms or ended; several described marriages that ended in the wake of the crisis, and others described partnerships that deepened but stayed marked. Many participants lost trust in the health system after iatrogenic harm, or found themselves treated differently afterwards, which made them reluctant to engage again:

they’re never gonna stop asking me about...like trying to kill [my]self. So that’s really upsetting. It’s very frustrating. I just wish it would stop, like... (P10, mother)

Another mother described lying to hospital staff after a later pregnancy for fear of consequences:

The hospital, like the diabetes educator, just laid it on so thick to me...that I was, you know... unequivocally ruining my child’s life forevermore because I was... wasn’t eating correctly. Yeah, so... so what I did was, instead of telling them, I just lied. Yeah. I just... I literally just did what I needed to do, and I lied. (P17, mother)

Participants also revised their careers. Some stepped back from professions that they could no longer sustain; others, examined in Theme 3, rebuilt their working lives inside the perinatal sector. A third group kept their occupation and kept the rupture secret. One participant, well by the time she returned from maternity leave, explained why disclosure might harm her career:

no one I've worked with has really known that I have bipolar (...) my psychiatrist always said to me, you can't untell people (...) you might always be the one they think of as the girl with bipolar, and we'd better triple check her work, and, oh, well, we won't get her to do that. (P12, mother)

Another stated the financial consequences: *"I lost my business. It's like the financial impact of (...) not working for 2 years. Massive. And depending on other people"* (mothers' co-design session). Friendships ruptured too, with several participants describing people who had offered support and then withdrawn it when it was asked for.

Within these ruptures, participants described their sense of self as most affected. One mother grieved the mother she had wanted to be:

I had this vision of me just being this earth mother who could breastfeed (...) And, like, I'm, like, rocking on the floor in a mental health facility. Like, this is not what I had planned. (mothers' co-design session)

The Gendered Burden of Responsibility

The aftermath did not fall evenly. Guilt and shame attached along gendered lines that long preceded it.

Mothers carried responsibility for the crisis itself, for having been unwell, for what the household went through, and for the effects on children, real and feared. Several men described guilt about specific actions or absences, but no father described the totalising self-indictment that mothers reported. Clinician participants described the same pattern: mothers years past the crisis still working at every service contact to be seen as a good mother (Scarth, Wereta, et al., 2026).

The mothers' co-design group discussed how guilt shaped their parenting:

I feel guilty for something that hasn't even happened yet (...) it's almost framed who I am as a mum, that I haven't let him experience adversity (...) before anything even happens, I'm in there fixing it. (mothers' co-design session)

The group worked out a distinction between shame and guilt: *"I think guilt is internal, and shame is external (...) all the shame out there from how you perceive the world (...) internalises into guilt"*. Another mother reasoned her way out of the shame and found guilt would not follow: *"I know this wasn't my fault, and I know I didn't choose it (...) so then the shame kind of then just gets debunked (...) but I feel guilty that this was an experience that my child had"* (mothers' co-design session).

One member compared the expectations placed on mothers with those placed on someone who has finished a triathlon:

If you signed up to do, like, a triathlon (...) you get to complain afterwards that it was really sore (...) But there's something about having kids that (...) Don't say you're not enjoying it. You asked for this. What is it about us having kids that changes that story for us? (mothers' co-design session)

What the Children Inherit

The crisis moved through the household. Participants whose children were older described those children processing the rupture in their own time and their own therapy: “[they are] unpacking that in therapy” (P21, mother).

Families described siblings who became watchful, children who internalised unexplained absences, and parents still negotiating and agonising over what and whether to explain. Co-design members described what such management takes: *“I’m constantly doing the threat scanning, so I’m trying to protect my children against things that haven’t even happened and may never happen”*. One mother described guilt *“towards my parents, because they had to look after [child] for so long while I was in hospital”* (mothers’ co-design session).

Another participant turned the inheritance into deliberate parenting:

I try to reframe it as an opportunity to help my children learn how to deal with shame. Through being able to (...) name it, because (...) for so many of us, it was just a thing you never talk about. (mothers’ co-design session)

Participants and clinicians alike identified the threat of child removal as the most annihilating loss of the aftermath. Some said they would still never ask services for help for fear of removal, years after the crisis, as a companion analysis discusses (Scarth, Wereta, et al., 2026).

