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SUICIDAL BEHAVIOR AND THE PERINATAL PERIOD: TABOO AND MISUNDERSTANDING

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El suicidio es la primera causa de muerte de las mujeres durante el periodo perinatal, que comprende desde el embarazo hasta un año después del parto. Hay apoyo empírico suficiente para afirmar que las mujeres embarazadas tienen mayor ideación suicida que su correspondiente grupo de comparación en la población general. A pesar de estos datos, este tipo de problemas no suelen ni prevenirse ni reconocerse adecuadamente. Sin embargo, si las disonancias y dilemas asociados a la maternidad, así como los problemas de salud mental, no se previenen o se abordan adecuadamente, éstos pueden afectar al bienestar de las mujeres, al de sus hijos y al de otros miembros de la familia. Se exponen los factores implicados en la conducta suicida de este grupo de mujeres, así como algunas directrices generales de actuación. Se reclama la necesaria puesta en marcha de estrategias de prevención.
Palabras clave: *Conducta suicida, Suicidio, Embarazo, Posparto, Perinatal, Prevención.*

Suicide is the leading cause of death for women during the perinatal period, which commences in pregnancy and finishes one year after delivery. Empirical evidence from previous studies shows that pregnant women have greater suicidal ideation than their comparison group in the general population. However, there is a tendency for these problems to be neither prevented nor adequately recognized. Nevertheless, if the dissonances and dilemmas associated with motherhood, as well as mental health problems, are not prevented or adequately addressed, they can affect the well-being of women, their children, and other family members. Risk and protective factors for suicidal behavior in this group of women are discussed, as well as general principles of action. The need for the implementation of prevention strategies is highlighted.
Key words: Suicidal behavior, *suicide, pregnancy, postpartum, perinatal, prevention.*

"No one tells you that this can happen, and when it does, you are so lost and everything is so dark that you don't even know you can ask for help." It is possibly not a mistake to think that most professionals in psychology (and other health professions) are unaware that suicide is the leading cause of death in women during the perinatal period, which spans from pregnancy to one year after childbirth (Enătescu et al., 2020; Gelaye et al., 2017; Knight et al., 2019).

The interest aroused by this topic is undoubtedly due, in part, to the sadness and perplexity aroused by the news about the suicides of (new or future) mothers along with the presence of other phenomena such as neonaticide or infanticide, events that are rare, but—like suicide itself—also complex and with deep psychological roots (Al-Halabí, 2019; Al-Halabí et al., 2019; Al-Halabí & García-Haro, 2021; Al-Halabí et al., 2021). However, after several decades of research we still do not have a coherent narrative to enable us to understand the complex association between motherhood and suicide (Fisher, 2016). What does seem clear is that myths about immediate love for newborn children pose a significant barrier to women asking for help or receiving the resources they need to cope with a suicidal crisis. As striking as the figure at the beginning of this article is, hardly any specific preventive interventions have been established to address this problem, the consequences of which are devastating, both for the babies who lose their mothers and for the families, whose suffering goes beyond the typical parameters regarding social and health costs (Al-Halabí et al., 2019).

The aim of this article is clear: to raise awareness of the taboo that exists, both in society and among professionals, about the relationship between suicide and motherhood, to draw attention to this problem by providing brief but relevant information, and to highlight the need for preventive interventions for suicidal behavior during this period of women's lives.

WHAT DO WE KNOW ABOUT SUICIDAL BEHAVIOR DURING THE PERINATAL PERIOD?

The scientific literature on this subject is not very abundant. It should be noted here that, in our country, the National Institute of Statistics does not have disaggregated data available to enable us to know the extent of this phenomenon. The scarcity and variability of the data may be due to the lack of consensus that still persists today in the nomenclature of suicidal behavior (on this issue we refer the reader to sources of great interest such as, for example, De Beurs et al., 2020; Fonseca-Pedrero et al., 2020; Hill et al., 2020; Leather et al., 2020; Silverman, 2016; Silverman & Berman, 2017; Silverman & DeLeo, 2016; van Mens et al., 2020; Turecki et al., 2019). It is now almost two decades since Silverman (2006) warned that because the term 'suicide attempt' can mean so many potentially different things, it runs the risk of meaning absolutely nothing. Since then, we have made progress, certainly, but we are still struggling with the same problem today (Berman & Silverman, 2017). In the words of Rendueles (2018) "there is

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knowledge about suicide that is limited to the artisanal". Therefore, more science and more awareness are needed in this field.

