**Clinical Chats Official Podcast Transcript**

**Title:** Addressing Pregnancy-Associated Deaths: Mental Health and Suicide

**Speaker:** Nicole Tchalim, MD

**Duration:** 00:18:31

**Katherine Atcheson (**[**00:05**](https://www.rev.com/transcript-editor/shared/KfsH75XaDX_7kC9TfLGb44lk8SFFLjJOwbzX147S0VBpjjeuwrHNmoROeDHvR6ir7bJ7cPPC0W9A0abXHB7qbMFojtw?loadFrom=DocumentDeeplink&ts=5.28)**):**

Hello and welcome to Clinical Chats, a podcast for sexual and reproductive health professionals. Clinical Chats, formerly known as the Family Planning Files, is a program from the Clinical Training Center for Sexual and Reproductive Health, or CTCSRH, formerly known as the National Clinical Training Center for Family Planning, or NCTCFP, and is funded by the Office of Population Affairs in order to enhance the knowledge of Title X clinicians and other staff.

**Katherine Atcheson (**[**00:35**](https://www.rev.com/transcript-editor/shared/XnFT0oz70Wbfqdn8UG_bYdAtcRScEDUOCQMtY2O3mfe3B01O5EnAmEibadifAQAUocH0Xr8hXQdp5OnLhY3BxT6xAWo?loadFrom=DocumentDeeplink&ts=35.46)**):**

In today's podcast, part of a multi-episode series on the role of Title X clinicians and pregnancy-associated mortality in the US, we'll be discussing the intersections of mental health and sexual and reproductive health, how suicide contributes to pregnancy-associated death rates, and how Title X clinicians and other staff can address mental health in their own practices.

**Katherine Atcheson (**[**00:58**](https://www.rev.com/transcript-editor/shared/L5UNuFEKxlEkilAgYtUyASlzN00GnnDP21P_San8SqMck9UytBoCWmWa6t4LLhufgyRkuadXhys2FP87lYYg6s86ewM?loadFrom=DocumentDeeplink&ts=58.95)**):**

Our guest today is Nicole Tchalim MD. Dr. Tchalim is a reproductive psychiatrist at the Columbia University Women's Reproductive Mental Health Program, or WARM, where she provides comprehensive mental health care to women throughout their reproductive lifespan. In addition to her clinical work, Dr. Tchalim is a clinical instructor of psychiatry at Columbia University and serves as the director of the WARM Program where she provides training and supervision to training clinicians. Welcome to the podcast, Dr. Tchalim. We're so excited to

speak with you today.

**Nicole Tchalim (**[**01:34**](https://www.rev.com/transcript-editor/shared/ESJuHAXxg2nQ_P9l54ANIKlla2GieTqrm0EW_Kx534aK-SULazudbId_Fbv62Z1gHbznMU1retYZum7OmWIc2XSeUGk?loadFrom=DocumentDeeplink&ts=94.2)**):**

Thank you. I'm excited to be here.

**Katherine Atcheson (**[**01:36**](https://www.rev.com/transcript-editor/shared/BZvWEgZmfKAJ_bIH2Ohn0NMc-L5ld439Tbt5GfaOQi-_lbxl54rygdz4Rz5ygqh7OywLGjvtCghKn44uvDr5RqiEKJA?loadFrom=DocumentDeeplink&ts=96.9)**):**

To begin with, for our listeners, how common is pregnancy-associated suicide as a cause of maternal death, especially compared to other causes of pregnancy-related or pregnancy-associated death in the US?

**Nicole Tchalim (**[**01:52**](https://www.rev.com/transcript-editor/shared/NnbZI1844pEuzMmeZT6x2MEIHtcL4eEw5wO-xB33xmfpeAacr1KLexjZmLCXOhNw65Y8h8Xc3DRdLaA0DyR1q2GgRDU?loadFrom=DocumentDeeplink&ts=112.8)**):**

Suicide is a leading cause of death in the perinatal period, with rates up to 20% seen internationally. In New York State where I'm currently practicing, the recent Maternal Mortality Review Committee looked at some data from 2018 and they found that for pregnancy-related deaths, about 12% were associated with suicide, and that number increased to about 15% when the category was brought into mental health conditions. And then comparing that to some of the other leading causes of pregnancy-related deaths, for the New York State data, we saw that embolism or thrombotic events were about 21% and hemorrhage was about 20%. And so any deaths related to mental health is really one of the leading causes and was rated as number three for New York State.

