Suicidality in Postpartum Women With Unipolar and Bipolar Depression:

A Secondary Analysis Comparing Self-Reported and Clinician Assessments

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Abstract

Objective: To investigate the alignment of self-harm ideation ratings with clinical assessments of suicidality in postpartum women diagnosed with unipolar and bipolar depression and the impact of trauma and psychiatric diagnosis on this alignment.

Methods: Data from the largest postpartum depression screening study (n = 10,000) in the US were examined in this secondary analysis. Inclusion criteria were a positive depression screen (Edinburgh Postnatal Depression Scale [EPDS] ≥10), a psychiatric diagnosis (Structured Clinical Interview for *DSM-IV*), and a suicidality assessment derived from the Structured Interview Guide for the Hamilton Depression Rating Scale with Atypical Depression Supplement (SIGH-ADS). Trauma exposure, including both childhood and adult physical and sexual abuse, was measured using 4 yes/no questions from the Dissociative Disorders Interview Schedule. Associations between key variables were examined using independent samples *t* tests, analysis of variance, χ^2 tests, or Fisher exact tests. Nonparametric tests were used for skewed continuous data. To assess the consistency between the EPDS and SIGH-ADS scales, Cohen κ statistics were used, with weighted κ applied to severity ratings and simple κ for binary categorizations.

Results: Among 1,155 screen-positive postpartum women (68% White, 25.5% African American, 6.6% other; mean age 27.93 years), 21% endorsed self-harm ideation and 10.1% reported suicidality. Compared to those with unipolar depression, women with bipolar disorder had more than twice the odds of suicidality (odds ratio [OR] 2.77, 95% CI, 1.86 to 4.13, $P < .001$) and nearly 4 times the odds (OR 3.92, 95% CI, 1.18 to 13.00, $P < .001$) of not self-reporting self-harm ideation. Overall concordance between self-report (EPDS10) and clinical evaluation (SIGH-ADS11) was 78.6% (κ = 0.28, 95% CI, 0.21 to 0.34, fair agreement) but varied significantly by diagnosis ($P < .001$), with lower concordance in the bipolar group (67.3%; κ = 0.21) compared to the unipolar group (80.4%; κ = 0.31). In the high-risk bipolar disorder group, concordance was no longer statistically significant, indicating poor alignment between self-report and clinical evaluation for these patients. Trauma was strongly associated with suicidality and a bipolar diagnosis.

Conclusion: The EPDS does not consistently detect suicidality in perinatal bipolar patients, with our study showing only slight and nonsignificant agreement with clinical assessment in this high-risk group. Given that risk can change quickly in postpartum bipolar patients, timely and frequent clinical assessments are needed to identify high-risk individuals. Tracking and integrating routine bipolar disorder screening and trauma assessments in perinatal care may enhance early identification of suicide risk and improve maternal mental health outcomes.

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Suicide, a leading cause of maternal mortality in the US,[1,2] Japan,[3] the United Kingdom,[4] and Australia,[5,6] has devastating effects on family, society, community, and has adverse child mental health and developmental outcomes.[7–9] The estimated economic cost of untreated maternal mental disorders over 5 years is $14.2 billion, maternal suicides accounting for $204 million.[10] Implementing strategies to identify and establish risk and provide targeted interventions is crucial.

Maternal suicidality, defined as the presence of suicidal ideation, gestures, or attempts during the perinatal period, is strongly associated with perinatal psychiatric conditions, including major depressive disorder (MDD) and bipolar disorder (BD).[8,11–15] The prevalence of self-harm and suicidal ideation among all postpartum women is 3%–10%.[16–18] This rate rises to 14%–37% among postpartum women with a history of psychiatric illness.[12,19–21] Women with perinatal depression have an elevated risk for suicidality from the time of diagnosis through 18 years of follow-up, which highlights the impact of perinatal psychiatric illness on suicidality across a woman's lifespan.[22] BD, the diagnosis

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Clinical Points

- The Edinburgh Postnatal Depression Scale does not consistently detect suicidality in perinatal patients with bipolar disorder, showing nonsignificant agreement with clinical assessment in this high-risk group.
- Clinicians should routinely screen all postpartum women for bipolar disorder and trauma history. Relying solely on self-report screening tools in those with a positive screen risks missing women with high-risk suicidality. Timely and frequent clinical assessments are essential to identify high-risk individuals.

most highly associated with postpartum psychosis, further elevates suicide risk[14,23,24] and is a psychiatric emergency associated with infanticide[25] and 38% of maternal suicides.[26] Recent population-based data demonstrate that postpartum individuals with BD face an 11-fold increased risk of suicide attempt compared to those without psychiatric diagnoses, with risk escalating further among those with comorbid conditions. These findings underscore the importance of a broader understanding of the relationship between suicide risk, perinatal psychiatric disorders, and the efficiency of screening tools.[14]

Although depression screening is recommended by various medical, advocacy, and government groups[27–33] and mandated in some states,[34–42] specific screening for suicidality during the perinatal period is not currently included.[43] Suicide screening is recommended in response to concerns emerging during clinical interactions or to a depression screen.[27,33] Ideally, women with positive screens are evaluated by a clinician to establish symptom severity and level of self-harm risk. The time between the screen and the follow-up assessment, which may be by referral to a mental health professional, varies widely with the resources available.

