The Suicidal Pregnant Patient: Crisis Management

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Objectives:

1) Consider risk factors for suicide unique to the perinatal period.

2) Review barriers to performing a suicide risk assessment in a non-psychiatric setting.

3) Demonstrate how to manage suicidal ideation in a pregnant or postpartum patient.

Definitions:

Fortunately, suicide remains a rare event but this also means it is particularly difficult to study

- Suicidal Ideation (SI) :
  - The wish to die
  - Thoughts* of killing oneself
  - The intent to kill oneself
- Suicide Attempts
- Suicide Completions
- Peripartum Period (conception, pregnancy, 12 months postpartum)

Orsolini 2016

Mood Disorders in Peripartum Patient

- Peripartum period → increased vulnerability to depression and mood disorders (Anxiety, Bipolar disorders)
- 10-15% of newly delivered women experience Major Depressive Episode (MDE)
- 50% with of women **previous mood disorder** will have recurrent symptoms in pregnancy or postpartum
- As high as 70% if previous mood disorder + **family history of post-partum psychosis**

  → Maintaining medications for MDD/BPAD does prevent recurrence

Orsolini 2016, Stevens 2019

Risk factors for Suicide in Peripartum Patient

- Suicide attempts and suicide completions occur at a LOWER rate in peripartum women compared to general population.
- Estimated prevalence of suicidal ideation (SI) in peripartum women is 5-14%
- Suicide attempts most strongly correlate to presence of major mood disorder (depression, bipolar disorder, postpartum psychosis)
- **Single most important risk factor: history of previous Suicide Attempt**
- Suicide attempts most frequent in 1st and 12th month postpartum

Orsolini 2016

Risk Factors for Suicide in Peripartum Patient

- Younger age
- Single / lack partner support
- Unplanned or unwanted pregnancy
- Nulliparity
- History of psychiatric disorders
- History of post-partum psychiatric hospitalization
- Family history of psychiatric disorders or suicide attempts
- Domestic Violence
- Lower education
- Current mood episode
- Anhedonia
- Hopelessness
- Psychosis
- Suicidal Ideation
- Suicidal Intent or Plan
- Recent suicide attempt
- Abrupt cessation of psychiatric medications
- Access to lethal means

Orsolini, Shea

But there are many barriers…

SUICIDE: It's just difficult to talk about

Leakage Myth: If they were really suicidal they would tell me

Fact: Suicide is often kept SECRET.

→ Few topics are more shame producing or conversationally taboo than the topic of suicide

Patients may:

- **Feel ashamed**
- **Feel that suicide is immoral or sinful**
- **Fear being crazy or even being locked up**
- **Be determined to die**
- **Feel hopeless that nobody can help them**

"The clinician's ability to calmly and matter-of-factly explore suicidal thought often provides a platform in which the patient's long endured silence about suicide can be broken"

Shawn Shea, The Practical Art of Suicide Assessment

Most patients will be honest if you ask them directly

Often persons with suicidal thoughts will only hint at how they're really feeling but will usually tell their physician if asked directly.

Vannoy et al. 2010; Murphy 1975

- Create a setting where patients can feel comfortable sharing their secrets
- Consider your body language
- Ask questions in a calm, direct manner
- May need to give them permission to talk to you about suicidal thoughts.

Vannoy et al 2011

Other Barriers…

"There's a reason I didn't go into psychiatry..."

"I'm no mental health expert… I don't know what to ask…"

SUICIDE RISK ASSESSMENT: Worth the Time

- Inquiring about suicide will take time and thoughtfulness.
- Appearing unhurried will help patients to be more forthcoming which will inevitably save you time. Vannoy et al. 2011

"Take your time. I know it is difficult to talk about this but I really want to sort out what you are feeling…"

Normalizing the Topic of SUICIDE

It's not uncommon that during pregnancy women can experience a wide range of emotions from fear to anger to guilt to anxiety and depression. Sometimes anxiety and depression can be so severe, women feel trapped, hopeless and can even consider suicide as a way out of their suffering. I want you to know that you can share those thoughts/feelings with me.