**Katherine Atcheson (**[**02:34**](https://www.rev.com/transcript-editor/shared/0DTf86Okq0OI2dwafuMccOUn4_SVAclcNqYK9LY-MaKuceNkppkvwUywOXYHHq8yV5vCYmfH7O4cAGez7_-5fZVlHYo?loadFrom=DocumentDeeplink&ts=154.77)**):**

Are there any disparities in pregnancy-associated deaths by suicide such as among age groups or racial or ethnic disparities, et cetera?

**Nicole Tchalim (**[**02:45**](https://www.rev.com/transcript-editor/shared/G5eqavAbUq2K48T8fethP76DFzcxjTbKDU92QfCxDCITQZ2xmnYUej_exZqn-Q2MGdx0502ngZPOHoCOGYzBrBPGG4o?loadFrom=DocumentDeeplink&ts=165.06)**):**

Great question. There was a recent paper in JAMA on trends in maternal mortality by racial and ethnic groups in the United States, and they basically took data from various different state maternal mortality review committees, and they showed that US American Indian, Alaska Native, and Black individuals are at an increased risk for prenatal mortality. This is consistent, again, with some of that New York State 2018 MMRI data that found that Black, non-Hispanic women accounted for about 53.2% of pregnancy-related deaths despite only accounting for about 14.3% of all live births.

**Nicole Tchalim (**[**03:18**](https://www.rev.com/transcript-editor/shared/JvfOdLrFL6AzuXUbosT6fCog_5pBWvoYh-dWERgmw1i5IUOYNCzkH0usz4KblpPhBhdb-XG3YLEg6Oez8n8ta-MPwpw?loadFrom=DocumentDeeplink&ts=198.96)**):**

What's important, though, is you notice these data does not go into specific racial and ethnic differences for pregnancy-associated deaths specifically related to suicide. And this is really because, at this point, we just don't have great data on that and some of that is because of the small sample size and also a history of poor monitoring and actually being able to appropriately identify that this death was related to suicide.

**Nicole Tchalim (**[**03:39**](https://www.rev.com/transcript-editor/shared/Bpimq_tqbH9IB7KOVtuMn1i53f75pMqq1-6TbjvFNUpP-NjF7rodPRNn3njgYk2L6wDXh21wmTcxy-7zDCYYG2ppDlI?loadFrom=DocumentDeeplink&ts=219.87)**):**

Nonetheless, though, we have good data around particular risk factors that could be helpful in understanding someone's particular risk profile for pregnancy-associated suicide. So generally speaking, some of the strongest risk factors or pregnancy-associated suicide is a history of severe mental disorder after delivery. Other important risk factors include low social support, isolation, intimate partner violence, unstable housing, history of any psychiatric illness, lack of continuity of care or poor healthcare access, as well as discriminatory medical practices.

**Katherine Atcheson (**[**04:15**](https://www.rev.com/transcript-editor/shared/40vsGaMJXXEueDAWfT_z_uoZHVrj1_NuEWgXqqyfRGXpHPz8QcjjLzqmC9miybbwM1n7yzf6aBigRsMYqDr5j4lCpxY?loadFrom=DocumentDeeplink&ts=255.27)**):**

How do mental health conditions, particularly depression, that you mentioned, intersect with the peripartum continuum, that is the start of pregnancy all the way through that end of the first year postpartum, and how can these conditions interact and affect each other?