Many of the organizations recommending screening, such as the American College of Obstetricians and Gynecologists (ACOG), recommend the use of the Edinburgh Postnatal Depression Scale (EPDS),[44] a validated and widely used screening tool for postpartum depression. Item 10 (EPDS10) is a query for self-harm ideation ("The thought of harming myself has occurred to me"). Few investigators have explored the concordance between EPDS10 and clinician assessment of suicidality. EPDS10 has been reported to be more sensitive than the Hamilton Depression Rating Scale (HDRS) clinician assessments for suicidality.[20,45] Howard et al[16] compared EPDS10 to clinical assessments using the Clinical Interview Schedule-Revised (CIS-R)[46] and found that concordance varied by EPDS response. Women who reported "sometimes" on EPDS10 had only a 68% concordance with CIS-R assessment, while all women who endorsed "quite often" were identified as suicidal by the CIS-R.[16] None of these studies contained diagnosis-specific or suicide-risk level concordance between the EPDS10 and clinical assessment.

Trauma exposure is another well-established risk factor for suicidality in the general and perinatal population.[8,15,19,47,48] Childhood maltreatment is significantly associated with increased risk of self-harm, suicidal ideation, and suicide attempts during the postpartum period.[8,15,19] Trauma contributes to altered stress regulation and affective instability, which heightens vulnerability to mood disorders and suicidality.[47,49] In women with BD, cumulative trauma exposure has been linked to earlier onset, more severe illness courses, and higher rates of suicide attempts.[50] However, few studies have examined how trauma relates to the concordance between self-report and clinician-assessed suicidality in the perinatal period. Delineating how trauma influences suicidality assessment across diagnostic groups informs suicide risk assessment and optimizes risk stratification for women during the perinatal period.

Understanding the relationship between psychiatric diagnosis, trauma, self-harm ideation, and clinician-assessed suicidality has important implications for preventing maternal suicides. To understand these relationships, we performed a secondary analysis of the data collected in a landmark investigation in which 10,000 postpartum women were screened for depression.[12] We sought to answer the following questions:

1. What is the level of intermeasure agreement between self-harm ideation scores and clinician assessments of suicidality in postpartum women, and how does this agreement differ by level of suicide risk and diagnoses of BD and MDD?
2. How are trauma variables differentially associated with psychiatric diagnosis, self-harm, and suicidality scores?

We hypothesized the following:

1. Kappa statistics would indicate a fair overall level of agreement between the EPDS10 and Item 11 of the clinician-administered Structured Interview Guide for the Hamilton Depression Rating Scale with Atypical Depression Supplement (SIGH-ADS11),[51] and κ agreement between EPDS10 and SIGH-ADS11 would be stronger for the MDD than the BD group.
2. Childhood trauma and a diagnosis of BD would be significantly associated with higher suicidality and self-harm ideation. Additionally, women with BD would have higher rates of individual and cumulative trauma than women with MDD.

To our knowledge, this is the first study to examine the concordance between self-report self-harm ideation and clinical suicidality assessment specifically by psychiatric diagnosis and suicide risk level.

METHODS

This secondary analysis was derived from Wisner and colleagues'[12] 2013 postpartum depression study, which involved screening 10,000 women at an urban academic obstetrical hospital in Pittsburgh, Pennsylvania. Newly delivered women were recruited by a nurse or social worker for a telephone-based EPDS screening at 4–6 weeks postpartum. Exclusion criteria included being under 18 years of age, non-English speaking, unable to consent, or lacking phone access. Eligible participants provided institutional review board–approved consent for contact and screening.[12]

The original screened sample was 80.3% White, 14.6% African American, 2.1% Asian, and 3.0% other race; 2.0% were Hispanic. Most had private insurance (71.9%), with 27.5% publicly insured. Education ranged from 4.4% with less than high school to 23.8% with graduate degrees. Screen-positive women (EPDS ≥10) were more often African American (20.2%), publicly insured (43.0%), single (42.7%), and less educated (8.4% < high school) than screen-negative women. All women who screened positive (EPDS ≥10) were offered a home visit or telephone evaluation for psychiatric diagnostic assessment, which was conducted within 2 weeks of the EPDS screening. Primary and secondary psychiatric diagnoses were established with the Structured Clinical Interview for *DSM-IV*[52] and the SIGH-ADS, which were conducted by master's-trained, experienced clinicians trained to reliability by K.L.W. Figure 1 shows the subject flow for this study sample.

Suicidality and Concordance Measures

Self-harm ideation and suicide risk were assessed using EPDS10 and SIGH-ADS11 sequentially. EPDS10 assesses self-harm ideation: "The thought of harming myself has occurred to me," with response options ranging from 0 to 3 (0 = never, 1 = hardly ever, 2 = sometimes, 3 = yes, quite often). SIGH-ADS is worded as "Have you had any thoughts that life is not worth living?" with responses ranging from 0 to 4 (0 = absent, 1 = feels life is not worth living, 2 = suicidal ideation, 3 = suicidal gesture, 4 = attempts at suicide). We created 3 categories for each scale by defining a "no-risk" level (EPDS10 = 0; SIGH-ADS11 = 0), a "moderate-risk" level (EPDS10 = 1; SIGH-ADS11 = 1), and a "higher-risk" level by combining the highest-risk categories of suicidality in EPDS10 (scores of 2 and 3) and SIGH-ADS11 (scores 2–4). We defined higher-risk suicidality as any response in the highest-risk categories on either scale (Supplementary Table 1).

