Maternal Suicide

CentraCare Collaborative Care Institute

March 1, 2024

Objectives

- **Identify maternal mental health and suicide risks that occur in pre and post natal periods.**
- **Utilize screening tools and best practices to identify and care for patients at risk.**
- **Be able to refer patients to maternal mental health and support resources.**

Maternal Suicide

Research suggests **suicide** is a **leading cause** of **maternal death** in the **1st year following childbirth.**[1]

Maternal **suicide deaths** are **more common** than maternal **deaths** caused by **postpartum hemorrhage or hypertensive disorders.**[2]

Suicide accounts for up to **20%** of **maternal deaths** that occur in the **postpartum period.**[3/4]

Maternal **suicide** is **most frequently completed** between **6** to **12 months postpartum.**[5]

The severity and rapidly evolving nature of **postpartum psychosis increases the risk** of maternal suicide.[6]

Depression during pregnancy greatly **increases thoughts** about suicide **while pregnant.**[4]

Learn more and find citation information at: 2020mom.org/maternal-suicide

20/20 mom
Visionaries for the Future of Maternal Mental Health

2020Mom.org

Maternal Suicide

- Suicide deaths are a leading cause of maternal mortality in the U.S.
- Maternal suicide deaths are under-reported
  - Maternal Mortality Review Committees (MMRCs)
- Suicide among pregnant and postpartum women is increasing
- 64% of the suicide deaths occur post-partum, a vast majority after the 6-8 week check up
  - Peak incidence is late postpartum period (9-12 months)
- CDC has determined that Maternal Mental Health Conditions are a leading underlying cause of pregnancy-related death & are the MOST COMMON complication of pregnancy & childbirth
  - 85% of cases go without treatment

Maternal Mental Health Conditions (MMHC)

- “suicide, overdose/poisoning related to substance use disorder, and other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder” – CDC definition
- MMHCs account for 23% of pregnancy-related deaths
- 80% of pregnancy-related deaths are determined to be preventable

Maternal Mortality Review Committees

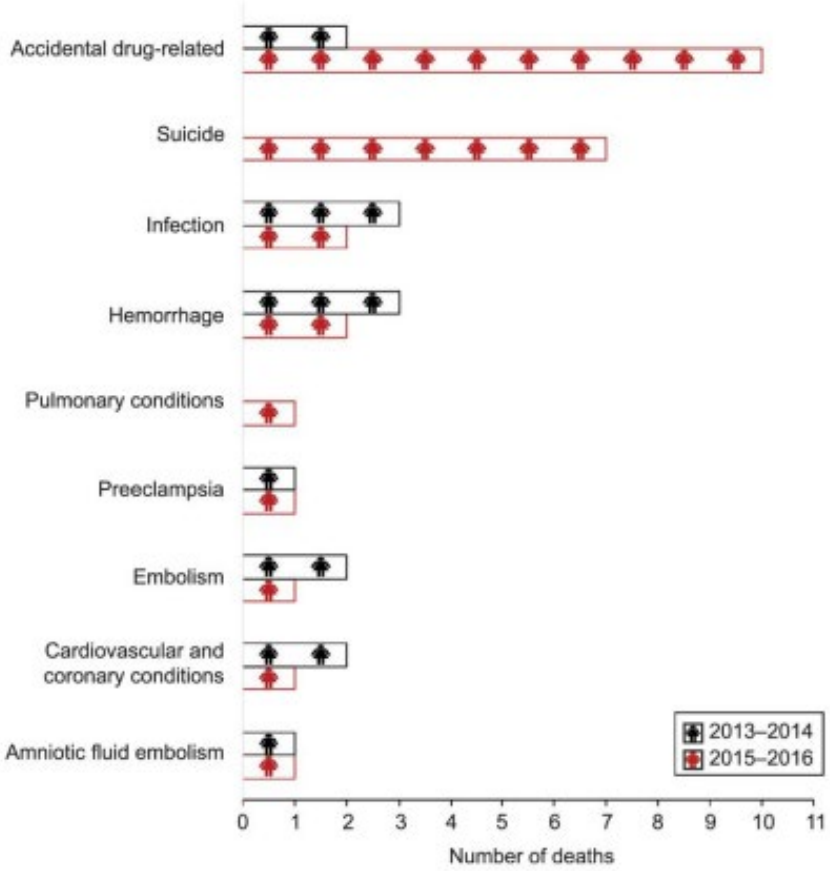


Fig. 2. Causes of pregnancy-related deaths, 2013–2014 and 2015–2016.

Smid. Drug-Related Death and Suicide Classification Criteria. Obstet Gynecol 2020.

