Postpartum Depression and Suicide

By Diana Lynn Barnes, Psy.D. & Jerrod Brown, Ph.D.

Abstract

Despite cultural perceptions of maternal bliss among new mothers, there is a dangerous risk of suicide among women with postpartum depression. This disorder is characterized by a range of symptoms including clinical anxiety, cognitive confusion, feelings of inadequacy, insomnia, and rapid weight loss. These symptoms can result in an increased risk of self-harm. This risk is exacerbated by the presence of pre-existing psychiatric disorders (e.g., psychosis, bipolar, and major depression) and traumatic experiences (e.g., physical and sexual abuse). To decrease the likelihood of suicide and filicide, increased screening for risk factors of postpartum depression is essential during pregnancy and the year after giving birth.

Overview

Pregnancy and motherhood are touted as the happiest time in a woman's life, yet there are more psychiatric admissions around the childbearing years than at any other time in the female life cycle (Munk-Olsen et al., 2006; O’Hara & Stuart, 1999). It is a time of tremendous physical and psychological vulnerability. For example, women with
histories of trauma are at a particularly higher risk for psychiatric problems around childbearing (Brand et al., 2010; Ross & Dennis, 2009; Seng et al., 2013; Sit et al., 2015). Individual circumstances, coupled with mental health history, relationships with partners and family, desire to become a mother, and beliefs about what society expects of mothers all contribute to how each woman is affected (Barnes, 2014).

Postpartum depression has a clinical presentation that is somewhat different from the typical symptoms of major depression (Ross et al., 2003). Women with postpartum depression are more likely to experience clinical anxiety, cognitive confusion and disorientation, feelings of inadequacy, insomnia, and rapid weight loss. There is often an accompanying guilt that they are not meeting mythological expectations of mothers. These expectations can range feeling the need to be all knowing to relentlessly available and forever loving. Of note, women with postpartum depression may even experience thoughts of self-harm.

Despite the cultural ideology that motherhood engenders a state of maternal bliss, suicide is one of the leading causes of death in postpartum women (Oates, 2003; Sit et al, 2015). In fact, suicide is the seventh-leading cause of maternal death within six months of childbirth (Lewis et al., 2011). A survey found that 59 percent of maternal suicides in the UK were the result of either psychosis or severe depression (CMACE, 2011). Strikingly, women with childbearing related illnesses use more violent methods of suicide (e.g., hanging, jumping from a tall building, or self-incineration) relative to less violent methods that are more common among non-pregnant women in the general population (i.e. overdose; Appleby, 1991; Oates & Cantwell, 2011). A prior suicide attempt can substantially increase the risk for death in a subsequent attempt (Lindahl et al., 2005).

Psychiatric comorbidity can substantially elevate the risk for lethality in suicide attempts (Appleby et al., 1998; Lindahl, Pearson, & Colpe, 2005). For example, research on mothers who died by suicide within six months following childbirth found that diagnoses of psychosis (38 percent), substance use disorders (31 percent), and severe depression (21 percent) were commonplace (Comtois et al., 2008; Lewis et al., 2011). In another study, those women diagnosed with bipolar disorder, schizophrenia, and anxiety disorders were also at a substantially increased risk for suicide, suicidal behavior, and infanticide (Parry, 1995). The prevalence of postpartum psychosis in the general population is one to two women per 1,000 childbirths whereas these prevalence rates are 100 times higher in women with bipolar disorder (Spinelli, 2009). In a study of 54,000 births over a 12-year period, Kendell (1987) found that of those women who developed psychosis after childbirth, 72 to 80 percent had bipolar disorder or schizoaffective disorder and 12 percent had schizophrenia. Because the symptoms of postpartum psychosis include confusion, cognitive impairment, severe thought-disturbance as evidenced by bizarre delusions, impulsive behavior, and commanding hallucinations along with lack of insight, this is a psychiatric emergency (Wisner et al, 1994).

There are several factors beyond mental disorders that increase a woman’s vulnerability for suicidal ideation and suicide attempts. In particular, women who experienced childhood physical abuse were at increased risk (Sit, Luther, & Buyesse, 2015). Similarly, histories of sexual abuse and neglect are also linked with later thoughts of self-harm and suicide attempts (Cavanaugh et al., 2003; Hawton & van Heeringen, 2009). Sit and colleagues (2015) even found that sleep disturbances increased the frequency of suicidal ideation.
In light of the dangers of postpartum depression, women should be routinely screened throughout pregnancy and during the year after birth. Screenings improve the identification of psychiatric risks during the peripartum period. Screenings should include questions about personal and family history of mental health, previous episodes of mental illness around childbearing, and the use of psychotropic medications to manage pre-existing mood disorders. Women with pre-existing histories of bipolar disorder or other mental disorders should be referred for psychiatric assessment and monitoring even if they do not present as a symptomatic (Healey, et al, 2013) to safeguard against potential risks of suicide and filicide.

**Author Biographies**

Diana Lynn Barnes, Psy.D. is editor and contributing author of Women’s Reproductive Mental Health Across the Lifespan (Springer, 2014). She is a past president of Postpartum Support International as well as a member of the training faculty of Maternal Mental Health Now in Los Angeles and the California Collaborative with 2020 Mom. She is widely published in the academic press on a broad range of topics pertaining to maternal mental illness and wrote guidelines on assessment and treatment for the Perinatal Advisory Council of Los Angeles County. She is a mental health consultant to the California Task Force on the Status of Maternal Mental Health as well as a member of the California Pregnancy-Associated Mortality Review Panel, a project of the California Public Health Institute. In addition to private practice specializing in women’s reproductive mental health, Barnes is frequently retained by legal counsel on cases of infanticide and neonaticide where perinatal illness is an issue.

Jerrod Brown, Ph.D., is an assistant professor and program director for the Master of Arts degree in Human Services with an emphasis in Forensic Behavioral Health for Concordia University, St. Paul, Minnesota. Brown has also been employed with Pathways Counseling Center in St. Paul for 15 years. Pathways provides programs and services benefiting individuals impacted by mental illness and addictions. Brown is also the founder and CEO of the American Institute for the Advancement of Forensic Studies, and editor-in-chief of Forensic Scholars Today and the Journal of Special Populations. Brown has completed four master’s degree programs and holds graduate certificates in autism spectrum disorder, other health disabilities, and traumatic brain injury.
References