In the case of women in the perinatal period, everything becomes even more complex, since together with basic experiences such as discomfort and fatigue, they may experience mood changes and other common components of depression as characteristics of pregnancy and postpartum (Rodríguez-Muñoz et al., 2021). And the opposite can also happen; characteristics of pregnancy and postpartum can be experienced as signs of an incipient mental disorder, which may lead to false diagnoses, increase stigma, and deactivate women's and their families' own coping resources. (Of course, there are women who do not experience any of these problems and enjoy this period of their lives or experience it with total normality). This circumstance means that greater expertise, sensitivity, and training are required on the part of the psychology professional to be able to establish clearly and precisely what we are talking about or, rather, what the women talk about and experience when they find themselves in a situation in which, to the bewilderment of those closest to them, they begin to think that "their families and their babies would be better off without them" (Rodríguez-Muñoz, 2019). Suicide is not something that occurs in a vacuum; rather it takes place in a specific context and under specific circumstances in the life of the (recent or future) mother in which hopelessness and suffering take on special relevance. Suicide is a multifactorial, plural, interactive, dynamic, and contextual-existential phenomenon, which translates into the fact that, for each woman, there are various problematic configurations that may be at the basis of her problems or difficulties in the experience of motherhood (Al-Halabí & García Haro, 2021; García-Haro et al., 2018). In the case at hand, as in all mental health problems, various biological, psychological, social, and cultural factors are present, as well as the psychological valence that motherhood has for each woman. It seems reasonable to think that the "value" of motherhood is not "absolute" or similar for all women or in all cultures, but that, far from the idea that it is a period of joy and emotional well-being, this "value" will depend—to a large extent— on the values and meaning it has for each woman, her personal and family situation, the support received from her partner, her previous experience, the social support available, the presence of health problems, the economic resources available, her expectations about how she will be able to cope with her new obligations, and the importance of these in her vision of the world and of herself, etc. (Al-Halabí et al., 2019; Rodríguez-Muñoz, 2019).

THE MYTH OF MOTHERHOOD IN THE PROCESS OF FEMALE IDENTITY CONSTRUCTION

Motherhood is an event (but also a construct) that has historically modulated the construction of female identity. Pregnancy and childbirth imply the birth of a new identity, often associated with rigid meanings around what it is to be a "good mother" (Paricio del Castillo & Polo Usaola, 2020). It refers to the set of social discourses around the maternal experience (typically as a period of personal fulfillment), the mother's happiness, nurturing, self-sacrifice, care, dedication, renunciation, etc. Although they are external discourses, they may end up being "internalized" in the form of personal self-prescription.

There are many tribulations that a woman faces during the perinatal period. Without wishing to be exhaustive, we will start with the most obvious, which are the biological, image, and role changes. We refer here to changes in body image, changes in biological rhythms, decreased productivity, overload due to double working hours, etc. It is of special interest to mention the situation of leave from work, which can be experienced by many mothers as a prelude to the loss of the professional project and the sense of continuity.

The birth of the identity as a mother implies a radically new way of being that goes beyond the mere "idea" of knowing *that one is a mother*. It is an intimate process of transformation that goes through all the psychological dimensions of subjectivity, from those related to the body to the processes of identity. This implies an effort of integration (one stops being only a daughter to be a daughter and a mother, one stops being only a partner to be a partner and a mother, etc.) and of revision of the previous models (with one's own mother, with one's partner, etc.) that is never free of difficulty, even more so if there is no caring bond on the part of the partner and the family towards the woman who is gestating this new maternal experience and identity, or—as seems likely in modern society—if the models of nurturing are less and less available. With respect to identity, there may be difficulties in integrating one's own decisions and professional project into the social narrative of the "good mother", which may give rise to dilemmas and crises. On the other hand, this stereotype may be underpinned by the positioning of significant others (partner, family, friends, co-workers, health professionals, etc.) and their prototypical ideas about good parenting, nurturing, etc. In this sense, and based on clinical experience, it is common to find that mothers who express a high level of concern about feeling bad ("I have no reason") and guilt in case their distress has a detrimental side effect on the well-being of their baby are often referred to mental health. It seems evident that all these adaptation difficulties and identity dilemmas are accompanied by experiences of distress, typically in the form of anxiety, sadness, fatigue, helplessness, frustration, anger, indecisiveness, concentration problems, etc. These manifestations, often understandable due to the biological state of pregnancy and postpartum, can activate control and experiential avoidance strategies in women which, rather than helping them to escape from their distress, form a loop that further submerges the protagonists in a state of suffering and loneliness, in turn lived with guilt and shame, as confirmation of a supposed inability or failure to be a "good mother".

