Case Report

Suicide Attempt without a Mental Health Diagnosis

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Abstract

Introduction: Suicide in people without a mental health diagnosis pose a clinical challenge that is still poorly understood by psychiatrists, generating the debate between respecting the patient's autonomy right or supporting involuntary admissions after a lethal gesture to rule out psychopathology.

Aims and Methods: The authors take a case of an 81-year-old man without mental health history who, after his first suicide attempt by ingesting floor cleaners, presented acute kidney failure that required to initiate haemodialysis to preserve his life. Despite being aware of the fatal outcome in case of rejecting it, he denied the dialysis and verbalize the persistence of suicide ideation. This publication complies with the agreements of the Declaration of Helsinki and the informed consent was obtained from his wife.

Results: It was finally considered that the patient maintained his capacity for judgment and no involuntary measures were taken, with family consent. Finally, he passed away ten days after carrying out the suicide attempt.

Discussion: He was evaluated up to three times by mental health professionals and, after deciding that he had preserved judgment, his decision was respected. The patient passed away ten days later.

Conclusions: This approach could help psychiatrics better understand suicide behaviour in cases we don't make a mental health diagnosis.

Keywords

suicide completed; suicide awareness; personal autonomy; psychopathol; situational ethics

Introduction

Since June 2021, euthanasia and physician-assisted suicide (EAS) has been regulated in Spain by the Organic Law Regulating Euthanasia (LORE) and most healthcare professionals support its existence but the majority of them do not meet the criteria for a patient to apply EAS. Among its requirements are: being over 18 years, capable and conscious at the time of requesting and suffering from a serious, incurable and chronic illness or disabling condition, understood as limitations that directly affect the autonomy and activities of daily living and associated with psychical or psychological suffer [1].

This term of disability is likely to involve doubts on doctors when they have to urgently evaluate a patient that ask for EAS, considering that previous literature found similar profiles between patients who requested it and psychiatric patients who commit suicide [2,3]. Moreover, studies support that 40% of suicide patients had no previous psychiatric condition and 37% of suicides had no axis I diagnosis [4–6].

In general terms, this law regulation is socially presented as an aid for patients in terminal phase of life, but it could present another risk factor for those psychiatric patients not previously diagnosed of depression who request EAS in a hospital emergency service, even more if they request it after a suicide attempt.

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In any case and pertaining to mental health realm, disabled patients must be evaluated by a psychiatrist after a suicide attempt, but this can suppose an ethical dilemma based on ethical and cultural biases of doctors between a disabling condition who fulfilled criteria for EAS and protecting a patient with a non filiated psychiatric diagnosis [3,7,8].

Material and Methods

We present the case of an 81-year-old patient who was taken by his wife to the emergency service of a Spanish Province Hospital on March 2024, after his first suicide attempt by ingesting floor cleaners the day before.

Medical History

As relevant medical history, he was diagnosed of Non-Hodgkin Lymphoma (NHL) on 2012, requiring his first hospital admission and starting chemotherapy. He completed seven cycles of chemotherapy in the following months with good response and no recurrence of disease was notified until today. Another point to highlight was glaucoma with no warning signs but starting signs of blindness, chronic constipation as a side effect of chemotherapy and low risk basal cell carcinoma diagnosed on 2023.

At mental health level, he was evaluated by psychologist during his chemotherapy treatment at the age of 69 as part of hospital's protocol for oncological treatment, and no acute psychopathology was notified. He did not have suicidal history or previous psychiatric records and he was not under psychopharmacological treatment.

History of Present Illness

Two hours after the initial clinical evaluation by emergency physicians (EP), mental health specialist came to evaluate the patient's self-harm ideation during his stay in emergency unit. On this first interview, the patient explained that he had noticed progressive physical worsening in recent years, mainly abdominal pain due to constipation secondary to oncological treatment and visual limitation due to glaucoma. In this context, he pointed out poor quality of life and progressive home isolation, low mood, clinophilia and ruminations of negative content, which had been worsening over the last six months.

Within this framework, he explained that he decided to stop attending check-ups three months ago and his Primary Care Physician (PCP) tried to introduce antidepressant treatment with sertraline in November 2023, but the patient abandoned it before completing four weeks of treatment due to worsening constipation.

Now, on March 2024 and after his first suicide attempt, he pointed out the persistence of autolytic ideation, explaining that his quality of life was not what was expected and he would try to end his life another way until he succeeded.

In the current interview with patient's family, his wife explained that he had always been a negative person, who made self-harm threats but had never tried to kill himself before. She denied any apparent triggers for emotional distress in recent months.

As a first conclusion, the initial psychiatric evaluation revealed a possible depression not previously identified, in a patient who maintained a discourse around self-harming ideation, without criticism of the previous gesture. It was decided to transfer the patient to the Psychiatry Unit to maintain observation and reevaluate the ideation in the following hours.

