Attempted "Suicide by Police" by a Patient With Bipolar I Disorder and PTSD on Paroxetine Monotherapy

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Bipolar disorder affects approximately 50 million individuals worldwide[1] and is associated with a significant burden of disability, with a high rate of delayed or misdiagnosis and low rates of appropriate treatment.[2,3] Among those diagnosed with bipolar disorder, the risk of attempting suicide is 31.1%,[4] and attempts are most likely during mixed episodes.[5] Up to 55% of individuals with posttraumatic stress disorder (PTSD) are also diagnosed with bipolar disorder. These individuals experience overall greater symptomatic burden and diminished quality of life compared to those diagnosed with either disorder alone.[6]

We report the case of a patient with bipolar I disorder and PTSD who experienced an unfavorable outcome following abrupt discontinuation of mood stabilizers and the introduction of an unopposed selective serotonin reuptake inhibitor (SSRI). Use of an SSRI is an appropriate treatment for PTSD alone but relatively contraindicated as monotherapy in individuals with bipolar disorder,[7] as serotonergic antidepressants are implicated in manic switch and poorer course of illness in a significant proportion of these patients.[8] The case demonstrates the risks of abrupt medication changes in complex psychiatric patients such as may occur during a change in providers without sufficient handoff or review of the patient's diagnostic and treatment history.

Case Report

A 52-year-old White man with bipolar I disorder and PTSD presented to the emergency department in a mixed mood episode with extensive injuries inflicted by police canines after attempting suicide by police. The patient's first depressive episode occurred at age 8 years. He first presented to outpatient psychiatric care at age 14 years after he was abducted and held by a pedophile for a period of months, an experience that resulted in a diagnosis of PTSD. In subsequent years, the patient and his providers largely attributed his psychiatric symptoms to PTSD, and he was treated with multiple SSRIs and prazosin, with minimal therapeutic effect.

After graduating high school, the patient joined the Navy SEALs, during which time he disengaged from psychiatric care and attempted to suppress his symptoms, despite frequent depressive and dissociative episodes and repeated traumatic experiences in the line of duty. He was ultimately diagnosed with bipolar I disorder in the context of a manic episode with psychotic features. He was then started on a combination of mood stabilizers, benzodiazepines, and SSRIs and underwent electroconvulsive therapy (ECT), all with minimal therapeutic effect.

The patient was psychiatrically hospitalized more than 20 times, primarily for depressive and mixed episodes with suicidal ideation or suicide attempts. His suicide attempts were highly lethal, including an overdose on alcohol, lithium, and benzodiazepines and an aborted attempt by gunshot to the head.

The patient's most recent prior severe mood episode occurred in 2011, when he ran out of medications and experienced a mixed mood episode leading to a suicide attempt by overdose. After this episode, he was well-maintained on risperidone, lithium, and gabapentin for 9 years, with no mood episodes necessitating hospitalization.

In 2019, the patient switched psychiatric providers. His new provider discontinued gabapentin, citing its potential for abuse. The patient stated that he then became increasingly depressed and reported this to his provider, who responded by discontinuing lithium and risperidone and initiating treatment with paroxetine.

After this medication change, the patient's depression continued to worsen, and he began to experience more frequent and longer dissociative episodes. He described the sensation of dissociation as being disconnected and confused, as though underwater, stating, "You bob up for a second for air, and then you're back under the water, where there's nothing." To compensate, the patient turned to alcohol. Both he and his wife reported that they repeatedly contacted his providers to convey their discontent with the medication regimen. In response, the psychiatric provider increased the dose of paroxetine.

The patient reported that as the paroxetine dose was increased, he became increasingly agitated, sleeping less, then not at all. He developed the delusional belief that he had to die for his and his wife's souls to be saved but

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that the sin of direct suicide would damn him, requiring that he die at the hand of another person. In the pursuit of this outcome, the patient told his wife to leave the house, retrieved a firearm, called 911, and instructed the police to kill him. His wife simultaneously called the police to inform them of her husband's mental health crisis. When the police arrived, they attempted to persuade the patient to emerge for evaluation. The patient then fired his weapon into a wall, hoping to make enough noise for them to come in and kill him. The police responded by battering down the door to his home and inserting tear gas.

The patient reported that he was completely dissociated and could not feel the injuries he sustained from police actions. He reported that the smell of tear gas woke him up enough to realize that he was making a mistake, at which point he attempted to surrender, but canines had already been released. The patient recalled seeing a police dog bite his arm, but he felt no associated pain or sensations despite a limb-threatening injury.

After his arrest, the patient was taken to the hospital, where our psychiatric team evaluated him in the emergency department. The patient had not slept in at least 1 week and had been engaged in bizarre goal-directed activity, including spontaneously removing the doors and roof from his vehicle, with concurrent low mood and suicidal ideation. We diagnosed an acute depressive mixed episode. We tapered paroxetine to discontinuation, then initiated lithium and quetiapine for management of his bipolar I disorder, yielding swift symptomatic improvement.

Upon medical clearance, the patient was taken to jail, where quetiapine was discontinued and paroxetine restarted, provoking symptomatic recrudescence. The patient was returned to inpatient psychiatric care and was stabilized on lithium, olanzapine, and venlafaxine. He now faces several felony charges related to his attempted suicide by police and likely will remain permanently disabled due to the significant functional loss of his arm.

Discussion

Suboptimal transfer of care, combined with a possible misunderstanding of the patient's illness, contributed to the irrevocable alteration of the patient's life. Studies[7–10] indicate that the use of antidepressants in patients with bipolar disorder is risky and likely ineffective at best; at worst, antidepressants can increase symptom burden and induce rapid cycling or mania. In a study[11] of 1,500 patients with bipolar disorder, individuals placed on antidepressants were 10 times more likely to develop a chronic irritable dysphoria, worsening patient function and quality of life.

The practice of prescribing long-term antidepressants to patients with bipolar disorder remains common,[12,13] despite evidence that their use should be limited to a subset of bipolar patients and remain largely short-term.[13,14] Current guidelines accommodate the use of SSRIs in bipolar patients only in conjunction with a mood stabilizer and not as monotherapy.[15]

In this case, it is possible that the patient's new provider prescribed SSRI monotherapy to manage his primarily depressive bipolar symptomatology alongside his posttraumatic symptoms. It is equally possible that this provider was unaware that the patient carried a diagnosis of bipolar I disorder. This underscores the importance of screening all patients with depressive symptoms for a history of manic symptoms. Careful screening for hard or soft signs of bipolarity increases the likelihood of accurate diagnosis and suitable treatment.

The patient's reported symptoms of agitation and worsening depression on paroxetine monotherapy may have represented an emerging mixed state. This report of symptoms did not result in a change of medication, and the patient felt that his experiences and preferences were not prioritized in the development of his treatment plan.

This patient's case serves as a warning and a reminder to providers to pursue collateral information and perform a careful history on all patients new to their practice. They should take into account the patient's experiences to formulate a comprehensive differential diagnosis. It is imperative to consider all aspects of a patient's psychiatric picture and clinical presentation when choosing a treatment course and stay abreast of the latest guidelines on the treatment of psychiatric disorders. Although adverse outcomes and errors are sometimes unavoidable, the greatest diligence should be employed to protect our patients and support their well-being.

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