

## Maternal Mental Health & Maternal Suicide Tip Sheet

Maternal Mental Health (MMH) disorders include a range of disorders and symptoms, including but not limited to depression, anxiety and psychosis. These disorders and symptoms can occur during pregnancy and/or the postpartum period (together often referred to as the perinatal period). When left untreated these disorders can cause devastating consequences for the mother, her baby, her family and society.

These illnesses can be caused by a combination of biological, psychological and social stressors, such as lack of support, a family history, or a previous experience with these disorders. Maternal anxiety and depression are the most common complications of childbirth, impacting up to 1 in 5<sup>1-3</sup> women, yet they are not universally screened for, nor treated. The good news is that risk for both depression and anxiety can be reduced and sometimes prevented, and with treatment women can recover.

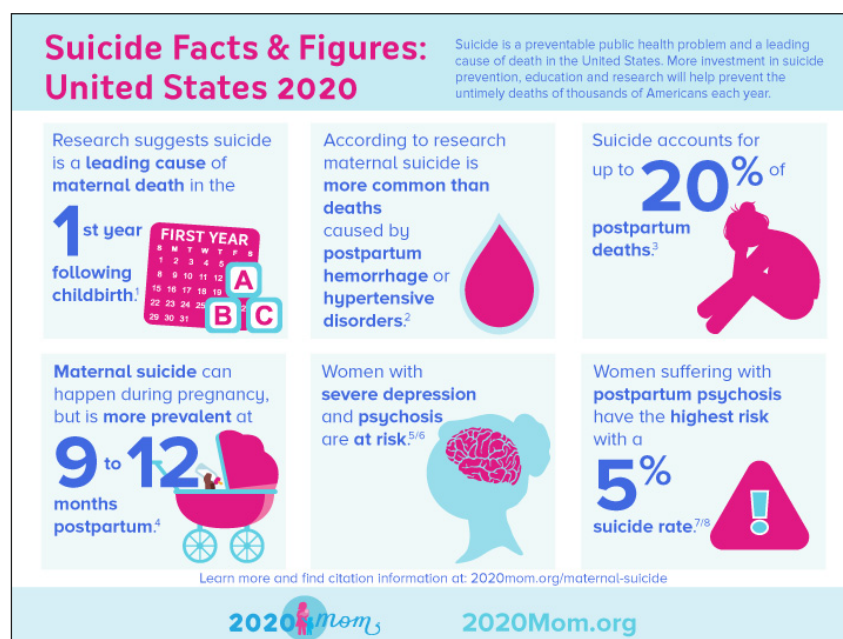
### Overview of Maternal Mental Health Conditions

- **The Baby Blues** - Up to eighty percent (80%) of women will experience the “baby blues” after giving birth, tied to sudden shifts in hormones.<sup>4</sup>
  - Women who experience the baby blues may feel sad, have mood swings and crying episodes.
  - The Blues are not considered a disorder as the symptoms often resolve within a few days. If symptoms persist, beyond two weeks, it’s likely the mother is suffering from depression.
- **Pregnancy and Postpartum Depression** - Up to twenty percent (20%) of women experience clinical depression during and/or after pregnancy.<sup>1-3, 5</sup>
  - Symptoms can range from mild to severe and, mothers with pre-existing depression prior to or during pregnancy are more likely to experience postpartum depression.
  - Pregnancy and postpartum depression are treatable and risk can also be mitigated.
  - Symptoms generally include sadness, trouble concentrating, difficulty finding joy in activities once enjoyed, and difficulty bonding with the baby.
- **Dysthymia/Persistent Depressive Disorder** - Dysthymia is defined as a low mood occurring for at least two years, along with at least two other symptoms of depression.
  - Women with pre-existing dysthymia may be at a higher risk for severe symptoms/depression during the perinatal period.
- **Pregnancy and Postpartum General Anxiety** - Up to fifteen percent (15%) of women will develop anxiety during pregnancy or after childbirth.<sup>2</sup>
  - Symptoms often include restlessness, racing heartbeat, inability to sleep, extreme worry about the “what if’s” - like what if my baby experiences SIDS, what if my baby falls, what if my baby has autism, etc.; extreme worry about not being a good parent/being able to provide for her family.
- **Pregnancy and Postpartum OCD** - The prevalence of maternal Obsessive-Compulsive Disorder (OCD) is 3-5%.<sup>6</sup>
  - OCD includes obsessions (an unwanted thought or feeling) that a person has an urge to relieve through an action or a “compulsion.”
  - OCD “obsessions” can include intrusive thoughts (see below for more information).
    - About 50% of women with OCD have intrusive/unwanted thoughts about intentionally harming their infant (e.g., throwing the baby).<sup>6</sup>
    - It is important to note that although obsessions often contain alarming content they **do not represent a psychotic process, where mothers are at a higher risk of harming themselves or their infants/children.**
- **Birth Related PTSD**
  - The prevalence of postpartum PTSD is 3.1%.<sup>7</sup> Most often, this illness is caused by a real or perceived trauma during delivery or the postpartum period.
  - These women experience intrusive memories and flashbacks of the event.