This dynamic process of ineffective struggle with the emotions and dissonance with the social mandate of "being a good mother" can lead many women to a real crisis, accompanied by the abandonment of child-care activities and even rejection of the baby. From what we have been describing, what can be seen is the existence of a context that forms psychological problems. This context can trap women in states of hopelessness and distress to such an extent that wishing to die and ideas of self-harming make sense, which—as we shall see below—are quite frequent in the perinatal period (Enătescu et al., 2020). In the light of this existential drama, one can think of maternal suicide as an escape from suffering or as self-culpability for not achieving the socially prescribed maternal ideal.

This being the case, the need for professional preventive intervention in the perinatal period is called for. But it would not be enough to attend without understanding, since without understanding what is activated is the explanation of the biomedical model (Pérez-Álvarez, 2019). It is necessary to help mothers (and their partners) to elaborate the meaning of their experience from a broader perspective, to deal

more effectively with distress, to integrate the different emerging identities and to recover the authorship and continuity of their lives. Psychological help should be provided without falling into the error of thinking that there is a mental "illness". We psychology professionals must remain attentive to the iatrogenic consequences in identity and self-esteem of the internal, stable, and global attributions that are often used to account for problematic experiences.

AGAINST THE TABOO: AWARENESS, EDUCATION, AND SCIENCE

Let us lay the facts out on the table: there seems to be a consensus among practitioners and researchers that during the perinatal period there can be wide fluctuations in mood that may require immediate and urgent attention to prevent the risk of suicide or filicide (Kimmel, 2020; Rodríguez-Muñoz, 2019). Moreover, contrary to the misconception that pregnancy might have a protective effect against suicidal behavior, a growing body of knowledge now points out that the prevalence of suicidal ideation may be even higher among pregnant women than in the general population of women (Enătescu et al., 2020; Khalifeh et al., 2016). Moreover, recent research suggests that suicidal ideation is a relatively common phenomenon in pregnancy globally, with an estimated prevalence of 5%-20%, although some studies in the United States have reported figures as high as 33% (Gelaye et al., 2016). Thus, there is sufficient empirical support to claim that pregnant women have higher suicidal ideation than their corresponding comparison group in the general population, although the data vary considerably by age and ethnicity (Enătescu et al., 2020; Gelaye et al., 2016). Despite this high prevalence, we still lack a comprehensive model integrating all the available knowledge on suicidal ideation before childbirth. Many studies have focused on the postpartum period and have generally limited their study objectives to suicide attempts, rather than the full spectrum of suicidal behaviors. However, the variety of suicidal behaviors in the postpartum period (ideation, attempted, or completed suicide) are often preceded by some expression of suicidal behavior prior to the birth. It seems that this "antepartum pattern", which predicts postpartum risks and persists beyond the prenatal period, is observed in maternal mood and in the presence of anxiety and other stress-derived disorders (Gavin et al., 2011; Nock et al., 2009). Therefore, some authors argue that the prepartum period represents a sensitive period and an important opportunity for prevention (Onah et al., 2017). This prepartum pattern, like any psychological phenomenon, does not occur in a contextual vacuum, but inserted in a life where the meshing of dominant discourses, identity conflicts, and lack of social support play a fundamental role.