Maternal Suicide Risk Factors

- Behavioral Health
  - Personal/family history of psychiatric disorders
  - Prior Suicide Attempt
  - Prior hospitalization for a psychiatric illness
  - Substance Use Disorder
    - Opiate overdoses in perinatal period is also a leading cause of maternal death
  - Discontinuation of pharmacological medications (during pregnancy)
  - Suicidal Ideation
  - Increased anxiety symptoms linked to frequent thoughts of self-harm in depressed postpartum individuals
  - Lifetime history of depressive and anxiety disorders
  - Bipolar Disorder increases risk of postpartum psychosis
  - Postpartum psychiatric admission – increased risk of suicide death 70x

Maternal Suicide Risk Factors - Environment & Social

- Lifetime history of abuse (ideation, attempt, and death)
- Lack of social support (suicidal behavior)
- Sleep disturbances (ideation, attempts)
- Obstetric and neonatal complications
- Disengagement from postpartum medical treatment
- Young age
- Unmarried
- Low household income
- Recent illness onset / abrupt onset of symptoms
- No active treatment
- Low maternal education
- Family conflict
- Loneliness
- Unwanted or unplanned pregnancy
- Crowded or inadequate housing
- Living in a rural area
- Exposure to disaster, conflict, war
- Social & gender inequalities
- Racial discrimination

Ethnic/Racial Demographics

- American Indians and Alaska Native individuals have higher rates of pregnancy associated drug-related and suicide deaths
  - Maternal Mental Health Conditions account for 31.3% of all perinatal deaths
- Non-Hispanic White individuals - 2nd highest rates for drug-related & suicide deaths
- Asian and Pacific Islander individuals - 3rd highest rate of maternal suicide but the lowest rates of pregnancy associated drug-related deaths.
- BIPOC women have higher risk for suicidal ideation while non-Hispanic White women have higher risk of suicide death
- Women of color have higher rates of perinatal depression but are less likely to receive treatment
- Pregnancy associated drug-related deaths most common among people aged 35 years & older
- Maternal suicide most common among youngest birthing people

Maternal Suicidal Ideation

- Found to range from 5-14% during perinatal period
- Strong association with depression (most individuals with postpartum ideation met criteria for a major depressive episode)
  - Also significantly higher for individuals with Bipolar Disorder
- Low self-directedness, low cooperativeness, higher anxiety and depression, lack of affection and anger/rejection towards baby were associated with ideation

Maternal Suicide

- 62% of pregnancy-related suicide deaths occur between 43-365 days
- 24% during pregnancy
- 14% within the first 42 days postpartum
- Characterized by: impulsivity, aggression, depression, anxiety, hopelessness, and self-consciousness/social disengagement
- Perinatal suicides tend to occur through more violent methods, indicating greater intentionality of the act
  - hanging, jumping from height
- Higher degree of contact with healthcare professionals
- Parenthood as a protective factor lessened; found to be impetus for those who report high parenting stress
- Fetal or infant death was strongly associated with hospitalization for attempted suicide

Maternal Mental Health Conditions – Perinatal & Postpartum

- Depression
- Anxiety
- Obsessive Compulsive Disorder
- PTSD
- Bipolar
- Postpartum Psychosis

Maternal Mental Health Conditions - Depression

- Approximately 20% of individuals will experience significant depressive symptoms during the year after birth
- About half of postpartum depression cases have onset during pregnancy
- American Psychiatric Association proposed “peripartum onset depression” to describe major depressive episodes developing during pregnancy and the postpartum period.
- Characterized by: low mood, sadness, irritability, impaired concentration, feelings of guild about childcare, and feeling overwhelmed
- Strong predictor of suicidal experiences in the postpartum period
- May experience shame and humiliation, viewing themselves as the worst mothers in the world, and imagining others see them this way (feeling her baby may be better off without her – can trigger suicidal ideation)
- Predictive of relationship difficulties (cyclical with increased depressive & anxiety symptoms)

Maternal Mental Health Conditions - Anxiety

- More common in individuals in the perinatal period than depression
  - Related to fetal heart rate, motor activity, and preterm delivery
- Perinatal prevalence 20-25%
    - Found to be a predictor of for postpartum depression and PTSD symptoms
- Postpartum prevalence 15-20%
    - Related to lower maternal self-confidence, low levels of perceived social support, poor relationship adjustment
- Strong relationship between postpartum anxiety & depression
  - 25-50% of individuals with anxiety disorders show symptoms of depression 2 months after childbirth
  - 2 in 3 people suffering from depression in the first 7 postpartum months have co-occuring anxiety disorder