The typical clinical strategy is to use EPDS10 to screen for suicidality as an initial step before clinical assessment. Our analysis focused on score pairings in which no self-harm ideation was reported on EPDS10, but suicidality was reported in the SIGH-ADS11 clinical assessment. We defined moderate discordance as no self-harm ideation on the EPDS10 but any level of suicidality on the SIGH-ADS11. Maximal discordance was defined as 0 on the EPDS10, followed by a score in the highest-risk category on the SIGH-ADS11.

Measures of Trauma

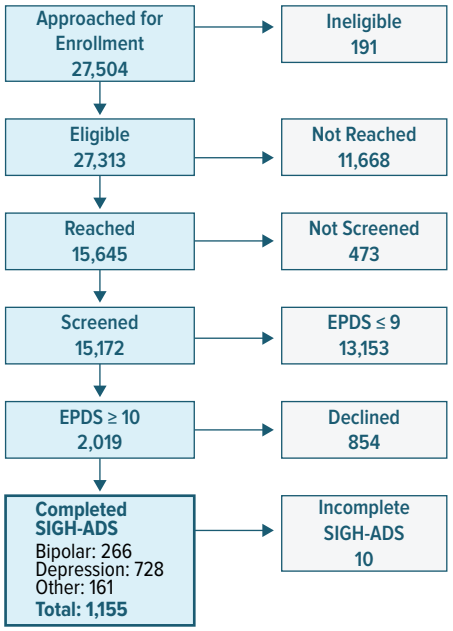
Exposures to childhood and adult physical and sexual abuse were assessed using standardized questions from the Dissociative Disorders Interview Schedule.[53] These included the following: "As an adult, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?"; "As an adult, have you ever been forced to have an unwanted sexual act?"; "Were you physically abused as a child or adolescent?"; and "Were you sexually abused as a child or adolescent?" Responses to each question were dichotomous and were totaled to create a 0–4 summary variable. Each trauma experienced was scored as 1 if present and 0 if absent, with the total score ranging from 0 to 4 (exposure to all 4 trauma types). Both individual and total scores were evaluated to assess specific type and ongoing, cumulative trauma effects on diagnosis.

Statistical Analysis

Data were analyzed using descriptive and inferential statistics to characterize the sociodemographic and clinical features of the study population, which were summarized using frequencies and percentages for categorical variables and mean (SD) for continuous variables. To examine associations between key variables (eg, BD diagnosis, trauma experiences), independent samples *t* tests, analysis of variance, χ^2 tests, or Fisher exact tests were employed. Nonparametric tests were utilized for skewed continuous data. To assess the consistency between the EPDS and SIGH-ADS scales, intermeasurement agreement was quantified using Cohen κ statistics; weighted κ was applied to the 3-level severity ratings, and simple (unweighted) κ was used for binary categorizations (higher-risk suicidality vs other). The strength of association for these binary outcomes was evaluated using odds ratios (ORs) with 95% confidence intervals (CIs) between participants with BD and MDD. These analyses were performed for the overall sample and stratified by diagnostic group. All statistical analyses were conducted using R (Version 4.4.2), with a significance threshold of $P < .05$.

Figure 1.

Participants in a Postpartum Depression Screening Study[a]



[a]The bolded cell depicts the cohort included in this study.
Abbreviations: EPDS = Edinburgh Postnatal Depression Scale, SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale With Atypical Depression Supplement.

RESULTS

Description of Sample

The sociodemographic characteristics of the study sample are summarized in Table 1. The sample included 1,155 postpartum women; 68% identified as White, 25.5% as African American, 6.6% as other, and 2.6% as Hispanic. The mean maternal age was 27.93 years, 90.7% of participants completed at least a high school education, and 51.3% were single, 46.2% were married, and 2.5% were divorced or widowed. Approximately 60% of the participants had public or no insurance.

Clinical Descriptors

Of the 1,155 screen-positive participants, 23% (n = 266) had a primary diagnosis of BD, 63% (n = 728) had MDD, and 13.9% (n = 161) had anxiety, substance use, or other disorders, which were combined into the "other" category. Over half (54.9%) of the participants reported experiencing at least 1 form of trauma, and 63.6% had a comorbid diagnosis. The mean (SD) EPDS score was 14.2 (3.81), and the mean (SD) SIGH-ADS29 score was 20.66 (6.59), indicating moderate depression symptom severity on both scales. Only participants with a primary diagnosis of MDD or BD (N = 994) were included in further analyses.

Rates of Self-Harm and Suicidality

Overall rates. The distribution of suicidality levels on the EPDS10 and SIGH-ADS11 is provided in Table 1. A significant association was found between EPDS10 and SIGH-ADS11 scores ($P < .001$). Among the 21% (n = 244) of participants who screened positive for self-harm thoughts on EPDS10, 27% (n = 66) reported experiencing these thoughts "sometimes" or "often." Among the 10.1% (n = 116) of participants who endorsed suicidality on SIGH-ADS11, 22% (n = 25) reported higher-level suicidality, including wishes to be dead, suicidal ideation or gestures, or suicide attempts.

By diagnosis. A diagnosis of BD was consistently associated with higher rates of self-harm ideation and suicidality scores compared to MDD. Participants with BD reported higher rates of suicidality on both the EPDS10 (28.2%) and SIGH-ADS11 (19.9%) scales compared to those with MDD (20.6% and 8.24%, respectively). The odds of self-harm ideation/suicidality were 1.42 times higher (95% CI, 1.03 to 1.95, $P = .037$) on the EPDS10 and 2.77 times higher (95% CI, 1.86 to 4.13, $P < .001$) on the SIGH-ADS11 for the BD group (Table 2).