Having said the above and given that—not without some debate (Berman & Silverman, 2017; Chiles et al., 2019)—, suicidal ideation is considered one of the main predictors of subsequent suicide attempts or completed suicide (WHO, 2014), assessing suicidal ideation should constitute a priority issue in clinical screening throughout the perinatal period, as well as an opportunity for intervention to prevent other more serious suicidal behaviors, such as the passage to action or suicidal acts of a more lethal nature (Orsolini et al., 2016). Relevant authors have noted that a history of mental health essentials should be taken during the first clinic appointment (ACOG Committee Opinion, 2018; Esscher et al., 2016; Knight et al., 2019). If the pregnant woman has previously been diagnosed with a severe affective disorder or psychotic disorder, she should be referred to mental health services for follow-up, even if she is currently stable and not undergoing treatment. A variety of questions open up here: who performs this screening in gynecology and obstetrics services; which professional assesses for the presence of mental health problems in these settings; and which professionals are responsible for following up these individuals (whether in mental health services or in other health care settings)?

NECESSARY RISK FACTORS AND DESIRABLE PROTECTIVE FACTORS

In relation to risk factors for suicidal behavior, the review by Gelaye et al. (2016) lists the presence of a previous history of child abuse, domestic violence, unwanted pregnancy, abortion intention, lack of social support, low academic and socioeconomic status, being single, an absence of religious beliefs, and the presence of a mental disorder. If we focus specifically on suicide attempts because of their relevance as a predictor for completed suicide, the published results suggest that during pregnancy the risk is higher for young women, especially adolescents, unmarried, with low educational level and alcohol consumption. It is not clear whether a previous history of miscarriage may be a risk factor, or the role of drug use during pregnancy, as there are studies with contradictory results (Gressier et al., 2017). During the postpartum period the main risk factor for a suicide attempt is a low educational level, while marital status, age or obstetric complications do not seem to be as relevant. Although there is little research on this subject, to the above risk factors should be added, even if only for consideration, those referring to identity dilemmas and dissonances between the maternal ideal and real motherhood (Paricio del Castillo & Polo Usaola, 2020). However, the profile of women at risk still needs to be improved (Gressier et al., 2017). The specific risk factors for suicide during the perinatal period collected in the review by Orsolini et al. (2016) can be found in Table 1.

Contrary to suicidal ideation, completed suicide among women in the perinatal period is a less frequent event than in the general population (Esscher et al., 2016; Fisher, 2016; Lega et al., 2020; Lysell et al., 2018). Overall, the relevant fact is that giving birth is associated with a lower suicide rate. However—and here the complexity begins—motherhood, for many women, is associated with increased difficulties, role transitions, and identity dilemmas. And it is these (and not the mere presence of previous diagnoses of mental disorder) that may increase the occurrence of mental health problems and suicide risk (García-Haro et al., 2020; Lysell et al., 2018). In other words, it would be of interest not so much to consider childbirth (as an event) as a period of high risk for women with mental health problems, but to analyze how motherhood and its conflicts end up causing some women to develop psychological problems. In any case, there does seem to be a consensus in the scientific community that, unlike the general population, these women tend to choose suicide methods with a high lethal probability, mainly by hanging, defenestration, or precipitation from high places (Khalifeh et al., 2016; Oates, 2003). Perhaps this differential characteristic should give us a clue about the degree of hopelessness present in these women?

Regarding protective factors, none have been described that are specific to the perinatal period, beyond those known for the general population: strong personal relationships with social, emotional, and financial support, religious or spiritual beliefs, emotional stability, well-being, self-esteem and optimism, personal skills (problem solving and conflict resolution), young children to care for, healthy lifestyle, access to clinical interventions and support in seeking professional help (Turecki & Brend, 2016; Turecki et al. , 2019; WHO, 2014).

These factors, alone or in combination, can influence the increase or decrease of suicide risk and should be managed during clinical intervention. Traditionally, more importance has been given to the study of risk factors than to protective factors, missing, perhaps, the possibility of anchoring to important aspects such as the feeling of belonging or the meaning of life. It is important to consider and enhance these factors that have been shown to increase resilience to difficulties and "connection to life" (Al-Halabí & García-Haro, 2021). Future research will have to discern which of these factors are key in the suicidal process of women during the perinatal period and what is the meaning of their functioning. Only then will it be possible to develop efficacious, effective, and efficient preventive interventions (Fonseca-Pedrero et al., 2021).