**Nicole Tchalim (**[**04:38**](https://www.rev.com/transcript-editor/shared/n_bJ_XLFJQZ3YwS3160bFp-SMTRLtqnOhicG6KbnShgCNZL5v0qlapX4uNi38Ju8F4Fj9VDVWIc0QIK5dH4-joF3HyM?loadFrom=DocumentDeeplink&ts=278.07)**):**

I'm going to introduce a new term here. It's called PMADs, or perinatal mood and anxiety disorders, and it's pretty much exactly what you're describing. The exact definition here is any onset or actually exacerbation of existing mental health conditions during pregnancy and that first year postpartum. And that part about the existing mental health is so important, because often what we do see is that, for many individuals, the psychiatric illness can actually start during pregnancy or before pregnancy. And so, we want to make sure there's more awareness, not just the postpartum period. And then, in general, the leading risk factor for developing what we consider a PMAD is having any history of psychiatric illness.

**Katherine Atcheson (**[**05:18**](https://www.rev.com/transcript-editor/shared/TbJq7CTtVBWDCrXlqhByf49HSXxJOz7LF6vQjLS7uLIzMrSJt_Eg33n5ZkvVmGET-ASuXiVeVRPeUeYchEtajPLjm0s?loadFrom=DocumentDeeplink&ts=318.96)**):**

What are some common myths around mental health and suicide, particularly as how they relate to women's health and reproductive health?

**Nicole Tchalim (**[**05:29**](https://www.rev.com/transcript-editor/shared/UwZ7srcMCmlcL1utCFk1jAM-JgVte97RA8vThfq5yzFrsbgrAeJNtSB4H_Jw8di9hIfBqfSq0xRnRKzvg5Rr33HH1D4?loadFrom=DocumentDeeplink&ts=329.61)**):**

One myth that comes to mind is that the perinatal period is protective against substance use. I link this myth to maternal suicide because per some of the recent data that we have, substance use disorder is a common factor in many pregnancy-associated deaths. Again, referring to that New York State data, about 86.5% of pregnancy-associated deaths due to mental health conditions had substance use disorder as a factor there. And so, this myth or idea really leads to some under-screening and some under-treatment of substance use disorder in pregnancy, and that's something that we can all do more on.

**Katherine Atcheson (**[**06:03**](https://www.rev.com/transcript-editor/shared/v31CbdF_3cLb6fnyhsuQy7KNG_4VHufi3uJev070TuaEce-OHEFNMrE-IGQZpSJ0cI0rIaEHginAM4DopoRlkcicKTw?loadFrom=DocumentDeeplink&ts=363.9)**):**

You touched on this very briefly in a previous question, but since Title X clinicians don't provide that prenatal or obstetric care, but they do see patients who are, before they get pregnant, maybe at risk of pregnancy or trying to get pregnant and then are in that postnatal period, what would be their role in addressing mental health and suicidal ideation with their patients?

**Nicole Tchalim (**[**06:29**](https://www.rev.com/transcript-editor/shared/9AzhFMrMUGiKP8XvVTnKZydaayWg17SuW13Vx5Z7ezLARN1hvXxNZMg2AzLlEyPHvdMjgf1lQf6-rgfyPXx-6IB-xFw?loadFrom=DocumentDeeplink&ts=389.4)**):**

Yeah, absolutely. There's so much that providers can do. I think one of the biggest ones is actually screening appropriately for mental health conditions and substance use prior to pregnancy as well and during pregnancy, of course, and then providing really relevant psychoeducation. We actually have pretty robust data out there that if you provide individuals with information on what to expect in pregnancy in the postpartum period, that in and of itself can actually be a prophylaxis against postpartum depression. There's actually this wonderful brief intervention called PREPP, or Practical Resources for Effective Postpartum Parenting, and it's a didactically oriented protocol for prevention of postpartum depression and various different individuals can do that and different types of providers. I'll also mention referring when appropriate. If you screen someone and you find that they are at a risk for any type of psychiatric illness, making sure they're connecting to the relevant providers.

**Katherine Atcheson (**[**07:21**](https://www.rev.com/transcript-editor/shared/WzhJG93OpncaS3IseP7kXf0hIGcZGXfFcRgLMGBxMSkDuYuOiJOKAU6ddB3C3ATn-LZzvcsDQQbkqwmoPpyJhoOdVbg?loadFrom=DocumentDeeplink&ts=441.12)**):**

Also, again, on that subject of screening, how often should patients in sexual and reproductive health settings be screened for mental illness and suicidal ideation? What are some of those good, validated tools to conduct that screening?