Higher-risk suicidality was higher in individuals with BD, who had higher rates on both the SIGH-ADS11 (4.1%) and the EPDS10 (7.1%) compared to participants with MDD (1.9% and 5.8%, respectively). However, this association was not statistically significant. The odds of higher-risk suicidality were 2.20 times greater for the BD group on the SIGH-ADS (95% CI, 0.96 to 4.95, $P = .062$) and 1.26 times greater on the EPDS (95% CI, 0.70 to 2.19, $P = .425$), but neither finding reached statistical significance (Table 2).

Concordance and Discordance

Concordance and discordance levels are shown in Table 3. Overall concordance between EPDS10 and SIGH-ADS11 was 78.61%. Moderate (EPDS10 = 0, SIGH-ADS11 > 0) and maximal discordance (EPDS10 = 0, SIGH-ADS11 ≥ 2) were observed in 3.2% (n = 37) and 1.1% (n = 11) of the participants, respectively. However, concordance varied significantly by diagnosis ($P < .001$). In the MDD group, concordance was 80.4% (64% of total concordant cases), with 2.1% showing moderate discordance and 0.7% showing severe discordance. In contrast, the BD group had lower concordance (67.3%, 19.7% of total concordant cases), with 7.9% showing moderate and 2.3% showing maximal discordance. Notably, patients with BD were almost 4 times more likely than those with depression to report no self-harm ideation but, in a later interview, reported the highest suicide risk (OR = 3.92; 95% CI, 1.18 to 13.00) (Supplementary Table 2).

The average time between concordant scores was approximately 10 days. While the number of days between assessments was not associated with

Table 1.

Socioeconomic, Demographic, and Clinical Characteristics of 1,155 Participants in a Postpartum Screening Study, Broken Down by Primary Psychiatric Diagnosis[a]

Characteristic	Depression (n = 728)	Bipolar (n = 266)	All (n = 1,155)	*P* value
Age, mean (SD), y	28.33 (5.88)	26.23 (5.28)	27.93 (5.85)	<.001
Race, N (%)				.032
White, non-Hispanic	508 (69.8)	160 (60.2)	785 (68)	
African American	177 (24.3)	83 (31.2)	294 (25.5)	
Other	43 (5.9)	23 (8.6)	76 (6.6)	
Hispanic ethnicity, N (%)	14 (2)	12 (4.7)	28 (2.6)	.044
Education, N (%)				<.001
<High school	54 (7.4)	42 (15.8)	107 (9.3)	
High school	165 (22.7)	82 (30.8)	275 (23.8)	
Some college	239 (32.8)	105 (39.5)	386 (33.4)	
College	151 (20.7)	22 (8.3)	229 (19.8)	
Graduate school	119 (16.3)	15 (5.6)	158 (13.7)	
Insurance, N (%)				<.001
None	6 (.8)	9 (3.4)	17 (1.5)	
Private	337 (46.3)	58 (21.8)	478 (41.4)	
Public	385 (52.9)	199 (74.8)	660 (57.1)	
Marital status, N (%)				<.001
Married	371 (51.0)	66 (24.8)	534 (46.2)	
Single	340 (46.7)	188 (70.7)	592 (51.3)	
Divorced/widowed	17 (2.3)	12 (4.5)	29 (2.5)	
Parity, N (%)				<.001
1	261 (35.9)	96 (36.1)	444 (38.4)	
2	283 (38.9)	76 (28.6)	409 (35.4)	
3	118 (16.2)	58 (21.8)	195 (16.9)	
4+	66 (9.1)	36 (13.5)	107 (9.3)	
SIGH-ADS29, mean (SD)	20.97 (5.66)	23.85 (6.69)	20.66 (6.59)	<.001
SIGH-ADS11, N (%)				<.001
Absent	668 (91.8)	213 (80.1)	1,038 (89.9)	
Feels life not worth living	46 (6.32)	42 (15.8)	91 (7.9)	
Thoughts/attempt suicide	14 (1.92)	11 (4.14)	26 (2.3)	
EPDS, mean (SD)	14.2 (3.67)	15.3 (4.35)	14.2 (3.81)	<.001
EPDS10, N (%)				<.001
Never	578 (79.4)	191 (71.8)	911 (78.9)	
Rarely	108 (14.8)	56 (21.1)	178 (15.4)	
Sometimes/often	42 (5.77)	19 (7.14)	66 (5.7)	
Comorbidity, N (%)				<.001
No	240 (33)	67 (25.2)	420 (36.4)	
Yes	488 (67)	199 (74.8)	735 (63.6)	
Sexual abuse/child, N (%)				<.001
Yes	174 (24.5)	110 (43.3)	307 (26.6)	
No	535 (75.5)	144 (56.7)	848 (73.4)	
Sexual abuse/adult, N (%)				<.001
Yes	99 (14)	68 (26.8)	173 (15)	
No	610 (86)	186 (73.2)	982 (85)	
Physical abuse/child, N (%)				<.001
Yes	139 (19.6)	104 (40.9)	256 (22.2)	
No	570 (80.4)	150 (59.1)	899 (77.8)	
Physical abuse/adult, N (%)				<.001
Yes	238 (33.6)	135 (53.1)	408 (35.3)	
No	471 (66.4)	119 (46.9)	747 (64.7)	
Trauma encountered, N (%)				<.001
0	347 (47.7)	69 (25.9)	521 (45.1)	
1	193 (26.5)	65 (24.4)	297 (25.7)	
2	124 (17)	67 (25.2)	204 (17.7)	
3	47 (6.5)	40 (15.0)	91 (7.9)	
4	17 (2.3)	25 (9.4)	42 (3.6)	
Trauma count, mean (SD)	0.89 (1.05)	1.58 (1.28)	0.99 (1.13)	<.001

[a]Data are presented as mean (SD) for continuous variables and as N (%) for categorical variables. *P* values for continuous variables were derived from independent samples *t* tests, and *P* values for categorical variables were derived from χ^2 tests.