Follow-Up Measured in Weeks

Against an aftermath measured in years, participants described support measured in weeks. One mother recalled a public unit that was *“very eager to kick people out quite quickly (...) I wasn’t super stable at that point on my meds”* (P10, mother). Another rejected the idea that recovery keeps to a clinical timetable: *“it doesn’t get better at 6 weeks, right? (...) it’s 6 weeks, and now you’re back to normal, yeah, the hell I am”* (P16, mother). No participant described scheduled contact months or years after the crisis.

The missing follow-up left self-surveillance behind:

Some of my big aftermath is my hypervigilance around my own mental health (...) every time something happens in my life now, I’m like, am I going to lose my shit again? (mothers’ co-design session)

The revised reproductive future belonged to the same uncertainty and self-surveillance: *“It makes me question whether I want to have a second child, because I’m scared that, if I do, I’m gonna go through all of that again”, one member said, and another replied, “a right of yours [to have more children] is being taken away”* (mothers’ co-design session).

Theme 3. More Than a Walking Diagnosis: Transformation Rather Than Recovery

Participants reflected on the relationship between a diagnosis and who they were, and they resisted collapsing the two.

The Box and the Key

Participants valued language that separated the person from the condition:

It just separates you from it, your identity from that mental illness (...) I can still be a very good mother, and I can still be a person who's experiencing this. (mothers' co-design session)

Participants described a diagnosis as working in two directions. It could explain what had happened, but it could also become a box through which other people, and sometimes the woman herself, saw her only as the diagnosis. One mother valued being freed from that box: *"I don't have to fit within anyone's box of 'I'm better now'. It's more, 'I'm a new person now'"* (P10, mother). Several participants, including clinicians, preferred framings that lifted shame from diagnosis: *"Not the illness model, [so] you reduce the shame, and when you reduce the shame, you make it possible to look and find out"* (P35, senior perinatal clinician).

A diagnosis posed the sharpest threat to identity for participants whose sense of self rested on being capable. High-achieving participants described delaying help-seeking because they did not see the need as applying to them. When a diagnosis finally came, they described deeper shame, because it contradicted the capable person they had understood themselves to be.

The Loss of Self, and Refusing Recovery

At its depths, participants described losing identity altogether: *"I often say I feel like I (...) my soul died in that period. Like, there was a death, a spiritual death"* (mothers' co-design session). Participants also rejected the language of recovery, because they could not return to who they had been before the crisis. One mother explained why:

I have mixed feelings about the use of the word 'recovery' in the perinatal space because it's actually not possible, you can't go back to who you were or the life you had before. You can't give the baby back and your body won't be the same. Becoming a mother is inherently transformational, so constant focus on the idea of recovery isn't helpful. It's about discovering and finding your new reality with a baby, and having the space and time to work that out. It's okay to not have all the answers right away, it doesn't mean that there's something wrong with you, it's a normal need to recalibrate. (mother, co-design session)

Another mother, responding when the interviewer described the co-design member's statement, agreed: *"Recovery's not really the word (...) I don't have to necessarily recover from this"* (P10, mother). The objection to recovery has service consequences. In participants' accounts, a service organised around restoring a prior self, sets a goal that cannot be met, then reads the failure to meet it as the patient's.

What Staying Alive Returned, and the Remade Self

Participants who described losing themselves also described building a new self on the other side. One framed survival itself as an opening: *"This is my second life (...) I am completely different (...) I've survived (...) what do I want my life to look like?"* (mothers' co-design session).

Participants often described rebuilding the self as lonely but necessary:

I think it can be such a lonely process though (...) All my relationships disintegrated (...) it's a lonely place to find yourself in. And having to reconstruct who you thought you were, who you are, and who you're becoming...without anyone around, it's hard. But at the same time, I guess, it almost needed to happen for me because I didn't need any of that external influence, I just needed to really focus on myself. (mothers' co-design session)

Participants described how they had been forced to rebuild their identity as mothers, and they were clear about how hard that was:

I feel like a really big thing (...) was also sort of losing my, like, self-identity, because after all of that, I didn't feel like a mum. But I didn't feel like myself as well, and I just felt like (...) like a complete different person with no sense of self (...). Like, there was that expectation of, you're a mum now, but (...) I think the biggest thing was just bonding with [child]. I struggled so bad with that (...) and with the psychosis, I was so convinced that [child] was someone else's (...) I just did not see myself as a mum at all after all of that (...) I do recognise myself as a mum now. But I guess with, like, my relapses it sort of takes that away sometimes as well, and so I have to sort of remind myself Like...[child] is mine, I am [child's] mum (...) So (...) I do feel more comfortable with that identity of being a mother. But at times, it does get difficult, and it goes down a little bit as well. (mothers' co-design session)

Some participants described gratitude that they had survived into a life they had not thought possible: "I have an overwhelming sense of gratitude, because I didn't think I would survive, and now I am, and I'm thriving" (mothers' co-design session).