WHO, HOW, WHEN AND WHERE IS THE EVALUATION CARRIED OUT? THERE ARE NO SATISFACTORY ANSWERS

Despite having specific instruments for the assessment of suicidal behavior, specific screening is rarely performed in women in the perinatal period mainly due to time constraints in health services, lack of training in suicide of professionals involved in perinatal care, and lack of collaboration between gynecologists, pediatricians, and psychologists (Rodríguez-Muñoz, 2019). In fact, suicidal ideation is often assessed along with depression screening through item 10 of the Edinburgh Postpartum Depression Scale or the Patient Health Questionnaire, rather than using tools specifically designed for that purpose (Muñiz et al., 2020). In addition, many women with suicidal ideation during pregnancy and postpartum do not meet the criteria for a diagnosis of depression and may not be adequately detected. Moreover, several authors have pointed out that the clinical relevance of the previously mentioned item 10 for the detection of these thoughts is unclear, and that it often generates more concern than usefulness, as many professionals do not know how to approach the question or the possible answer, or how to interpret the "normality" of having suicidal thoughts (Berman & Silverman, 2017; Howard et al., 2011). Thus, many of them are afraid to ask these questions for fear of inducing such thoughts, which evidences a worrying existence of myths about suicide among professionals in the National Health System (Stanley et al., 2020). Therefore, we underscore here the necessary presence of the clinical interview and the training and education of all professionals involved in the health care of expectant or new mothers (Al-Halabí & García-Haro, 2021; Rodríguez-Muñoz, 2019). Orsolini et al. (2016) propose including careful (and preventive) screening and assessment of suicidal ideation throughout the perinatal period (see Table 2). To this end, despite the difficulties noted previously, they propose specific instruments such as the Beck Suicidal Ideation Scale, the Columbia Scale to Assess Suicide Risk or the Suicide Probability Scale (Al-Halabí et al., 2016; Orsolini et al., 2016).

TABLE 1
RISK FACTORS FOR SUICIDAL BEHAVIOR IN THE PERINATAL PERIOD

Individuals	✔ Being young and single ✔ Family or personal history of mental disorders or suicidal behaviors
Socioeconomic	✔ Family conflict ✔ Domestic violence ✔ Loneliness and lack of social, family, or partner support ✔ Rejection of paternity by the partner
Environmental	✔ Social, racial, religious, or gender inequality or discrimination ✔ Overcrowded, inadequate, or rural housing ✔ Wars, conflicts, or natural disasters
Gestational	✔ Unwanted pregnancy ✔ Nulliparity
Clinicians disorder	✔ Previous or current presence of a diagnosis of mental ✔ Previous suicide attempts ✔ Previous suicidal ideation ✔ Presence of a disease of short evolution ✔ Psychological aspects such as premenstrual irritability, insomnia, perception of complicated pregnancy, negative attitudes towards pregnancy, anxiety about childbirth, inadequate coping strategies, etc.

Note. adapted from Orsolini et al. (2016).

TABLE 2
ASSESSMENT OF THE RISK OF SUICIDAL BEHAVIOR IN THE PERINATAL PERIOD

Medical history	✔ Current suicidal manifestation ✔ Mental disorders ✔ Presence of physical illness or pharmacological treatment ✔ Psychosocial environment ✔ Current use of alcohol and other drugs ✔ Individual strengths and difficulties
Suicidal ideation	✔ Nature of thoughts ✔ Frequency and duration ✔ Persistence of the wish to die ✔ Intensity
Suicide plan	✔ Potential lethality of plan ✔ Level of detail and violence of the chosen plan ✔ Level of access to potentially lethal means
Previous or current suicide attempts	✔ Frequency and duration ✔ Intention to die ✔ Method ✔ Medical consequences or damages
Suicide risk assessment	✔ Risk and protective factors ✔ Methods to mitigate distress, strengths, or protective factors for suicide risk.

Note. adapted from Orsolini et al. (2016).