Would you say that you feel hopeless? Like there's no meaning in life?

Should I be worried about your safety?

Are you someone who's ever struggled with severe depression or anxiety in the past? Have you ever worked with a psychiatrist therapist and, if so, has that been helpful?

Normalizing the Topic of SUICIDE

If at some point you do have mental health symptoms that are continuing to get worse (severe anxiety, not eating/sleeping, not getting out of bed/not functioning, feeling very hopeless, having suicidal thoughts, etc), I may want to refer you to talk with either our social worker here in OB/GYN or even one of our psychiatric doctors or nurses for a consultation.

How would you feel about talking with someone from our mental health team about your symptoms of … or do you think you'd be more interested in talking with your family, friends, spiritual community or a support group?

If you'd like I can even refer you to our Social worker to at least get some information about resources in the community and then we'll continue to check in…. ok?

Clarifying Suicidal Ideation

- Use clear wording:
  - "Have you had thoughts about killing yourself?"
  - "Do you wish you were dead?"
  - "Have you thought of taking your life?"
  - "Have you thought of how you might do it?
- Be specific:
  - "How far have you gotten in your planning?"
  - "How close have you come"
  - "Would you say you feel hopeless?"
  - ***Should I be worried about your safety?***

Clarifying Suicidal Ideation

"Gaining access to a client's concrete suicidal planning provides the most reliable data for a sound suicide assessment."

Shawn Shea, The Practical Art of Suicide Assessment

- Consider Mitigating (Protective) Factors:
  - Ability to make future plans for dealing with their acute stressors
  - Available supports
  - Strong religious beliefs against suicide
  - Access to immediate mental health care
  - Removal of access to lethal means

- If possible… get collateral information

Documenting the Suicide Risk Assessment

1) Risk Factors (Modifiable vs Nonmodifiable)
2) Protective Factors
3) Level of anhedonia, hopelessness
4) Suicidal intent AND extent of suicidal planning
5) Your Clinical Decision Making (High vs Low Risk) and PLAN
6) Address removal of lethal means (guns)
7) Inform collateral supports (including other physicians)

Higher Risk Patients

- Multiple Risk Factors with few protective factors
- Very Hopeless, Anhedonic
- Triad of lethality: recent severe suicide attempt, acutely psychotic, active plan with intent

→ Main Campus: Call security and Refer to ED

→ Satellite Campus: Call 911

→ Complete a Pink Slip (Application for Emergency Admission)

Lower Risk Patients

- Risk factors + Protective factors
- No active suicidal intent NOR plans
- Not psychotic, not hopeless, not anhedonic

→ Schedule regular follow up appointments or phone call check-in
  - Ask more questions at next appointment
  - Obtain collateral and involve family/supports

→ Offer psychiatric referral:
  - Psychiatry Walk-In Clinic
  - Community Mental Health Centers
  - Mobile Crisis Line (Cuyahoga Co.): 216-623-6888
  - Emergency resources for patient (Talk Lines): 1-800-273-TALK

Summary

- The pregnant patient may be especially vulnerable to mood changes including depression, anxiety, and suicidal ideation.
- Younger unmarried women with low education and personal or family history of psychiatric disorders, especially in the peripartum period, are likely to be at greatest risk.
- The most importance predictor of a future suicide attempt is a previous suicide attempt.
- Other key risk factors for suicide include hopelessness, anhedonia, presence of psychosis, abrupt cessation of psychiatric medications, and access to lethal means.

Summary

- Most patients will be honest about suicidal ideation if asked directly.
- Understanding the degree of suicide intent and extent of planning can help clinicians BEST predict future suicidal behavior.
- Appropriate documentation of a suicide risk assessment includes risk factors, protective factors, degree of hopelessness, suicidal intent and planning as well as clinical decision making and plan.
- High Risk patients should be referred for emergent psychiatric evaluation.
- Lower risk patients should be followed closely and engaged in non-emergent psychiatric services.

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