Maternal Mental Health Conditions - OCD

- Affects 1% of individuals perinatally & 2.9% postnatally
- Symptoms
  - Obsessions could present as persistent doubts about safety of child
    - Reoccurring “what if” questioning & thinking related to child
    - Series of images (or thoughts) in which harms comes to child
  - Compulsions often carried out as a way to stop the perceived harm from happening
    - Staying up all night to check on child’s breathing
    - Excessively cleaning to stop spread of germs/contamination
    - Insisting child stay in house at all times
    - Spending hours checking for information on the internet
    - Rituals designed to keep baby safe
- Common for many new parents to experience intrusive thoughts or urges about deliberately harming or abusing their child
  - Difference between these common thoughts/experiences and OCD is the interpretation and distress felt by an individual with OCD
    - They may begin to avoid the child, be left alone with the child, leave the family home, question others about the nature of their thoughts

Maternal Mental Health Conditions - PTSD

- About 1/3 of individuals who give birth commonly experience birth as traumatic
- Up to 9% of individuals suffer from PTSD following birth and up to 34% develop childbirth-related PTSD symptoms
  - Since routine screening is not common, it is estimated that an additional 21% of individuals who give birth meet criteria for PTSD for varying amount of time
- “Experience of delivery” was important predictor
- Symptoms are found to increase overtime, highlighting need for early intervention
- Traumatic childbirth: “an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant; the birthing woman experiences intense fear, helplessness, loss of control and horror”.
- People with P-PTSD 72% more likely to experience postpartum depression

Maternal Mental Health Conditions – Bipolar Disorder

- Screening for postpartum depression can miss individuals who have Bipolar Disorder vs. those with just unipolar depression
- Estimated that screening with only the Edinburgh Postpartum Depression Screen can miss about 1/3 of people with Bipolar Disorder
- Concerning as this population is at high risk for postpartum psychosis
- Recommendations for depression treatment would be different than recommendations for Bipolar Disorder.

Maternal Mental Health Conditions – Postpartum Psychosis

- Occurs approximately 1-2 in 1,000 individuals
- For people with Bipolar Disorder, can occur as high as 1 in 4 individuals
- Individuals who had experienced childhood trauma were more likely to develop postpartum psychosis
- Approximately 60% of individuals already have a diagnosis of Bipolar Disorder or Schizoaffective Disorder
  - Careful screening and assessment of pre-existing mental health concerns is critical, along with support during pregnancy and postpartum periods

Suicide Prevention – Maternal Suicide

- Requires early screening, assessment, monitoring, and intervention for ALL women during the peripartum period, regardless of emotional affect, appearance, or presentation.
  - Especially important for women already being treated for mental health conditions
  - High prevalence of suicidal ideation in women without a history of mental health conditions highlights importance of screening all women, completing psychosocial assessments that include psychiatric history, social support, domestic violence, etc.
- Recommendations are to screen during pregnancy and postpartum periods
  - keeping in mind a majority of suicide deaths occur well after established OB/GYN visits have resolved for pregnancy

Identifying Risk – Screening for Maternal Mental Health Disorders

- Edinburgh Pregnancy/Postnatal Depression Scale (EPDS)
  - Preferred screener for peri-postnatal individuals but PHQ-2 or 9 are also considered
  - Should be used up to a year postpartum
  - Positive score for depression should have additional diagnostic evaluation
  - May not screen the best for suicidal ideation or anxiety
    - “the thought of harming myself has occurred to me”
    - Does not distinguish whether anxiety items are a feature of depression or separate entity
- Anxiety screener
  - EPDS is considered best tool to screen for both depression & anxiety
  - Generalized Anxiety Disorder screen (GAD 3 or 7)
  - Postpartum-Specific Anxiety Scale (PSAS)
    - 51-item measure of postpartum specific anxiety; initial research has found it is a valid & reliable tool
    - 4-factor structure: 1) competence and attachment anxieties, 2) infant safety and welfare anxieties, 3) practical baby care anxieties, 4) psychosocial adjustment to motherhood
    - May be sensitive to postpartum women experiencing clinically significant maternally focused worry who fail to meet diagnostic criteria for an anxiety disorder

Identifying Risk – Psychosocial stressors

- Postpartum Stressors Scale
  - Recommended for use at 6-week postpartum visit or during any other visit in which distress of any kind is noted
  - It identifies specific stressors and may help with targeted referrals (lactation consultant, parenting classes, counseling, community resources)
  - 9-item scale where various stressors fall into 3 basic categories
    - Baby care, well-being, work problems
- Please rate how stressful each of the following has been for you since you had your baby:

Relationship with spouse/partner
Breastfeeding
Being a mother
Fussy baby
Financial worries
Work problems
Concerns about own health
Concerns about physical appearance (weight, shape)
Lack of sleep

Identifying Risk – Screening for Maternal Suicide Risk

- Alliance for Innovation on Maternal Health (AIM) issued best practice alert
  - Screening for maternal suicide should occur when “concern exists for suicidality due to response in depression screening tool or interaction with patient, further assessment is required”.
  - Recommendation is to use a suicide specific screening instrument & clinical interview
  - Use Columbia Suicide Severity Rating Scale (CSSRS) where available or asking directly about suicide
    - “Are you thinking about killing yourself?”

