CASE ONE

Short case number: 3_5_1
Category: Mental health and human behaviour
Discipline: Psychiatry
Setting: General Practice
Topic: Self Harm_Suicidal patient [SDL}

Case

Mark Chalmers, 25 years old accountant, is brought in by ambulance with bilateral wrist lacerations. Mark is extremely upset informing you that his girlfriend of 3 years had broken up with him 3 weeks prior, saying that she could not live with him anymore as he was too 'high maintenance'. Since the break-up he has been feeling miserable, has not been sleeping, has not been enjoying life much and has lost his appetite. Today he felt it was too difficult to go on and so decided to cut his wrists in an attempt to "end the pain".

Vitals: Well perfused, nil pallor: BP 110/80 HR: 75 bpm RR: 18/min
Both wrists have been bandaged at the scene and bleeding is controlled. You find superficial lacerations that do not require sutures and an intact neurovascular system.

1. What further history and examination would help you define Mark's risk of suicide? How would you ask Mark about his self-harm?

During your assessment Mark reports he has been drinking more heavily as alcohol makes him feel relaxed and helps him to sleep. He is feeling worthless because he put so much effort into the relationship and it did not work out – Mark had thought they would get married. He does not have many friends, he spent most of his spare time with his ex-girlfriend. He is close to his mother but his father died in from complications of alcoholism when Mark was in his teens – he had not seen much of his father as his parents divorced when he was aged eight. He has never seen a mental health professional and is not currently on medication, but he does disclose that during his teens he used to cut himself when he was stressed. Mark is still attending work and finds it to be a good distraction.

2. Use a formulation grid to list common predisposing, precipitating and perpetuating factors that help explain how and why Mark in presenting thus.

You diagnose him with Adjustment Disorder with depressed mood.

3. What is your management plan for Mark? Use a biopsychosocial approach and specifically address how you will manage his self-harming behaviour.

Suggested reading:

- **Selzer, R., & Ellen, S. (2014). Formulation for beginners. Australasian Psychiatry, 22(4), 397-401. https://journals.sagepub.com/doi/pdf/10.1177/1039856214536240**
- **Casey P, Jabbar F. (2013) Adjustment disorder considered. Advances in Psychiatric Treatment, 19(2), 99-107**
- **Carter G. et al, Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. Australian and New Zealand Journal of Psychiatry 2016, Vol. 50(10) 939-1000 and https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/deliberate-self-harm-cpg.aspx**

Answers

1. **What further history and examination would help you define Mark's risk of suicide? How would you ask Mark about his self-harm?**

   From Mark:

   1. What were the circumstances? How influenced by alcohol or other substances?
   2. How impulsive was the DSH? What does he mean by 'end the pain'?
   3. Does he have thoughts of wishing to 'end it all' or die?
   4. Has he done this before (or had other borderline traits)?
   5. Is there evidence of a preceding depression? any mood elevation? Evidence of psychosis?
   6. How is his medical health? Does he have a substance use disorder?
   7. Who is there he can talk to? Support him?
   8. Has he done this before? What happened previously?
   9. What is he generally like at his best?
   10. (Is he usually 'high maintenance' or is this due to current mood state?)
   11. What has he learnt from all of this?
   12. What does he want to do now? What are his plans for now and future?

   From others:

   1. Is this characteristic behaviour (or surprising)? Anything unusual pre-DSH?
   2. Is he usually high maintenance or is this part of current mood state?
   3. Was Mark realistic about his appraisal of the relationship?

2. **Use a formulation grid to list common predisposing, precipitating and perpetuating factors that help explain how and why Mark in presenting thus.**

   The Adjustment Disorder diagnosis implies the episode is related to recent events but is an over-reaction (see article below). This may indicate a number of underlying vulnerabilities. Aetiology of psychiatric disorders is multifactorial (combination of biological, psychological, social causes) which may predispose, precipitate, perpetuate illness and protect.

   Predisposing factors

   Biological/genetic factors:

   Genes are a causal factor in several psychiatric disorders, including schizophrenia, bipolar affective disorder, not so much in Adjustment Disorder, although some people are more sensitive to stressors than others, (which has a genetic component).

***Brain structure and function*:** Brain structure usually appears normal in psychiatric disorders, but brain function is commonly altered. There may be changes in neurotransmitter levels, eg, dopamine, noradrenaline (norepinephrine) and 5hydroxytryptamine (5-HT, serotonin), and differences in regional activity, shown on single photon emission tomography (SPECT) or magnetic resonance imaging (MRI) scans. Serotonin is important in suicidal, impulsive behaviours. Brain damage, as in head injury or stroke, may precipitate psychiatric illness.

Psychological and behavioural factors:
***Perceived stress and trauma*:** Early childhood experiences, such as, in Mark's case, parental marriage breakdown and his father's alcoholism increase risk of developing psychiatric illnesses, such as depression. In adult life events perceived as stressful may trigger psychiatric illness: eg, PTSD, but Mark's relationship breakdown is not a sufficient trigger for this.

***Personality*:** The relationship between personality and psychiatric illness can be difficult to assess trying to compensate for father's absence/neglect? Or it is more to meet her own needs?

***Behaviour*:** A person's behaviour may predispose to the development of a disorder (e.g. excess alcohol intake leading to dependence) or perpetuate it, as in persistent avoidance of the feared situation in phobia. The issue is whether Mark's alcohol use is a 'one off' or part of a pattern suggesting alcohol misuse/dependence, which may even have led to the breakup.

***Social and environmental factors*:** Most psychiatric disorders have their roots in childhood and adolescence. Experiences during development often cause individual vulnerability or dysfunctional personality styles and early stressors (eg, abuse/neglect, inadequate parenting, social disadvantage) are very important.

***Social isolation*:** The lack of a close, confiding relationship predisposes to psychiatric illnesses such as depression. Also, reduced social support resulting from illness may perpetuate it. We need to find out whether Mark has other relationships: one explanation for perception of 'high maintenance' was that he had too much invested in this relationship and ex-GF felt smothered. This is more likely if he had had a 'smothering' relationship with his mother.

Stressors: Social and environmental stressors can precipitate illness in vulnerable people. Their effect is modified by how they are perceived by the individual, although some may be so severe that they precipitate illness in most people. Events perceived as losses (such as bereavement) or leading to helplessness/feeling trapped commonly precede the onset of depression, and events perceived as threats commonly precipitate anxiety.

Perpetuating factors
These may include some of the predisposing factors if left unaddressed. Some may be the same as predisposing (if not addressed); others are a consequence of the condition (how the individual and others respond to the situation/episode).
Biological: Mark may have developed illness or effects of alcohol
Psychological and behavioural factors: Mark's initial reaction (cognitive, emotional and behavioural) to breakup, but also factors pre-breakup need to be explored.

Protective factors
These include family/friends/hobbies/self-care, being able to learn from experience, sense of humour, good self-esteem.

3. **What is your management plan for Mark? Use a biopsychosocial approach and specifically address how you will manage his self-harming behaviour.**

The plan will vary depending on the answers to questions below but this is a broad approach.

Immediate

1. Safety plan, annexe support, check history
2. Assess level of depression, need for admission, antidepressants or night time sedation
3. Discuss counselling around breakup and any other immediate issues
4. Encourage self-care (good diet, sleep, stay away from substances)
5. Encourage exercise, getting out/having plans

Next stage

1. Assess vulnerabilities - need for psychotherapy (CBT/IPT/DBT or other as appropriate)
2. Is there indication for counselling around drug/alcohol use disorders/smoking cessation/gambling
3. Make advance plan if likely to happen again.