**Nicole Tchalim (**[**07:39**](https://www.rev.com/transcript-editor/shared/0cIn0kudbWCtlJvanTLXJKDUf8Jy7bj4Hv18obv3uPUmzmoVe7ViTdOxeX8Kt7pv4Kp1jjr0Gkc1YtIxxINCwk1ZJlg?loadFrom=DocumentDeeplink&ts=459)**):**

I'm a little biased as a mental health provider, and so I think you really should be trying to screen whenever possible and at every visit. And the screening can be done in various way. That can be with the provider in office or that can be a form given before. The most important thing is just to make sure that it's very clear where that information is going, and then if there is a positive screen, that there's a protocol of what happens with that positive screen.

**Nicole Tchalim (**[**08:02**](https://www.rev.com/transcript-editor/shared/ZebBIiBUFJc2XmJrhLZKXSEAFeUGdXuovSrYJxpIfVgXB6FkxvavKPAFiNdwMHLgcpfKh-l0Su3jhZAipRml-6uRh7Q?loadFrom=DocumentDeeplink&ts=482.28)**):**

But in regard to specific guidelines for screening of mental health, ACOG, or the College of Obstetricians, actually recently released new guidelines for screening and they recommend that everyone receiving well-women pregnancy, prenatal, and postpartum care be screened for depression and anxiety using some standardized validated instruments.

**Nicole Tchalim (**[**08:21**](https://www.rev.com/transcript-editor/shared/jjeamLXg3Xf8r0valG14gpJHwBovEKTM3FTREJo4yCtB3B9AdX-X0frQuHoNRx3TvXARX5E-lU_fQ2TxwHcicL4yEEw?loadFrom=DocumentDeeplink&ts=501.57)**):**

I'll just go through them briefly. For depression, there's really kind of two main ones that we use. One is the PHQ-9, or the Patient Health Questionnaire, which I imagine many of our listeners today will know what that is. It's pretty commonly used for regular kind of depression screen outside of pregnancy, but it also is validated for the perinatal period as well. The PHQ-9 is nice because it actually has many different languages that it's been validated in, and because it's already pretty common, a lot of the different online systems with things like Epic and Allscripts already has it built.

**Nicole Tchalim (**[**08:55**](https://www.rev.com/transcript-editor/shared/pV8z6g4P3-vm1ZlZ_0lHsvnsWdnXQ5GSpAAbSrK-KSKJuilYRnrBwVZJDNLrSSwPqMp06CojM8KTvei5DwagxjGO7Oo?loadFrom=DocumentDeeplink&ts=535.53)**):**

The other option is something called EDPS, or the Edinburgh Postnatal Depression Scale Tool. This one specifically designated for the perinatal period and how it's a little bit different from the PHQ-9 is that it has less questions about physical symptoms. I'm sure you can imagine most of who pregnant and postpartum are going to have some physical symptoms, so the PHQ-9 just focuses in a little bit more on some of those mental health questions. Both the PHQ-9 and the EDPS have about a score of 10 as a positive screen, and they both have questions around suicidality.

**Nicole Tchalim (**[**09:26**](https://www.rev.com/transcript-editor/shared/0oPiA3EGEmh9qo8I9Lo2DYRfF41d7ItyZ7QSASHZKjFdJ6ynrJB7HUN2a_mtb06QwPX6ZznTCg7auVMlZJN5D1hwjNs?loadFrom=DocumentDeeplink&ts=566.82)**):**

I'll mention for some of the other big ones. For anxiety, using your typical General Anxiety Disorder 7, or the GAD-7, has been shown to be validated for the perinatal period. And then the EPDS itself actually has a small anxiety subscale built in, and so you can use that as well as a little screener. Bipolar disorder is a little bit more tricky, but there are two that have been recommended by ACOG to use. One is the CIDI, or the Composite International Diagnostic Interview. It's a shorter screen with about two to three questions, so it can be pretty quickly done in an evaluation. And then there is also a longer form called the Mood Disorder Questionnaire, or the MDQ, which requires a little bit more work, and so that would likely be something that someone does as like a pre-screener before coming in.