Recommendations for Frequency & Timing of Screening

- Postpartum Support International
  - 1st prenatal visit
  - At least once in 2nd and once in 3rd trimester visits
  - 6-week postpartum OB appt (or at first postpartum visit)
  - Repeated screening at 6 and/or 12 months in OB and Primary Care
  - Screening at Pediatric settings
    - At 3-, 9-, and 12-month pediatric well-child visits

Identifying Risk - Barriers

- Patients may not be comfortable in telling providers about suicidal thoughts
  - Stigma
  - Fear of having children removed from custody (especially for women of color)
  - Fear of being perceived as a bad parent

Normalizing the Conversation

- Normalize how stressful parenthood is and validate any feelings of anxiety & depression
  - “It’s common for new parents to feel overwhelmed, anxious, depressed ,or have intrusive or scary thoughts. Sometimes when people are struggling, they can have thoughts of death or dying. These thoughts can feel awful, and we don’t want you to feel alone. We ask all patients questions about their mood and if they are having any thoughts of wanting to hurt themselves or their baby so we can find the best ways to help”.
- Ask specific & direct questions (screeners can be used here)
  - How are you feeling about being pregnant/parent?
  - What things are you most worried about?
  - Is there anyone you feel comfortable with talking about your anxieties?
  - Who do you have for support?
  - Having you been having any thoughts of wanting to kill yourself?
  - What are your hopes for the future?
  - Have you had any thoughts of wanting to harm the baby?

Assessing Thoughts of Harming Baby

Low Risk →	Moderate Risk →	High Risk
• Symptoms indicative of depression, OCD, and/or anxiety • Thoughts of harming baby are scary, cause anxiety, or are upsetting • Mother does not want to harm her baby and feels it would be a bad thing to do • Mother very clear she would not harm her baby	• Thoughts of harming baby are somewhat scary • Thoughts of harming baby cause less anxiety • Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do • Mother less clear she would not harm her baby	• Symptoms indicative of psychosis • Thoughts of harming baby are comforting • Feels as if acting on thoughts will help infant or society • Lack of insight (inability to determine whether thoughts are based on reality) • Having auditory and/or visual hallucinations • Bizarre or fixed untrue beliefs that are not reality

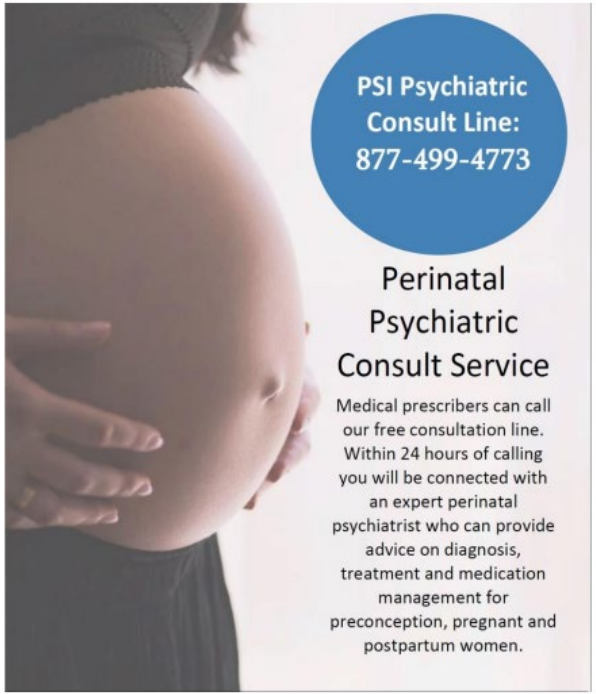
Maternal Suicide and Risk Assessment Toolkit. (2023). www.ucmatters.org