However, assessment through self-reported questionnaires is not without limitations (Berman & Silverman, 2017; Vourilehto et al., 2014). Moreover, we cannot forget the fluctuating nature of suicidal behavior, which may not be present during screening, precluding its necessary follow-up throughout the perinatal period. To alert of such an extreme, it is necessary to know how suicidal crises "work", as well as to have dynamic models, outpatient assessment systems, and general intervention proposals (Fonseca-Pedrero et al., 2020; Labouliere et al., 2018). Again, the presence of myths among health professionals poses a huge barrier to the adequate support and follow-up of these women. Self-administered questionnaires are an ideal complement to the interview, but they should never replace it. For this reason, we emphasize once again the importance of perinatal psychology. The implicit idea, experienced by many women as a social mandate, that they should be in one of the happiest stages of their lives can create enormous guilt and shame that prevents them from expressing their doubts, fears, and thoughts of death. Therefore, it is vital to have a psychological professional attending to the suicidal woman, managing the emotions. The importance of therapeutic interviewing skills in assessing and helping people at risk of suicide cannot be overemphasized enough (Al-Halabi & Garcia-Haro, 2021). This is due to the very dynamic, interactive, contextual, and existential nature of the phenomenon of suicide. In the suicidal crisis there is a great ambivalence or dilemmatic conflict between remaining alive and deciding to die. On the one hand, women struggling with the persecution of suicidal ideation may feel that they have lost the reins of their life, that they have made a mistake in their decision to become mothers, and that nothing will ever be the same again. The idea is so devastating that a period of the baby's continuous crying or the obligation to have to bathe it can devastate the precarious equilibrium of the mother, who can no longer see beyond her distress, the effects of her prolonged sleep deprivation (Gelaye et al., 2017), and the changes in her daily life, her body, her work, her partner, her sexuality; in short, her life and her identity. In the words of Chiles et al. (2019), these women are trapped in what they call the "three I's", a pain that they consider Inescapable, Intolerable, and Interminable. But, as previously stated, beyond the presence of a psychological problem or the presence of a mental disorder, motherhood involves difficulties, renunciations, and new identities that may be conflicting for some women. It is necessary for the professional psychologist to validate their suffering, questioning the social consideration of motherhood as a "necessarily" happy stage. This does not mean renouncing the possibility of a joyful motherhood, especially now, when motherhood is an option and not a destiny.

In any case, the evaluation of suicide risk should be done in collaboration with the individual woman being assessed, considering her particular experiences of motherhood and listening carefully to her reasons for contemplating suicide instead of staying alive (NICE, 2020). In addition, the woman's ability to care for her child should always be assessed, as well as any thoughts of harm to the baby. Guidelines established by The Centre of Perinatal Excellence (COPE) (Austin et al., 2017) can be found in Table 3.

When the risk of suicide has been identified, Austin et al. (2017) propose the following additional considerations:

Low risk: analyze the events that precipitate the fleeting thoughts of suicide. If the triggers are inherent to the current experience of motherhood (e.g., embarrassment about negative thoughts toward the baby), a safety plan must be developed (Stanley & Brown, 2012).

TABLE 3
GENERAL PRINCIPLES OF ACTION

ASK QUESTIONS* Suicide ideation - Plan - Lethality - Means - Previous history		
Fluctuating thoughts of suicide or self-injury without lethal plans or means.	Thoughts and intentions of s uicide without plans.	Continuous thoughts of suicide, intention, plan, and means.
⇩	⇩	⇩
Low risk	Medium risk	High risk
Analyze the availability of support and treatment options.	Analyze availability of support and treatment options. Establish weekly follow-up.	Ensure the safety of the woman (controlled and safe environment).
Organize appropriate follow-up and supervision according to clinical judgment.	Make a contingency plan in case the situation worsens and there is a "suicidal" escalation.	Establish follow-up in the next 24 hours with supervision and continuous evaluation.
Provide contact to community resources.	Carry out a safety plan.	Control the risk to the baby.

Note. *Always consider the mental health of the mother and the risk to the baby.
Adapted from Austin et al. (2017)

Medium risk: assess the general context in which thoughts of suicide occur (e.g., previous suicide attempts) and establish the factors that may contribute to the escalation of risk (e.g., the baby crying or an argument). Caregivers who can care for the infant and the mother must be available.