Nevertheless, in the following six hours and before transferring the patient, he came into acute renal failure due to the floor cleaner's ingestion. Emergency haemodialysis was considered as the first option but the patient denied any treatment. Despite explaining in several occasions the fatal outcome, the patient refused to start the process and maintained his desire to die.

Current Dilemma

With the patient's refusal to be treated and the possible interference of depression in the decision-making capacity, EP contacted again with Mental Health Service twelve hours after the suicide attempt. A second psychiatrist who was on call had doubts about respecting the patient's autonomy right or supporting involuntary. When having doubts about the background described previously and the possibility of apply EAS, it was finally decided to contact the judge on duty.

The judge agreed that the patient had impaired judgment, in context of a previously unrelated depression, and determined that another person should make the decision for him. From the court it was stated that it should be his wife that decided in the following hours.

Finally, the patient's wife decided to respect the patient's decision and haemodialysis was not performed, with progressive worsening of kidney function on the next four days.

In subsequent evaluations by the mental health team on the third and fifth days after the gesture, the patient maintained the same speech around this functional limitation and progressive loss of quality after chemotherapy. Different mental health professionals came to evaluate him with no signs of depression that could interfere with the patient's judgment.

Results

It was considered in order to previous and subsequent mental evaluations that he maintained his capacity for judgment and no involuntary measures were taken, with family consent. Finally, the patient passed away ten days after carrying out the suicide attempt, without requiring psychopharmacological medication.

Discussion

Spain has recently been added to the group of European Union countries that consider euthanasia as a way to improve quality for those patients with severe and incurable disease associated with intense physical or mental suffering. According to national records, approximately 350 people per year request to start the euthanasia process and the most common physical profile of applicants is neurological and oncological patients between 60 and 80 years old. While the majority of them have full capacity to act and decide, records point that around 15% of them are at imminent risk of losing this capacity and 30% of them die before EAS is resolved [7–9].

Anyway, this is complex issue for psychiatrics, both ethically and professionally, considering this regulation as a double-edged sword by opening the door to those patients without a history of mental health who commit suicide for the first time. It must be taken into account that mental disorders, especially depression, are very prevalent and its incidence increases with age, reaching a suicide peak over 80 years. In elderly people, affective symptoms can present in a more latent and insidious way and normally have greater cognitive and behavioural effects [2,5,10].

Affective disorder can greatly affect the quality of life and are often resistant to treatment, and suicide associated with mental disorders is one of the main causes of death in elderly people. What's more, a relevant percentage of suicides do not have previous contact recorded in public health networks, which could mask psychopathology that interferes with the judgment capacity of those requesting a euthanasia process [3,4,11].

Chronic feelings of desperation and impotence are both included into psychological distress which can share both profiles of mental and no mental health patients that apply to EAS. Sometimes, being calm and conscious and maintaining suicidal ideation, without a Mental Health service being able to make an axis I diagnosis, represents an ethical dilemma when it comes to avoiding self-harm of the patient against his will. Is not uncommon that EP needs to contact with the judge on duty to make a decision.

Despite not having a history of mental health, suicide and self-harming gestures must be taken into consideration and psychopathology behind the gesture must be ruled out by a psychiatric emergency and liaison consultation services due to the fact that almost 50% of patients with depression refuse treatment and have cognitive impairments in taking decisions, based on short-term rewards and leading to riskier decisions.

More studies are necessary to identify the mechanisms, sociodemographic profile, and ethically optimal resolution of self-harm attempts in patients without a mental health diagnosis, but prior to approving the EAS request of a patient, in order to protect non-diagnosticated psychiatric patients, it should be firstly considered psychotherapy and treatments with analgesic properties as a solution to psychological distress [5,10,12].

Once the psychological stress has been reduced, it would be the optimal time to reassess whether the patient understands the risks and benefits of starting a euthanasia process, both in the short and medium term, to avoid interference from possible acute suffering in making decisions [4–6].

Conclusions

Suicide attempts in patients without a mental health diagnosis are a reality that, given the diagnostic and therapeutic difficulties they pose, must be taken into account in clinical practice, especially in psychiatric emergency and liaison consultation services.

Availability of Data and Materials

Not applicable.

Author Contributions

AJM and MIO contributed to conception and design of the case. AJM performed the research and studied the

relation between an autolytic attempt and EAS. MIO provided relevant information about the psychopathology behind suicide. Both authors contributed to editorial changes in the manuscript. Both authors read and approved the final manuscript. Both authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

As an observational clinical case (n = 1), no evaluation was requested by the institutional ethics committee, although this work complies with the agreements of the Declaration of Helsinki. This is a unique and isolated case, so informed consent was obtained from the patient's family, highlighting that today the data is completely anonymized, making it impossible to identify the patient, preserving the privacy of both the patient and the family.

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Conflict of Interest

The authors declare no conflict of interest.

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