Abbreviations: EPDS = Edinburgh Postnatal Depression Scale; EPDS10 = EPDS Item 10 assessing self-harm; SIGH-ADS = Structured Interview Guide for the Hamilton Depression Rating Scale With Atypical Depression Supplement; SIGH-ADS29 = full 29-item version; SIGH-ADS11 = Item 11 assessing suicidality.

concordance in the MDD group ($P = .193$), this association approached statistical significance ($P = .051$) in the BD group. The most discordant cases with BD had the longest average time between assessments at 21 days (Supplementary Table 3). Additionally, public insurance status was significantly associated with concordance in the MDD group ($P < .001$), while education was a significant factor in the BD group ($P < .001$).

Kappa Analysis. For the overall sample, the weighted κ for the 3-tiered risk level was 0.28 (95% CI, 0.21 to 0.34, $P < .001$), consistent with fair agreement, while the unweighted κ for the binary tiers (higher-level risk vs not higher-level) was 0.16 (95% CI, 0.09 to 0.23, $P < .001$), reflecting only slight agreement.

For the diagnosis-specific 3-tiered analysis, weighted κ was higher among participants with MDD (κ = 0.31, 95% CI, 0.24 to 0.38, $P < .001$; fair agreement) compared to those with BD (κ = 0.21, 95% CI, 0.10 to 0.32, $P < .001$; borderline slight/fair). Agreement declined for the binary higher-level risk analysis: There was only slight agreement for the MDD group (κ = 0.19, 95% CI, 0.11 to 0.26, $P < .001$), while the agreement became nonsignificant and showed no difference from chance (κ = 0.09, 95% CI, −0.03 to 0.21, $P = .147$) in the BD group (Table 3).

Trauma

Trauma was significantly associated with both suicidality and BD diagnosis. Women who experienced childhood physical abuse endorsed higher self-harm ideation on the EPDS10 (36.5% of "sometimes/often" vs 21.1% of "never," $P = .008$) and suicidality on the SIGH-ADS11 (40.0% vs 21.2%, $P = .001$). Childhood sexual abuse was also strongly related to suicidality, with 42.0% of women reporting "life is not worth living" on the SIGH-ADS11 having a history of abuse compared to 26.2% of those without suicidality ($P = .006$). Adult physical abuse was significantly associated with suicidality as measured by SIGH-ADS11 (68.0% vs 35.0%, $P = .001$), while adult sexual abuse was not significantly associated with suicidality in either measure ($P = .311$) (Table 4).

A clear relationship between cumulative trauma burden and suicidality was also observed. The mean number of trauma types significantly increased across EPDS10 self-harm ideation categories (from 0.95 [1.12] in "never" to 1.24 [1.16] in "sometimes/often," $P = .044$) and SIGH-ADS11 categories (from 0.95 [1.12] with no suicidality to 1.46 [1.07] with suicidal thoughts/attempts, $P < .001$).

When examined by diagnosis, the BD group consistently had significantly higher levels across all trauma variables than the MDD group. Compared to women with MDD, women with BD had more than twice the odds of experiencing any sexual abuse (childhood OR = 2.33, 95% CI, 1.72 to 3.13; adult OR = 2.27, 95% CI, 1.59 to 3.23) or adult physical abuse (OR = 2.22, 95% CI, 1.67 to 3.03) and nearly 3 times the odds of experiencing childhood physical abuse (OR = 2.86, 95% CI, 2.08 to 3.85). With respect to cumulative trauma, women with BD reported 1.58 trauma types compared to 0.89 in the MDD group (OR = 1.64, 95% CI, 1.45 to 1.85, $P < .001$). Of women with BD, 25% reported 3 or more trauma types compared to 8.8% of those with MDD. Strikingly, women with BD were over 7 times more likely than women with MDD to report 4 or more trauma types (OR = 7.33, 95% CI, 3.77 to 14.6, $P < .001$) (Table 4).

DISCUSSION

In this study of 961 depressed postpartum women with BD and MDD (derived from a screened sample of 1,155 screened women), 21% of the women endorsed self-harm ideation on EPDS10, and 10.1% endorsed suicidality on the SIGH-ADS11. The observation of higher levels of self-harm ideation on the EPDS10 than clinical assessment of suicidality is consistent with several prior studies. Coker et al[45] found the prevalence of self-harm ideation and suicidality in postpartum women with neuropsychiatric illness to be 22.3% (EPDS10), 16.1% (self-rated Beck Depression Inventory), and 11.5% (HDRS). Pope et al[20] reported that 16.79% of postpartum women endorsed thoughts of self-harm on EPDS10, while 6.16% endorsed suicidal ideation on the clinician-rated HDRS question 3. Concordance (78.61%) was consistent with results from previous studies investigating alignment between EPDS10 and various clinician-administered suicidality assessments.[16]

A contributing factor toward discrepancies between EPDS and clinician assessment is the EPDS language referencing thoughts of "self-harm" rather than suicidal behavior or thoughts. Nonsuicidal patients experiencing intrusive obsessional thoughts about self-harm or who have a history of nonsuicidal self-injury may screen positive. Stigma and fear of the involvement of child welfare authorities may also influence responses that mothers give to questions regarding suicidality and self-harm. Clinical assessment allows for nuanced discernment between intrusive thoughts and active and passive suicidality, which may contribute to lower and more accurate levels of assessed suicidality.

