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Attempted suicide by hanging in a pregnant adolescent with psychiatric illness: A case report

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Abstract

Cases of mental illnesses and suicide attempts while pregnant are of grave concern because they negatively affect both the mother and her fetus. Here we report a case of an 18-year-old woman, who was found at 35 weeks into her pregnancy. She was unconscious when her sister-in-law rescued her. Upon arrival, she was agitated and had respiratory distress. She went into spontaneous labor the next day and delivered a premature infant who succumbed within 24 h. She had a history of mental illness in the past and previous suicide attempts. The reason for her suicide stemmed from conflicts within her family and disagreement with her husband. Various psychosocial elements play a role in suicide risk, such as young age, having a history of mental health issues, experiencing trauma facing domestic violence, and dealing with financial stress. This underlines the need for mental health screening in the course of antenatal visits for a complete risk assessment.

Keywords

Pregnancy in adolescence, attempted suicide, hanging, fetal death, forensic psychiatry

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Introduction

Mental illness and suicidal attempts during pregnancy are significant concerns that can have severe repercussions for both a woman and her fetus. Risk factors include the use of violent methods in perinatal suicide attempts, severe postpartum mental disorders, depression and anxiety during pregnancy, and frequent consultations for psychotropic medication use.[1,2] These factors escalate the risk of suicide in pregnant and postpartum women.

Perinatal suicide is a complex issue involving various biopsychosocial risk factors. These include mood disorders, lack of sleep, pregnancy complications, extreme maternal age, stress, intimate partner violence, low education, and physical or mental illness.[1–5] Although most risk factors are non-modifiable, identifying them can help healthcare providers and researchers understand the biopsychosocial mechanisms contributing to perinatal suicide and develop more effective suicide prevention strategies.[5]

Case report

An 18-year-old primigravida at 35 weeks of gestation presented to the emergency department of a tertiary hospital after an alleged suicide attempt by hanging at about 10 am that morning. The informant was her sister-in-law, who found the patient unconscious and partially suspended by a twisted nylon rope with her feet touching the ground. The informant reported an estimated 10 min of unconsciousness prior to discovery. Early symptoms noted include tongue biting, urinary incontinence, foaming at the mouth, and drooling. The patient was initially taken to a nearby hospital where she was given a diazepam injection to subdue her violent behavior before being referred to our tertiary care center for further evaluation and management.

On arrival, the patient was anxious, agitated, and disoriented toward time, place, and person. Her Glasgow Coma Scale[6] score was 11 out of 15 and she exhibited respiratory

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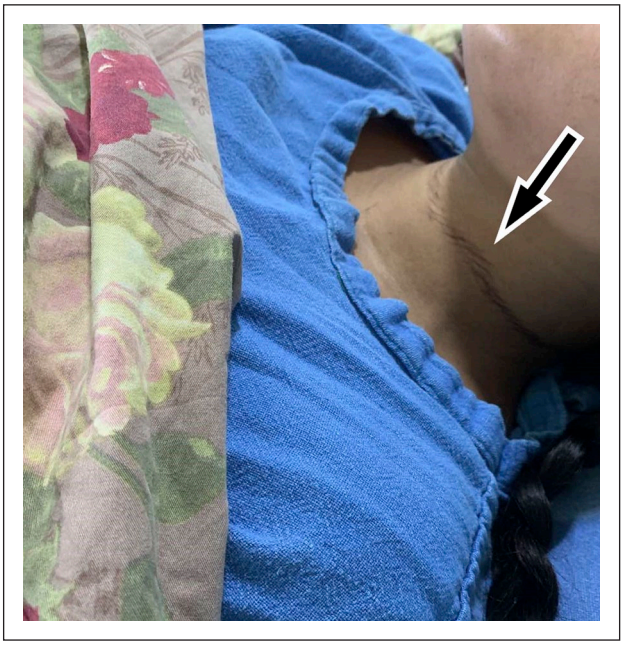

Figure 1. Patterned pressure abrasion high up in the neck directed upwards and backwards.