**Nicole Tchalim (**[**10:09**](https://www.rev.com/transcript-editor/shared/1qh0XMC-UM7YEWbvak4uJRSJOma3D60vosq4Di0ceKtIYzn7Whtw-wCr9kAyzNnLHe-Os3Iegvr2SGzwygEuiMfJrjg?loadFrom=DocumentDeeplink&ts=609.15)**):**

I'll say, often people are asking me where they can find these screening tools. I usually refer people over to the Project TEACH Maternal Mental Health website. All the screening tools are there for free, including some of the different languages as well.

**Katherine Atcheson (**[**10:23**](https://www.rev.com/transcript-editor/shared/PaqFyPA1ayFepQi4zaDWAwtyBQ8lCZM05bVkBx0GHGg9ZE1j9cjAD3wcRKC_yKoLx_LnPQqUusOaM2c0wuIDi4-PRDQ?loadFrom=DocumentDeeplink&ts=623.73)**):**

Late last year, the first oral medication for postpartum depression became available in the US approved by the FDA. Could you tell us a little bit about that medication and how it works specifically for postpartum depression and why?

**Nicole Tchalim (**[**10:39**](https://www.rev.com/transcript-editor/shared/MVJRZDXgLWcqM1DrVBrQ5DJFYLaSluaBeAGOjYCR0NlSpo8WCzsccRje9e3tRdVhrhC0QVW-7bNUxG5ywvsk7xr2MXw?loadFrom=DocumentDeeplink&ts=639.42)**):**

Yeah. In order to understand zuranolone, we should talk a little bit about neuroactive steroids and particular one called allopregnanolone, which is basically a potent neurosteroid and it's a metabolite of progesterone. Allopregnanolone is believed to play an important role in perinatal depression, as you see significant fluctuation of this steroid during pregnancy. And so, naturally, if you can almost picture it with me, you see kind of a gradual increase in levels in pregnancy, which peak in the third trimester, and then after the baby is born or in the immediate postpartum period, it drops quite suddenly.

**Nicole Tchalim (**[**11:12**](https://www.rev.com/transcript-editor/shared/tifq1ZKx6l56vDWQgyZdDXEmQB4W0EcYQWDfeQ-p73uglPb-v_vlKXqEi0-4zKGc9nJMifPbATdlYpi9mx4qaEGP99s?loadFrom=DocumentDeeplink&ts=672.69)**):**

And so, in general, one of the theories of postpartum depression is that there's a dysregulation in mood that occurs through a sensitivity related to these hormonal changes in that postpartum period, and allopregnanolone in particular has been shown to regulate activity and expression of these GABAA receptors, which is important because dysfunctional GABA signaling has been linked to depression. I link it now back to zuranolone because zuranolone is actually a positive modulator of GABA receptors and it's believed to alleviate some of that GABA dysfunction that we can see during the postpartum period where we have that significant drop off of allopregnanolone.

**Nicole Tchalim (**[**11:49**](https://www.rev.com/transcript-editor/shared/GPhr7XwYNQ2-5l6yvFsNg9sKvIIpoZICih-EUl99K1dUZh4QjhXpTHUd4VhApoCyrnJ2XfNGQdAe9rT4C8yku_WBpKA?loadFrom=DocumentDeeplink&ts=709.41)**):**

I'll say, too, just to give a little bit more information on zuranolone, as you mentioned, new to the market, was just only approved in 2023, and it's quite novel in some ways, because though there are other medications that we do use for depression in the prenatal period, so there's your classical Zoloft and Lexapro, those medications can take up to 48 weeks to reach full efficacy. But zuranolone has been shown to work faster than that, and right now it's actually recommended as a 14-day oral pill regimen. It's been shown to be relatively well tolerated, with some of the most common symptoms being sedation, sweating, and dreams.