**Other features and factors:**

- **Birth Loss and Grief**
  - Expectant mothers who experience miscarriage or stillbirth are also at risk for postpartum mental health disorders including PTSD in addition to grief or complicated grief.
- **Mania**
  - Women may suffer from an extreme inability to sleep, where a mother simply isn't tired. She generally feels elated, and enthusiastic about completing tasks and motherhood. This is considered a state of hypomania or mania which may or may not be tied to an underlying bipolar disorder.
  - A state of mania is not in and of itself dangerous but because mania/severe lack of sleep may lead to impulsive and high-risk behavior and can be a precursor to psychosis, it's critically important that the mother receive clinical support from a psychiatric provider experienced in reproductive mental health.
- **Postpartum Psychosis**
  - Postpartum psychosis is a rare symptom and occurs in approximately 1 to 2 out of every 1,000 deliveries, or approximately 1 -.2% of births.<sup>3</sup>
  - The onset is usually sudden, most often within the first 2 weeks postpartum.
  - The most significant risk factors for postpartum psychosis are a personal or family history of bipolar disorder, or a previous psychotic episode.
  - **Postpartum Psychosis is considered a medical emergency due to the potential for a mom to harm herself or her baby.**
- **Intrusive Thoughts**
  - 70-100% of women (and their partners) have "intrusive" thoughts surrounding childbirth/the postpartum period.<sup>6</sup> These thoughts may include thoughts of infant harm (e.g., dropping the baby or a woman herself harming her baby). These thoughts are unwanted (ego-dystonic) and recognized by the woman as inappropriate and concerning, (which is why these thoughts alone are not cause for alarm).
  - It is important to note that although obsessions often contain alarming content they **do not represent a psychotic process, where mothers are at a higher risk of harming themselves or their infants/children.**
  - Intrusive thoughts are not considered a "disorder." When symptoms become persistent and are disabling, they are generally thought to be tied to OCD.

**Maternal Mental Health and Suicide**



**Suggestions for crisis counselors in working with maternal populations:**

- **Be aware of feelings** the person in crisis might be experiencing related to maternal mental health:
  - Mothers often experience significant stigma and shame, particularly if she had a wanted and an uneventful pregnancy/delivery and healthy baby. Stigma and shame surrounding mental health can also be culturally grounded and it can be helpful to recognize cultural nuances.
  - Many mothers, particularly those with depression or intrusive thoughts have a fear of speaking up, as uneducated or racially biased providers, have inappropriately filed reports with child protective services.
- **Normalize** how stressful motherhood is and how hard it is to function normally with anxiety, depression, etc. can help with identifying who in the mother's life may be able to provide practical support.
- **Be sensitive but not afraid to ask specific and direct questions** to know how to best assess safety and identify appropriate resources.
- **Listen for or ask about the caller's "healthy self"** as this can be helpful in determining small behavioral activation goals (small behaviors which are known to help mood and anxiety symptoms).

**Referrals:**

**Postpartum Support International**

- Volunteers offer encouragement, information, and treatment resources in your community. The warmline can be reached at 1-800-944-4773 (4PPD) in Spanish or English.
- Those in need can also send a text message to 971-420-0294 for Spanish-speakers or 503-894-9453 for English-speakers.
  - *NOTE: Postpartum Support International is **not a crisis hotline** and does not handle emergencies.*

**References:**

- <sup>1</sup>Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol.* 2005;106(5 Pt 1):1071-83. doi:10.1097/01.AOG.0000183597.31630.db.
- <sup>2</sup>Fairbrother N, Janssen P, Antony MM, Tucker E, Young AH. Perinatal anxiety disorder prevalence and incidence. *J Affect Disord.* August 2016;200:148-55. doi:10.1016/j.jad.2015.12.082.
- <sup>3</sup>Ryan D, Kostaras X. Psychiatric disorders in the postpartum period. *British Columbia Medical Journal.* 2005;47(2):100-103. <http://www.bcmj.org/article/psychiatric-disorders-postpartum-period>.
- <sup>4</sup>Massachusetts General Hospital. Postpartum psychiatric disorders. MGH Center for Women's Mental Health. Published 2015. [https://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/?doing\\_wp\\_cron=1485807063.98182391](https://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/?doing_wp_cron=1485807063.98182391).
- <sup>5</sup>Committee on Obstetric Practice. Screening for perinatal depression: committee opinion no. 630. Washington, DC: American Congress of Obstetrics and Gynecology; 2015:1-4. <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co630.pdf?dmc=1&ts=20161227T1417252146>.
- <sup>6</sup>Collardeau, F., Corbyn, B., Abramowitz, J. *et al.* Maternal unwanted and intrusive thoughts of infant-related harm, obsessive-compulsive disorder and depression in the perinatal period: study protocol. *BMC Psychiatry* 19, 94 (2019). <https://doi.org/10.1186/s12888-019-2067-x>
- <sup>7</sup>Grekin, R., & O'hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review*, 34(5), 389-401. doi:10.1016/j.cpr.2014.05.003