Figure 2. Old healed scars over the forearm and wrist suggestive of self-inflicted injuries.

distress. She was hypotensive with reactive pupils bilaterally. An obstetric examination revealed a longitudinal, distended gravid uterus measuring 32 weeks by fundal height with a longitudinal, cephalic presentation. The fetal heart rate was 162 beats per minute. Routine laboratory investigations and obstetric ultrasound were within normal limits.

The next day, the patient went into spontaneous labor. Artificial rupture of membranes was performed, and a female fetus was delivered weighing 1400 g at 35 weeks of gestation. The newborn demonstrated poor respiratory effort with subcostal retractions and nasal flaring and was admitted to the neonatal intensive care unit. However, the newborn succumbed to death in 24 h due to respiratory failure.

A medicolegal consultation was made on the third day of admission. Externally, an incomplete ligature mark was evident in the anterior neck located above the thyroid cartilage, measuring approximately 25 cm in circumference, with a patterned abrasion consistent with the described rope (Figure 1). However, the rope was not brought by the patient's side. Old healed horizontal scars from prior incised wounds were also noted on the left ventral forearm and wrist (Figure 2). During the interview, the patient reported a severe headache on the morning of the attempt. She described a history of altercations with her in-laws who she believed disliked her. She was an 11th-grade student before she married the 28-year-old man 8 months ago after meeting on social media. She stated that her husband loved her, but admitted that they had an argument the night before after he asked her to avoid spicy food due to gastritis-like symptoms. Following the argument, the husband left the house only to return in the morning. The husband confirmed this sequence of events and added that the patient had been hospitalized a year earlier due to a seizure, which required 15 days of inpatient treatment.

Psychiatric consultation confirmed a history of thought disorders, seizure disorders, headaches, dizziness, impulsivity, anger, anhedonia, and auditory hallucinations. In addition, it was revealed that she had attempted suicide multiple times in the past by hanging and slitting her wrists. She was then admitted to the psychiatry unit as an inpatient where she was closely monitored and managed with antidepressant medications. The supportive therapy from the psychiatry team showed a marked improvement in her mental health status, a reduction in suicidal ideation, and control of symptoms such as auditory hallucinations and impulsive behavior. The patient was in stable condition, was compos mentis, and was discharged on day 8, with advice for outpatient follow-up in 2 weeks. However, the patient has not followed up for the past 6 months. Written informed consent was obtained from the patient prior to handing in the discharge papers.

Discussion

Several psychosocial factors significantly impact the risk of suicide during pregnancy, including younger age, unmarried status, personal or family psychiatric history, and prior suicidal behavior.[2] Other contributors include childhood trauma, physical or mental illness, and intimate partner violence which are also associated with heightened perinatal suicidal risk.[4,5] Socioeconomic factors, such as family conflict, low

education, and financial stress, also contribute to the risk of perinatal suicide.[2,4]

Comprehensive assessment of suicide risk in pregnancy requires evaluating psychiatric disorders, psychosocial factors, trauma history, intimate partner violence, and socioeconomic stressors using a multidimensional approach.[1,2,4,5] This helps identify those at higher risk and guide appropriate support and interventions.

In resource-limited settings, barriers to the management of perinatal suicidality include limited mental health services, lack of awareness and stigma, inadequate training of healthcare workers, poor follow-up, and socioeconomic factors.[3,7–9] Stigma hinders the identification and management of at-risk individuals.[7,8] Underdiagnosis or misdiagnosis can occur due to limited provider training. Follow-up and support may be inadequate.[7] Addressing socioeconomic factors through poverty reduction, social support programs, and education initiatives may help prevent perinatal suicidal behavior.[3,7]

Depression and anxiety are common disorders in perinatal women.[10] Early detection and treatment can mitigate the severity of symptoms.[11] Screening for common mental health disorders during pregnancy can improve maternal mental health and fetal outcomes.[12] A complete assessment of mood and emotional well-being should be included in preconceptional, antenatal, and postnatal visits.[10]

Mental health screening faces challenges due to limited access, shortage of professionals, and stigma surrounding perinatal mental health issues.[10] Lack of awareness and understanding can hinder identification and management, while limited resources and training for healthcare providers can lead to underdiagnosis or misdiagnosis of at-risk individuals.[10–12]