**Katherine Atcheson (**[**12:24**](https://www.rev.com/transcript-editor/shared/39IVoBluyggEh3wwsgKUxUZMnWIna5D5V1RSEwKIcZrYrzKV0nRxVLwuLMbKpbSxhGM5sSVyCS5IdRQfQEqYHQk4QI0?loadFrom=DocumentDeeplink&ts=744.36)**):**

You talked, again, a little bit about this earlier in the podcast, but what are the particular considerations that clinicians should keep in mind when they're seeing a patient who has had a mental illness such as depression or anxiety in the past that is that risk factor for developing depression in the perinatal period and how can they help support that patient?

**Nicole Tchalim (**[**12:50**](https://www.rev.com/transcript-editor/shared/81NeAONfQTbiy-fuAwKAWNO2jvzVQ24vsYmXaB80gaT_DcX4Qa5DEGlZvvMnHCwkxrJWjj1d6XMRpNAcsT_ZlayuPsM?loadFrom=DocumentDeeplink&ts=770.13)**):**

Yeah, absolutely. As I mentioned earlier, any history of psychiatric illness increases the risk of perinatal illness. So really kind of early adequate screening and monitoring is important. I'll say here too, if you get a positive screen, then thinking about what do they actually need is so important, in particular thinking about referral services. We know that the majority of individuals who actually screen positively on some of these initial screeners are given a referral sheet they don't actually follow up. And so, what I generally recommend for individuals is to kind of work and make sure that you're actually helping set up that first appointment and then doing follow up with that appointment.

**Nicole Tchalim (**[**13:29**](https://www.rev.com/transcript-editor/shared/C4u1WP9trNJdv6xnqMlFu3Ozoo08BXakX5t4zHcJsZ6zzyZq4QbQQtmKfN_HcQZhF5ZH7Qw9noO6DtF83UGennlyxRY?loadFrom=DocumentDeeplink&ts=809.13)**):**

Additionally, even just outside referring to mental health providers, there are other ways that you can think about enhancing support for these individuals. For example, we know that factors like low financial and social supports increases risk for PMADs. So, helping patients have access to support such as WIC programs, doulas, lactation consultants, support groups, or even helping them understand how to talk to their HR about parental leave can really do significant prophylaxis. In fact, there's actually some evidence, and I don't want to say some, there's a lot of evidence out there that about 12 weeks of paid parental leave has shown to decrease risk of postpartum depression. And so, helping your patients through that process can be really helpful.

**Nicole Tchalim (**[**14:12**](https://www.rev.com/transcript-editor/shared/qwLqvuG7mNr4SflCEcrJvAKUYFx8iNo90h_CvGyIAsX9mgvPL_BZADOciyYx27P4ulSlrdjgCBW_RfvhQ0Zkn1D5vic?loadFrom=DocumentDeeplink&ts=852.66)**):**

And then lastly, I'll say just psychoeducation and planning is very useful. Myself, I usually have an extended either family or support meeting with patients and their preferred support people before the baby is born, potentially before that birth, to really think through their postpartum plan, as well as just provide some general education on what PMADs are and kind of what to look for.

**Katherine Atcheson (**[**14:35**](https://www.rev.com/transcript-editor/shared/yZNO-A_gs0-5lQN7YeHFj_0H1JLZLMR2DDCC_n_PU6xuZOz8KzYMxbEWVbMDJS4NZSv3Y1tjrv16kRYLQokhZ3Uzegc?loadFrom=DocumentDeeplink&ts=875.19)**):**

Where are some good places for clinicians to go to learn more about this intersection of reproductive health, mental health, and preventing pregnancy-associated suicide?

**Nicole Tchalim (**[**14:46**](https://www.rev.com/transcript-editor/shared/lY85pTPHID1AGds3vrdGhTptYLoijdvcP9i13M0cUQlDzuj1PL2A6Frd_LUCzy50c4b3ttxxePIDcJfG8uvN399MBKA?loadFrom=DocumentDeeplink&ts=886.35)**):**

I think one of my favorites is Postpartum Support International, or PSI. They have both wonderful local resources, so you can kind of look up your own states, but also the national website is so helpful. What's nice about PSI is that it's both for patients and providers. So, patients can, themselves, go on the website and look up different treatments and providers, and then they also have free online support groups as well. And then for providers, they'll have some kind of educational information as well.