Our intermeasurement agreement (κ) analysis provides additional insight into the consistency and agreement between self-report self-harm and clinician-assessed suicidality. The weighted κ was 0.284 overall, 0.31 for MDD, and 0.21 for BD, indicating a significant "fair" level of agreement between the EPDS and SIGH-ADS and confirming our first hypothesis. The MDD group had the highest level of agreement, followed by the overall group and the BD group. While there were

Table 2.

Suicidality, Higher Risk Suicidality, and Self-Harm Ideation by Diagnosis[a]

Item	Diagnosis	Suicidality N (%)	No suicidality N (%)	Odds ratio (95% CI)	*P* value	Higher-risk suicidality[b] N (%)	Non-higher risk N (%)	Odds ratio (95% CI)	*P* value
SIGH-ADS11	Depression (n=728)	60 (8.2)	668 (91.8)	Reference		14 (1.9)	714 (98.1)	Reference	
	Bipolar (n=266)	53 (19.9)	213 (80.1)	2.77 (1.86 to 4.13)	<.001	11 (4.1)	255 (95.9)	2.20 (0.96 to 4.95)	.062
EPDS10	Depression (n=728)	150 (20.6)	578 (79.4)	Reference		42 (5.8)	686 (94.2)	Reference	
	Bipolar (n=266)	75 (28.2)	191 (71.8)	1.42 (1.03 to 1.95)	.037	19 (7.1)	247 (92.9)	1.26 (0.70 to 2.19)	.425

[a]Chi-square tests (or Fisher exact tests, as appropriate) were used to examine the association between diagnosis (bipolar disorder vs MDD) and higher-risk suicidality status.
[b]Binary outcomes comparing higher-risk suicidality groups vs. non-higher-risk groups by diagnosis.
Abbreviations: CI = confidence interval; EPDS10 = Edinburgh Postnatal Depression Scale, Item 10; MDD = major depressive disorder; SIGH-ADS11 = Structured Interview Guide for the Hamilton Depression Rating Scale With Atypical Depression Supplement, Item 11.

Table 3.

Concordance Between EPDS10 and SIGH-ADS11 by Risk Level and Diagnosis[a]

Group	Concordant, n (%)	EPDS10=0/0,[b] n (%)	EPDS10=0/SIGH-ADS11≥2,[c] n (%)	Weighted κ[d] (95% CI)	*P* value	Unweighted κ[e] (95% CI)	*P* value	Interpretation[f]
Overall (n = 1,155)	908 (78.6%)	37 (3.2%)	11 (1.1%)	0.28 (0.21 to 0.34)	<.001	0.16 (0.09 to 0.23)	<.001	Fair/slight
Depression (n = 728)	585 (80.4%)	15 (2.1%)	5 (0.7%)	0.31 (0.24 to 0.38)	<.001	0.19 (0.11 to 0.26)	<.001	Fair/slight
Bipolar (n = 266)	179 (67.3%)	21 (7.9%)	6 (2.3%)	0.21 (0.10 to 0.32)	<.001	0.09 (-0.03 to 0.22)	.147	Fair[g]/none

[a]Cohen κ statistics were used to assess the intermeasure agreement between the EPDS and SIGH-ADS measures.
[b]Moderate discordance: defined as EPDS10 = 0 with SIGH-ADS11>0.
[c]Maximal discordance: defined as EPDS10 = 0 with SIGH-ADS11 ≥2.
[d]Weighted κ was used to assess agreement between the 3-level risk ratings.
[e]Unweighted κ was used to assess agreement for binary classifications (higher-risk suicidality vs not higher-risk).
[f]Interpretations based on Landis and Koch benchmarks: 0.01–0.20 = slight; 0.21–0.40 = fair agreement.
[g]Borderline fair.
Abbreviations: CI = confidence interval; EPDS10 = Edinburgh Postnatal Depression Scale, Item 10; SIGH-ADS11 = Structured Interview Guide for the Hamilton Depression Rating Scale With Atypical Depression Supplement, Item 11.

similar patterns in the unweighted κ analysis of a patient being at "higher risk" for suicidality or "not higher risk," there was less agreement (overall κ = 0.16, MDD κ = 0.19, BD κ = 0.09) between the 2 scales when identifying patients at the highest risk. Most importantly, the unweighted κ for the BD group of 0.09 was nonsignificant ($P = .147$). This finding has clinical implications: Despite having nearly 3 times the odds of suicidality, BD patients were 4 times more likely to show maximal discordance, endorsing no self-harm on the EPDS but later reporting high suicidality in a clinical interview. Thus, the EPDS10 alone cannot be considered a reliable tool for detecting high-risk suicidality in this patient population.

This notable discordance in the BD group may reflect rapid mood fluctuations during the assessment interval (9–21 days) or a reluctance to disclose suicidal thoughts on a self-report form. The fact that the most discordant BD cases also had the longest assessment intervals (21 days) further supports that a patient's risk level can evolve quickly over time. This highlights the importance of heightened awareness of suicidality in BD patients and frequent screening to capture these shifts.