Clinical (Mental) Health Interventions

- Psychoeducation: what is normal, how to prepare for challenges, when to ask for help or see providers (typical in group options)
  - Increases positive perinatal experience and decreases likelihood of postpartum depression
- Debriefing – structured psychological intervention to prevent postnatal psychological problems, particularly symptoms of PTSD and depression. Has been established in many UK maternity services.
- Cognitive Behavioral Therapy (CBT) – found to assist with adjustment to motherhood and preventing and treating postpartum depression, PTSD symptoms resulting from birth
  - A form of CBT: Exposure & Response Prevention has been found helpful for treatment Maternal Obsessive-Compulsive Disorder
- Group therapy – supports connection to other birthing parents
- Interpersonal Therapy – especially effective when maternal mood disorders. Found to reduce stress and depressive symptoms while increasing happiness and self-efficacy in new mothers
  - One study showed decreased depressive symptoms by 50% at twelve week of group treatment with sustained 20-week postpartum follow up
- Centering Pregnancy (CP) Groups – models of prenatal care that incorporates psychoeducation, health assessment, and support for women during pregnancy. Improves birth outcomes, decreased preterm birth, and higher rates of initial breast feeding

Professional Resources

National Psychiatric Consultation Line

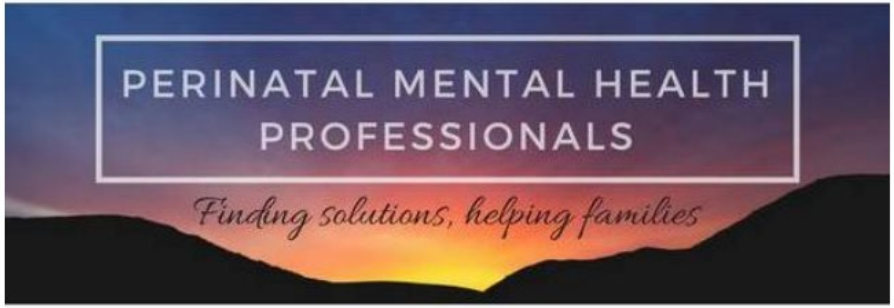


For Medical Prescribers Only

- Free, expert consultation line.
- Connected with a perinatal psychiatrist within 24 hours who can provide advice on diagnosis, treatment, and medication management for preconception, and pregnant and postpartum women.
- NOT an emergency hotline.

Professional Resources

Professional FB Groups



Client Resources – Postpartum Support International

- Support Groups (run by individuals with lived experience)
  - Groups can be found at www.postpartum.net (unless otherwise specified)
  - Perinatal OCD Support for Moms
  - Maternal Near Miss Survivors Closed FB Group
  - Bipolar Support for Perinatal Moms & Birthing People
  - Action on Postpartum Psychosis www.app.network.org
  - PSI has Postpartum Psychosis Coordinator to support women and families not in an emergency situation www.postpartum.net/get-help/postpartum-psychosis-help/
  - Perinatal & Postpartum Psychosis support group / separate group for families
  - Dad's Chat support group for postpartum fathers

Get Help

Call the PSI HelpLine:

1-800-944-4773

#1 En Español or #2 English

Text in English: 800-944-4773

Text en Español: 971-203-7773

FIND LOCAL RESOURCES

- PSI "Warmline", the Helpline (800-944-4PPD) is active and helps individuals navigate resources and connect with volunteers and support groups.

National Maternal Mental Health Hotline
1-833-852-6262
1-833-TLC-MAMA

- National MMH Hotline launched by HRSA; PSI is the Contractor
- 24/7/365; Call or Text
- English & Spanish; other languages by request
- Staffed by licensed mental health and healthcare clinicians, certified peer specialists and childbirth professionals

Client Resources - Local

- Pregnancy & Postpartum Support MN www.ppsupportmn.org
  - 1-800-944-4773
  - Peer support, Postpartum Doula program, Virtual Support groups, Crisis resources, Screenings & Handouts, community resources
- Nystrom & Associates Mother-Baby Support Group Program
  - Offered St. Cloud, Baxter/Brainerd, Otsego, Eden Prairie
- First Steps Central MN (Stearns, Benton, Sherburne, Wright counties)
  - For pregnant or people parenting a newborn or young child
  - Team of nurses to support a healthy pregnancy, be the best parent you can be, provide a safe/loving home, connect to community resources

Summary

- Suicide deaths are a leading cause of maternal mortality in the U.S.
- CDC has determined that Maternal Mental Health Conditions are a leading underlying cause of pregnancy-related death & are the MOST COMMON complication of pregnancy & childbirth
- Screening & assessment for maternal mental health conditions and directly asking/screening for suicide should be done at regular intervals in the first year postpartum
- Equip new parents and their support system with postpartum and maternal mental health resources
  - Optimizing telepsychiatry and integrated mental health treatment approaches

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