Meaning Made, and Growth Beside Grief

Participants constructed meaning deliberately and over years, and they described explanation as its foundation. The right explanation, usually provided through a diagnosis, converted chaos into a narrative; storytelling built that narrative. Participants described telling their story to partners, to children at the right age, to other mothers, and to this study, as work that organised the experience and put it to use. This process is consistent with the place of storytelling and self-disclosure in growth after suicidal experiences (Scarth et al., 2021).

For some participants, advocacy and sector work extended their meaning-making further. Many participants became perinatal peer workers as a way of making the crisis useful, while also describing its costs. The sessions themselves showed the collective form of meaning-making: *"there's five of us sitting in a room, naming this misjustice, and saying it needs to be better (...) what drives me is, like, for this to not happen to someone else. For the learnings, and that's how I've made meaning"* (mothers' co-design session).

Participants held growth alongside grief for what they had lost during their period of suicidal crisis and early motherhood, and one participant located that pairing in the diagnosis itself:

In terms of growth, ADHD, figuring that out caused a huge amount of grief. But also, I'm so glad that I know. But there was such a huge grief in looking back on my entire life and realising that, what could have been different, if only they'd known. If only I'd known (...) how much could have been saved, how much pain might not have happened. (P10, mother)

The diagnosis both explained the experience and itemised the cost of not having it sooner.

Discussion

In this study, we asked how women experienced diagnosis and misdiagnosis before, during and after perinatal suicidal behaviour, what the crisis left behind, and how women and families rebuilt and healed afterwards. Diagnosis was an identity event as well as a clinical one. Bury (1982) described chronic illness as a biographical disruption that forces people to rework their account of who they are, and participants described diagnosis doing similar work in both directions. Women in this study received mental health diagnoses before, during and after their suicidal crisis, some only years later. A diagnosis that fitted, arrived with validation and carried no shame gave participants coherence to their suicidal experience and a care pathway. A wrong, dismissive or absent diagnosis fragmented their self-understanding and could deepen distress. Diagnostic communication therefore requires a skill distinct from diagnostic accuracy, and clinicians receive little training or attention for it (Milton & Mullan, 2014; Perkins et al., 2018).

Misdiagnosis harmed participants when they received the wrong treatment, and when they tried to make themselves fit a diagnosis that did not describe them. BPD recurred as the clearest case, and participants with lived and professional experience described it as changing how clinicians engaged with them, which aligns with existing research on stigma and clinical process in BPD (Stiles et al., 2023). For one participant, a refused assessment withheld the treatment she needed, and she connected that refusal to her suicide attempt. The participant who had a framework ready for her BPD diagnosis points to the value of scaffolding around the moment of diagnosis (Stiles et al., 2023).

Timing mattered too, and participants described needing trust built over time with the diagnosing clinician, a finding in the broader psychiatric diagnosis literature (Milton et al., 2016; Perkins et al., 2018). Some participants did not want to accumulate further labels because they already felt overwhelmed by the ones they had, and researchers appear to have done little empirical work on what accumulating diagnoses does to a person (Brossard & Chandler, 2022).

Participants described the aftermath as long, uneven and largely unsupported. The ongoing impact ran through parenting, relationships, healthcare encounters, employment and identity, and it fell on mothers far more heavily than on fathers. Participants attributed that to cultural and institutional forces that scrutinise mothers more closely, which aligns with the existing research on motherhood (Lucas et al., 2019). Mothers wanted support in rebuilding a self and a parenthood, and they wanted it after the crisis as well as during it.

Participants described that rebuilding as transformation rather than recovery, with growth held alongside grief for ruptured relationships and disrupted motherhood. They made meaning deliberately in two senses: they built an account of why the crisis had happened, and they found uses for what they had learned from it through storytelling, peer work and advocacy. Participants also held that a goal of restoring a prior self set them up to fail. They asked for space, time and permission to recalibrate, and for research and services to stop requiring a triumphant 'recovered' ending. The literature on post-traumatic growth is well established (Frey et al., 2019; Scarth et al., 2021; Tedeschi & Calhoun, 2004), and personal recovery in mental health has been framed around connectedness, hope, identity, meaning and empowerment (Leamy et al., 2011). Participants wanted these things for themselves while rejecting the word recovery entirely. Its perinatal application here carries a caution from participants: they described growth beside grief, never instead of it. If no explanation or understanding came, participants could not begin the process of making meaning of the crisis. Diagnostic accuracy and communication have effects beyond what clinicians often acknowledge (Milton & Mullan, 2014): they shape treatment decisions (Stiles et al., 2023) and a woman's capacity to build a coherent account of what happened to her that enables her to transform and make meaning from the crisis.