High risk: find a support person to care for the baby. The mother may deny intent to commit suicide but still be at high risk. A woman with significant mental health deterioration, inability to sleep, distorted thinking, inability to care for herself or the baby, etc., may be at the same risk as a woman with declared suicidal intent.

TIMES OF CHANGE

Explicitly addressing and preventing suicide risk in these women is essential to reduce the rates of suicide in this population which, as we have seen, represents the leading cause of death during the perinatal period in developed countries (Enătescu et al., 2020). Some empirically supported preventive interventions are being carried out in other countries with very promising results (Kimmel, 2020). In Spain, there are several initiatives focused on perinatal depression that could constitute a model for addressing suicide risk factors (Marcos-Najera et al., 2017). Rodríguez-Muñoz et al. (2017) have highlighted that, following the recommendations of The American College of Obstetricians and Gynecologists (ACOG Committee Opinion, 2018), it is possible to carry out health routines and screening for mental health problems in a public hospital setting and in collaboration with obstetric services. Of course, any prevention initiative would have to start with a detailed assessment and analysis of the phenomenon, which, for the time being, is not yet available. Likewise, it would be necessary to deal with the difficulties of lack of consultation time and the absence of specialized units, to manage the available resources and to build programs or propose empirically supported interventions. The need to use empirically supported psychological treatments must be highlighted (Fonseca-Pedrero et al., 2021; Rodríguez-Muñoz & Al-Halabí, 2020). It is not the purpose of this article to develop this aspect (for detailed information see Al-Halabí & García Haro, 2021 and Al-Halabí et al., 2021), however, by way of summary, the studies reviewed support the efficacy of cognitive behavioral therapy and dialectical behavioral therapy. These types of therapies offer the opportunity to discuss existential problems in a safe environment, where psychologists can validate the suffering of women who wish to die or are struggling to stay alive, guiding them to reorientate themselves toward life with new coping strategies. In addition, a body of brief interventions has been developed to respond to the clinical emergencies of people in suicidal crisis. Support contacts and follow-up or the Safety Plan of Stanley and Brown are some of the most effective interventions and can be combined with other more comprehensive therapies (Al-Halabí & García Haro, 2021; Al-Halabí et al., 2021).

RECAPITULATION

Mental health problems during the perinatal period usually require urgent attention because of the potential consequences for the well-being of the baby and for the woman's own life. However, these problems are often under-recognized. Many women do not seek help for fear of stigma or social service intervention. In addition, motherhood itself may pose a barrier, as the demands of the baby may interfere with the ability to attend treatment sessions regularly. Other barriers may also be present, such as financial problems, fear of having to interrupt breastfeeding, mismanaged priorities, or a lack of partner and family support. However, if the dissonances and dilemmas associated with motherhood, as well as the mental health issues, are not addressed, these can affect the women's well-being, that of their children, and that of other family members (Al-Halabí et al., 2019; Rodríguez-Muñoz, 2019). We adopt the maxim "an ounce of prevention is better than a pound of cure", especially in the face of outcomes that involve the loss of people's lives due to psychological pain that they cannot tolerate.

Finally, it is necessary to have comprehensive psychological models focused on these women and their experiences of motherhood. Once again, we demand the structural presence of the psychology professional in the staff and units of gynecology and obstetrics for good mental health in the perinatal stage, both for the mothers and for their babies in the future. We understand that the prevention of problems in mothers bestows good psychological health on their children. Otherwise, what affective relationship does a mother with suicidal ideation establish with her baby? It is not our intention to provide an answer to this question, but we do wish to invite reflection and emphasize once again that the advantages of prevention go beyond the mere health of mothers. Psychology professionals must be trained and prepared to lead initiatives aimed at preventing and addressing a phenomenon that, we understand, is genuinely psychological. In the words of the director of the Maternal Mental Health Alliance in the UK, "We must remember the individual women and families behind the devastating numbers of suicide deaths and seek to honor their memory by urgently addressing the gaps in perinatal mental health care. In order to save precious lives, we must ensure every woman has access to essential care and support, when and where she needs it."

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CONFLICT OF INTEREST

There is no conflict of interest.

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