Affirming our second hypothesis, we found that a diagnosis of BD doubled the odds for suicidality when compared to an MDD diagnosis. We also found that psychiatric diagnosis was significantly associated with comorbidity ($P < .001$), with the BD group having higher rates of comorbidity than the MDD group (74.8% vs 67%). This finding is consistent with reports that patients with BD, especially those with comorbid conditions, have a higher risk of suicidality in the perinatal population.[14] Additionally, trauma significantly correlated with both suicidality and psychiatric diagnosis. While the link between trauma and abuse as risk factors for self-harm and suicidality is documented,[8,15] our study is among the first to examine its contribution to discordance between self-report self-harm ideation and clinical assessments of suicidality. Self-harm ideation was linked to childhood physical abuse, while suicidality was significantly associated with 3 experiences of trauma: adult physical abuse, childhood physical abuse, and sexual abuse. Childhood physical abuse was most strongly correlated

Table 4.

Associations Between Trauma Variables, Suicidality, and Diagnosis[a]

Variable	EPDS Item 10				SIGH-ADS Item 11				Diagnosis			
	Never (N = 911)	Rarely (N = 178)	Sometimes/ often (N = 66)	*P* value	Absent (N = 1,038)	Not worth living (N = 91)	Thoughts/ attempts (N = 26)	*P* value	Depression (N = 728)	Bipolar (N = 266)	OR (95% CI)	*P* value
Sexual abuse, N (%)												
As child	236 (26.6)	52 (30.2)	19 (30.2)	.55	264 (26.2)	37 (42.0)	6 (24.0)	.006	174 (24.5)	110 (43.3)	2.33 (1.72 to 3.13)	<.001
As adult	127 (14.3)	35 (20.3)	11 (17.5)	.122	150 (14.9)	18 (20.5)	5 (20.0)	.311	99 (14.0)	68 (26.8)	2.27 (1.59 to 3.23)	<.001
Physical abuse, N (%)												
As child	187 (21.1)	46 (26.7)	23 (36.5)	.008	214 (21.2)	32 (35.4)	10 (40.0)	.001	139 (19.6)	104 (40.9)	2.86 (2.08 to 3.85)	<.001
As adult	315 (35.6)	64 (37.2)	29 (46.0)	.241	353 (35.0)	38 (43.2)	17 (68.0)	.001	238 (33.6)	135 (53.1)	2.22 (1.67 to 3.03)	<.001
Trauma types,[b] N (%)												
0	429 (47.1)	69 (38.8)	23 (34.8)	.088	489 (47.1)	26 (28.6)	6 (23.1)	<.001	347 (47.7)	69 (25.9)	Ref.	Ref.
1	233 (25.6)	47 (26.4)	17 (25.8)		267 (25.7)	24 (26.4)	6 (23.1)		193 (26.5)	65 (24.4)	1.69 (1.15 to 2.48)	.007
2	146 (16.0)	43 (24.2)	15 (22.7)		169 (16.3)	24 (26.4)	11 (42.3)		124 (17.0)	67 (25.2)	2.71 (1.83 to 4.03)	<.001
3	70 (7.7)	12 (6.7)	9 (13.6)		76 (7.3)	13 (14.3)	2 (7.7)		47 (6.5)	40 (15.0)	4.26 (2.59 to 7.01)	<.001
4	33 (3.6)	7 (3.9)	2 (3.0)		37 (3.6)	4 (4.4)	1 (3.8)		17 (2.3)	25 (9.4)	7.33 (3.77 to 14.6)	<.001
Trauma count, mean (SD)	0.95 (1.12)	1.11 (1.12)	1.24 (1.16)	.044	0.95 (1.12)	1.40 (1.17)	1.46 (1.07)	<.001	0.89 (1.05)	1.58 (1.28)	1.64 (1.45 to 1.85)	<.001

[a]Strength of association for these binary outcomes was evaluated using ORs with 95% CIs between bipolar and MDD patients.
[b]Trauma types encountered.
Abbreviations: CI = confidence interval; EPDS10 = Edinburgh Postnatal Depression Scale, Item 10, MDD = major depressive disorder, OR = odds ratio; SIGH-ADS11 = Structured Interview Guide for the Hamilton Depression Rating Scale With Atypical Depression Supplement, Item 11.

with suicidality, which is consistent with literature in the general and perinatal population.[8,15,19,47,48]

Women with BD exhibited higher rates of multiple traumas compared to those with MDD. Moreover, women with BD reported substantially higher trauma exposure than women with MDD, with over 7-fold increased odds of experiencing 4 or more trauma types. These findings suggest that trauma burden contributes to the weaker concordance in the BD group, either by amplifying affective instability or by shaping patterns of disclosure. These possibilities are consistent with a systematic review showing that 29%–82% of individuals with BD experienced multiple traumas.[50] While trauma is an established risk factor for perinatal psychiatric conditions and suicidality,[8,15,19] and comorbidity increases suicidality for patients with BD,[5] the mediating, confounding, and multidirectional nature of the relationship between cumulative trauma, comorbidity, BD, and perinatal suicidality remains underexplored.