Limitations

Participants gave retrospective accounts, which carry both distance from events and the meaning-making that distance allows. Neither gives a transparent record. This matters especially in a paper about meaning-making, since the accounts are themselves instances of the process described.

We recruited substantially through perinatal mental health networks, and sixteen participants had built working lives in the sector. That bounds the transformation claim. People who made meaning by entering the field are more likely to join research about the field.

Diagnostic histories are self-reported and we did not verify them against records, which suits the research question, since the paper concerns the experience of being given an explanation. It limits any claim about actual rates of misdiagnosis.

Index experiences span more than two decades and several service systems, which gives unusual reach into the long aftermath and limits claims about any single current service. Participants included Aboriginal and Torres Strait Islander people, Māori people and people from culturally and linguistically diverse backgrounds, and we report their contributions as contributions; diagnostic experience and aftermath in these communities both require dedicated, community-governed research.

Implications for Practice and Research

Participants' accounts suggest changes that perinatal services could make. Clinicians could treat giving a diagnosis, or better still a diagnostic formulation, as the start of a conversation, with time to explain it, to check how the woman receives it, and to revisit it when it does not fit her experience. Services could consider neurodivergence and postpartum psychosis when a woman describes years of unexplained

distress, and take care before giving a BPD diagnosis during an acute perinatal crisis. Follow-up could extend well beyond the weeks of acute care, because participants described effects that lasted years.

Future research could follow women for several years after perinatal suicidal behaviour, well beyond the first postpartum year. Studies could also examine how clinicians communicate perinatal diagnoses and how that communication affects later help-seeking, and could test whether extended follow-up reduces later suicidal behaviour.

Conclusion

Participants described an arc of transformation from perinatal suicidal distress that began with the search for an explanation, passed through crisis and its enduring aftermath, and eventually led to the reconstruction of self. A diagnosis that fitted and was offered without stigma gave them the framework to make meaning and rebuild. The wrong diagnosis, or none at all, prolonged confusion and distress for years.

That aftermath persisted for years, while follow-up support lasted only weeks. Participants rejected the language of recovery as inadequate to what they had been through: they had rebuilt, and been transformed. They asked perinatal services to attend to what surrounds a diagnosis as well as its accuracy, to validate what women describe, and to stay alongside them over time.

Declarations

Ethical Statement

Our study was approved by the Monash University Human Research Ethics Committee (Project ID 50913, qualitative interviews, approved 20 February 2026; Project ID 49134, co-design workshops, approved 6 October 2025). The co-design study was first approved by The University of Melbourne in May 2025, and participants enrolled under that approval were re-consented under the Monash approval. All interview and co-design participants provided written informed consent, including consent to publication of de-identified excerpts. Practitioner survey respondents gave consent by completing the anonymous online survey, with the explanatory statement presented as its landing page. The study was conducted in accordance with the Declaration of Helsinki.

Use of Artificial Intelligence and Other Technologies

We did not use generative artificial intelligence to generate or analyse participant data, and we did not use automated coding functions in qualitative data analysis software. During preparation of the manuscript, the first author used voice-to-text for drafting, followed by Microsoft Copilot to support editing and formatting, as part of her disability support plan. The authors reviewed and edited all output and take full responsibility for the content.

Declarations of Conflicting Interests

The authors declare that there is no conflict of interest.

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Author Contributions

Bonnie Scarth: Conceptualisation; Methodology; Investigation; Data curation; Formal analysis; Funding acquisition; Project administration; Writing – original draft; Writing – review and editing. Julie Levin, Nicola Akeroyd, Hiro Kojo, Courtney Patten, Andrée Balzer: Conceptualisation; Formal analysis (sense-making session); Writing – review and editing. Kylie King: Supervision; Investigation; Data curation; Writing – review and editing. Anne Buist: Supervision; Investigation; Data curation; Writing – review and editing. All authors approved the final manuscript.

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Data Availability

Participants did not consent to the sharing of full transcripts, and several are identifiable within their own communities, so the data are not publicly available. Enquiries about the interview guides can be directed to the corresponding author.

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