**Nicole Tchalim (**[**15:14**](https://www.rev.com/transcript-editor/shared/MPzZWCU6AzdQMafSKqTxSIwYJuKvtJLC0wR857CERbAE5HnSZnVWCVOHB4TdyAl9fbBO2qPurxwYajpPCk8gQgf_bWQ?loadFrom=DocumentDeeplink&ts=914.67)**):**

I'll also mark Project TEACH, which I had mentioned a little bit before in terms of the screening, but really what Project TEACH is it's a free consultation service for any prescriber in New York State. And basically, what happens is if you call, you'll be connected with a reproductive mental health specialist or psychiatrist within a half an hour, and you can ask any question about medications. Additionally, there's also social workers on staff, and so they can kind of help you link care to individuals as well. There are other similar resources for other states that are starting to pop up now as well. So really looking for, what we call, maternal mental health hotlines.

**Katherine Atcheson (**[**15:54**](https://www.rev.com/transcript-editor/shared/OgY4W-dNqyTmiZe5xa-RhViLkhMucTdJrnZ9bjhWYa_rnErpZV2EcOiwD1xCR__jvTUDqIrEbbNufGPnkESQT1Qkkpk?loadFrom=DocumentDeeplink&ts=954.21)**):**

This has been a really informative talk, but it is just kind of a taster. But before you go, Dr. Tchalim, if you could give your top takeaway, the one thing you would want our listeners to bring into their practice moving forward, what would that be?

**Nicole Tchalim (**[**16:12**](https://www.rev.com/transcript-editor/shared/siehqUSFFXeENojPdg6eYOQFyb3fE8HG8astGMoiIMMSJVRuhMUfNpREsdC4C5onJWO-20pKh_K3i0T8P2gFig0lOZs?loadFrom=DocumentDeeplink&ts=972.09)**):**

I think that maternal suicide is preventable, right? We can all do more to decrease the rate of this happening and just try to think a little bit more outside of the box when working with individuals to make sure that they're getting the support they need.

**Katherine Atcheson (**[**16:26**](https://www.rev.com/transcript-editor/shared/7nc23tsuLaTriD6bGPG29Cwa_epRLYi9KOh0_QTfpBcL4OPoz2LYkq_1Su096KV0eJPv2Vnv1GQCCO6T1vbprvWxyMA?loadFrom=DocumentDeeplink&ts=986.88)**):**

Well, thank you so much for joining us today, Dr. Tchalim, and for sharing your time and expertise with our listeners.

**Nicole Tchalim (**[**16:33**](https://www.rev.com/transcript-editor/shared/Q0k8b9YMnBE0mgdGK1NaefvE5hSgnm9J_lIUIIMGJLmKjGmOzfkE79FaoKbboMV8TI5sFlzh4PbU2kUa3NgfvJRoMZo?loadFrom=DocumentDeeplink&ts=993.03)**):**

Absolutely.

**Katherine Atcheson (**[**16:34**](https://www.rev.com/transcript-editor/shared/cFeRE4JRJUo6AodBU714BgeswkElmo8LvCvojureQCzJXdj5qtIlrB1fmLk-Gi0Upri23sxmV8sPnKsG5y2ZqEr3tmI?loadFrom=DocumentDeeplink&ts=994.17)**):**

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**Katherine Atcheson (**[**17:32**](https://www.rev.com/transcript-editor/shared/97XsnArMrgMVK6hoeEGVSqIjT7EYPZqu7YxIP2tIAsLXdfJyOCsI-NRr5Rn-GC0o3BPBc9e4hQVs-dYx7oGA_qS1fAA?loadFrom=DocumentDeeplink&ts=1052.4)**):**

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**Katherine Atcheson (**[**18:03**](https://www.rev.com/transcript-editor/shared/sQT3_tmA-Zmy3VuZhuTQBxOe7ZBSqjjLj3MsEszsmZR-q3DD8GOO9j-GqWKSxgOk6Ox2IvbbTgyiDXbrIQcOuc2W-Tc?loadFrom=DocumentDeeplink&ts=1083.9)**):**

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