Clinical and Policy Implications

The postpartum period represents a critical period with the highest lifetime risk for both the initial and recurrent onset of episodes of BD, which underscores the importance of screening.[54,55] Clinical implications from this study include routine screening for BD in perinatal patients and frequent screening for suicidality. If an immediate clinical interview is not feasible, additional evaluation of suicidal risk can be ascertained with the Columbia-Suicide Severity Rating Scale-Screen Form.[56]

Clark et al[57] found that the use of the Mood Disorder Questionnaire (MDQ)[58] in conjunction with a positive EPDS (≥10) identified BD in 50% of women with traditional MDQ scoring and by nearly 70% when the MDQ was scored without the impairment criterion. While validated and widely used, the length of the MDQ can be a barrier to routine use in busy clinical settings. The Rapid Mood Screener[59] is a shorter alternative that may facilitate more frequent BD screening but has not been validated for use in the perinatal population to our knowledge. Expanding policy measures to address BD screening in the perinatal population could mitigate missing BD diagnoses. Although the ACOG recommends BD screening for perinatal women,[33] data regarding the frequency and consistency of these screenings are lacking. Addressing this gap through targeted policy initiatives is necessary for improving early detection and intervention through a comprehensive, systems-based approach to suicide prevention in maternal health. Research on integrating the Zero Suicide Framework, considered the gold standard of systemic suicide prevention, into maternal clinical settings is warranted.[60,61] Finally, integration of trauma assessment during perinatal visits is recommended given the strong association between trauma history and suicidality in perinatal patients, particularly those with BD.

Strengths and Limitations

This study is derived from the largest population of women screened for postpartum depression in the US,

which provides a robust dataset for examining suicidality in the perinatal population. This study is the first to investigate the concordance between EPDS self-harm ideation and clinician-assessed suicidality by comparing differences between patients with postpartum BD and MDD. Focusing on this unique comparison, our findings offer novel insights into suicidality in these two groups. Additionally, our study is one of the few to examine suicidality rates in postpartum women with BD, which addresses a gap in the literature and advances our understanding of the specific risks faced by this population.

A limitation of this study is that assessments were conducted 4–6 weeks postpartum, while most completed suicides occur between 6 and 12 months postpartum.[62,63] This early post-birth time is critical for the identification of suicidality before the period of high prevalence for suicide completion. Future research should implement a prospective, longitudinal design with assessments at multiple time points through the first year postpartum.

Another limitation is the study's focus on individuals aged 18 years or older, which excludes adolescents. Additionally, the study only included women with a positive EPDS screen, which excludes those with BD who did not endorse depressive symptoms and were experiencing euthymia or hypomania/mania. The original study also did not capture women with overt psychotic symptoms due to the design, which required answering a phone call at 4–6 weeks post-birth, when most acutely ill women declined to be screened, may have been unable to respond, or were hospitalized. Future research should also explore the independent influence of trauma and BD on suicidality, which provides a more nuanced understanding of the unique risks faced by this population.

CONCLUSION

This study highlights critical implications for clinical practice, particularly in the screening and assessment of perinatal women at risk for BD and suicidality. Implementing comprehensive screening protocols that include assessments for BD and suicidality[64] is essential. Prescribing an antidepressant may trigger mania, worsen the course of BD, and/or delay effective treatment.[64,65] Our research confirms the importance of screening for BD, as the EPDS alone may fail to identify suicidality. Overall, these findings emphasize the need for comprehensive screening strategies to improve the identification and management of BD and suicidality in perinatal women to reduce adverse outcomes during this critical period.

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The Journal of Clinical Psychiatry

Supplementary Material

Article Title: Suicidality in Postpartum Women with Unipolar and Bipolar Depression: A Secondary Analysis Comparing Self-Reported and Clinician Assessments

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LIST OF SUPPLEMENTARY MATERIAL FOR THE ARTICLE

DISCLAIMER

SUPPLEMENTARY TABLES

SUPPLEMENTARY TABLE 1. Combined EPDS10 and SIGH-ADS11 Response Groups and Combined Study Categories

Study Categories	EPDS10 "The thought of harming myself has occurred to me"	SIGH-ADS11 "Have you had any thoughts that life is not worth living?"
1: No Risk	0: Never	0: Absent
2: Moderate Risk	1: Hardly Ever	1: Feels life is not worth living
3: High Risk	2: Sometimes	2: Suicidal ideation
	3: Yes, Quite often	3: Suicidal gesture
		4: Attempts at suicide

Abbreviations: EPDS10: Edinburgh Postnatal Depression Scale, Item 10; SIGH-ADS11: Structured Interview Guide for the Hamilton Depression Screening Scale Atypical Depression, Item 11

SUPPLEMENTARY TABLE 2. Highest-Risk Discordance by Diagnosis

Group	EPDS0/S=3[a] (N, %)	OR	95% CI	P-Value
Depression (n=728)	5 (0.68)	Ref	Ref	Ref
Bipolar (n=266)	6 (2.26)	3.92	1.18-13.00	<.001

[a] Highest-Risk Discordance: defined as EPDS10=0 with SIGH-ADS11=3
Abbreviations: EPDS10, Edinburgh Postnatal Depression Scale, Item 10; SIGH-ADS11, Structured Interview Guide for the Hamilton Depression Rating Scale, Item 11

SUPPLEMENTARY TABLE 3. Days Between EPDS10 & SIGH-ADS11 Assessments by Concordance and Diagnosis

Group	Concordant Days (mean, SD)	EPDS0/S>0[a] Days (mean, SD)	EPDS0/S≥2[b] Days (mean, SD)	P-Value
Depression	10.54 (7.55)	13.13 (12.89)	11.8 (9.15)	.193
Bipolar	10.22 (8.08)	9.33 (8.86)	21 (17.91)	.051

[a]Moderate Discordance: defined as EPDS10=0 with SIGH-ADS11>0; [b]Maximal Discordance: defined as EPDS10=0 with SIGH-ADS11 ≥2
Abbreviations: EPDS10, Edinburgh Postnatal Depression Scale, Item 10; SIGH-ADS11, Structured Interview Guide for the Hamilton Depression Rating Scale, Item 11