Healthcare workers should identify women with risk factors for mental health problems and be familiar with relevant screening tools.[10] Integrating screening for common mental disorders into primary care and maternal and child health services offers benefits like holistic care, increased accessibility, reduced stigma, and reduced costs.[12]

After a suicide, care is largely driven by the community: patients often stop taking medications and drop out of treatment and follow-up once they leave the hospital.[13] Follow-up care is critical to evaluate patient progress and the effectiveness of the treatment.[13] There is a stigma surrounding mental health in Nepal and the patient may not follow up due to the fear of judgment and societal disapproval.[14] In addition, logistical hurdles such as transportation and treatment costs may also act as barriers to follow-up care.[14] Although this is a common misconception, attempted suicide under Nepali law is not a punishable offense, while abatement of suicide is. Healthcare systems can improve follow-up rates by destigmatizing, offering telehealth options, and providing patient privacy.[13,15] Creating safe spaces for them, recourses within the community to help with transportation and reframing follow-up appointments as a road toward recovery are all key to getting these high-risk individuals, the care that they need.[13,15]

This is a unique case that illustrates a critical interplay of mental illness, psychosocial factors, and adverse fetal outcomes in an adolescent pregnant woman who attempted suicide. This requires a multidisciplinary approach involving specialties such as otorhinolaryngology, obstetrics/gynecology, forensic medicine, and psychiatry. There is a need for comprehensive risk assessment in such a woman with consideration of psychiatric disorders, psychosocial factors, trauma history, and socioeconomic stressors. Recommended strategies for preventing future suicide attempts in patients with similar risk factors include ongoing psychiatric care, safety planning, family education, and regular mental health check-ups during and after pregnancy. Challenges in the management of perinatal suicidality in resource-limited settings include mental health services, stigma, inadequate training, and poor follow-up. The case aims to raise awareness about perinatal suicidality and the need for improved screening, support, and intervention strategies to improve both maternal and fetal outcomes.

This case report has a limitation, that is, it is heavily based on the patient's history, which may be influenced by recall bias. It is important to acknowledge that the details shared by the patient may be incomplete or inaccurate. Since there was no access to the patient's pastmedical records on mental health treatments, there was limited information available on her history of mental illness diagnoses, prescribed medications, and treatment. This limitation hinders our ability to offer a psychiatric overview. Follow-up was limited to the initial inpatient psychiatric admission. Long-term psychiatric outcomes and adherence to treatment for the patient are unknown. Being a single case report, these findings may not be generalizable to broader populations of pregnant women with suicidal ideation or attempts.

Conclusions

This case report highlights the complex interaction between mental illness in suicidal pregnant adolescent women, psychosocial factors, and adverse fetal outcomes. It stresses the importance of addressing perinatal suicide which can have a devastating effect on both the mother and the fetus. A multidisciplinary approach including specialties such as otorhinolaryngology, obstetrics and gynecology, psychiatry, and forensic medicine is essential for the holistic management of such cases. The risk assessment should be carried out by considering the past medical history, especially mental illness, psychosocial stressors, history of trauma/abuse, and socioeconomic factors. However, some challenges hinder access to mental health care services, such as limited availability, social stigma related to mental illness, inadequate providers, untrained providers, limited resources, and discontinuation of treatment and follow-up. In addition to addressing these challenges, the risk of perinatal suicide might be reduced by

regular antenatal checkups. It could serve for both mental health screening and also to help with a prompt risk assessment and intervention. Running public campaigns is another measure to alleviate the stigmatization associated with mental illness. Perinatal suicidality is a public health issue that interwinds the complex interaction of physical health, mental health, and psychosocial factors requiring a multi-faceted strategy.

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Author's contribution

A.A. Conceptualization, Data curation, Investigation, Supervision, Visualization, Writing – original draft, Writing – review & editing; S.C.: Data curation, Writing- original draft; B.S.: Data curation, Writing – original draft; A.A.: Data curation, Writing – original draft; D.S.: Data curation, Investigation, Validation, Writing – review & editing; B.A.: Data curation, Investigation, Validation, Writing – review & editing.

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Ethics approval

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Informed consent

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