Multiple Violent Suicide Attempts in a Not So Depressed, Not So Psychotic Patient: A Diagnostic Challenge

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Violent suicide is generally defined by method. Strangulation, firearm or deep blade wounds, fall from significant heights, or vehicle collision are examples of violent suicidal behavior, as opposed to medication or substance poisoning, which are usually regarded as nonviolent.[1] The multitude of comorbid conditions, personality traits, and psychosocial factors motivating suicide may pose diagnostic and management challenges. We present the case of a middle aged African-Portuguese man admitted to the inpatient psychiatry unit after attempting suicide by repeatedly stabbing himself in the neck and abdomen.

Case Report

A 50-year-old man presented to the emergency department (ED) displaying multiple self-inflicted penetrating wounds in his neck and abdomen and a kitchen knife lodged within cervical muscular tissues and tendons. Radiologic study identified an internal jugular vein lesion (Figure 1), prompting urgent intervention by vascular and plastic reconstructive surgery. After stabilization, a psychiatric evaluation was conducted.

The patient's history revealed a depressive syndrome for the last 2 months, which he associated with financial struggles. He described this event as unpremeditated, unrelated with any trigger or stressor event, and unpreceded by alcohol or substance intake, yet with a clear suicidal intention. We found 2 previous attempts: jumping out of a window of his fourth floor flat 5 years ago, from which physical sequelae limited his ability to work and forced him into early retirement and subsequent financial hardship, and deliberate benzodiazepine intoxication 2 years ago. He denied chronic suicidal ideation, instead referring to a "momentary urge to do it."

The history also revealed brief self-limited psychotic experiences (hallucinatory commanding voices saying, "do it, do it, do it" and calling his name) that he had experienced intermittently for 7 years but that were not present during our assessment or during the current suicidal behavior. The patient's wife confirmed a history of heavy drinking for 25 years, which he disregarded, and transient persecutory and infidelity delusions associated with periods of increased alcohol consumption.

However, he had received no prior psychiatric or addiction treatment. There was no family history of psychiatric illness or suicide, and he reported no adverse childhood experiences or adulthood trauma. On admission, a full workup including laboratory evaluation, cerebral magnetic resonance imaging, and the Montreal Cognitive Assessment (MoCA)[2] revealed no pathological findings.

A dual diagnosis of major depressive episode of moderate severity (*ICD-10* code F32.1) and alcohol-induced psychosis (*ICD-10* code F10.259) was proposed. Despite impulsivity manifestations, diagnostic criteria for personality disorder, attention-deficit/hyperactivity disorder, and impulse control disorders were not met.

Treatment with sertraline and lorazepam and psychotherapy interventions to gain insight into his substance abuse and motivation for avoidance produced significant clinical improvement. He maintained clinical remission and alcohol abstinence at discharge and follow-up.

Discussion

In this case, depressive and psychotic symptoms were not sustained or severe enough to fulfill criteria for a severe depressive episode with psychotic characteristics or a primary psychotic disorder, while the robust association between psychopathology and alcohol intake indicated an evolving dual diagnosis. Furthermore, all his suicide attempts were carried out with various methods and levels of lethality and violence, suggesting an association with impulsivity and low tolerance to frustration traits, but also an important role of access to different means.

Recognition of violent attempts as a poor prognosis factor is well established.[3] Numerous factors such as male sex, history of mental illness,[4–6] substance abuse,[7,8] and impulsivity and aggressiveness traits,[9] but also genetic polymorphisms,[10,11] altered serotoninergic neurotransmission,[1] and metabolic syndrome[1,12] appear to be correlated with violent suicide attempts. In the interest of prevention, expanding and translating this knowledge into clinical guidelines and public health interventions is paramount for an evidence-based approach to suicidality.

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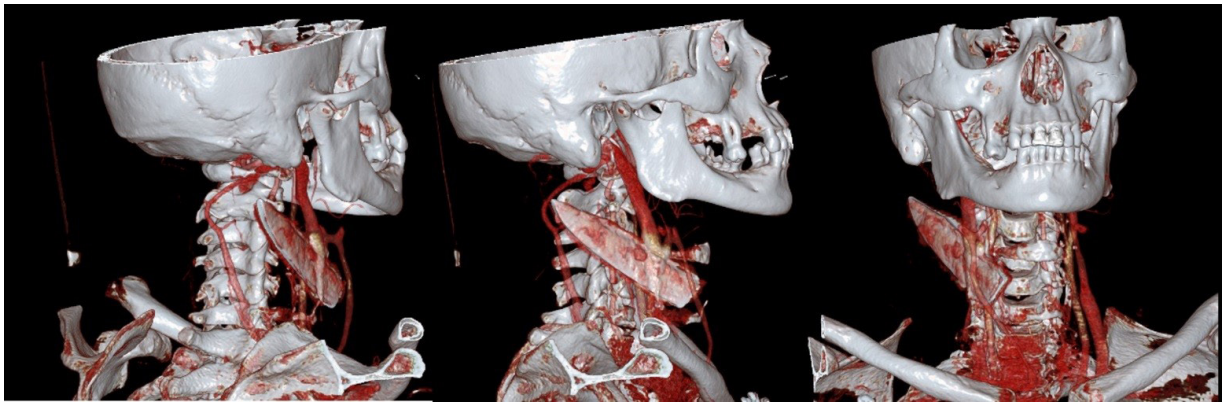
Figure 1. Computed Tomography Scan 3-Dimensional Rendering at Admission to the Emergency Department



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