

# One patient's 'shot' at redemption

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Mr. B believes shooting himself in the abdomen expunges his guilt. Is he delusional? Depressed? Obsessive-compulsive? Is another psychopathology driving his self-harm urges?



## How would you handle this case?

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### CASE A 'purification'

Mr. B, age 61, is in the ICU after shooting himself in the abdomen. The trauma team asks our psychiatry consultation/liaison service to determine if he needs special observation to prevent further self-harm.

Two days ago, Mr. B stood in the parking lot of a nearby hospital, aimed his rifle toward the left upper part of his abdomen, and fired. Bleeding profusely, he dragged himself to the hospital's emergency room. ER staff stabilized him hemodynamically, then transferred him to our hospital's regional trauma center, where surgeons performed an emergency laparotomy and found 2 sigmoid colon perforations, with feces floating outside the bowel.

After a partial colectomy and colostomy, Mr. B received broad-spectrum antibiotics, narcotic pain medication, and bowel rest in the ICU. When the trauma team called us, the patient's condition was stable and he had awakened enough to communicate, although he still needed frequent monitoring.

We visit Mr. B in the ICU and ask him why he shot himself. He denies he was attempting suicide but adds that for months he has been feeling depressed, stressed, and guilty about "all the bad things I've done in my life." Shoot-

ing himself helped him forget these negative thoughts.

A devout Roman Catholic, Mr. B has been researching flagellation and other forms of physical penance and considers the shooting a purification. He says he shot himself in the abdomen 2 previous times and felt better for months or years after each shooting.

Four years ago, Mr. B donated his left kidney to an unknown recipient. He does not equate the kidney donation with the shootings but says he felt happy while recuperating. He was later disappointed, however, because the procedure did not help him attract the "attention" he had hoped for.

Mr. B says he had been considering the latest shooting for at least 8 months and had carefully planned it. After studying anatomy textbooks, he figured he could fire into the left upper portion of his abdomen without striking a vital organ.

For several evenings, Mr. B aimed his rifle toward his abdomen but could not bring himself to pull the trigger. On the night of the shooting, he said, he "accidentally" fired at a more damaging angle than he had planned.

Cognitive examination results are mostly normal, although Mr. B has trouble interpreting similarities and proverbs. He appears pale but well-nourished, well-groomed, and serene. He speaks softly, often closing his eyes or staring into the distance. He says he feels "relieved"

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### Clinical Point

When classifying a self-injurious patient as a low suicide risk, be sure to list your rationale in the chart

and “happy” after the shooting but did not anticipate such a severe injury. He denies suicidal thoughts and—because of his current euphoric mood—he hopes he never “needs” to shoot himself again.

#### What diagnosis would you consider?

- Delusional disorder
- Major depression with psychotic features
- Obsessive-compulsive disorder (OCD)
- Personality disorder

#### The authors’ observations

We first considered delusional disorder and major depressive disorder with psychotic features. Mr. B’s belief that shooting himself would solve his problems seemed delusional, although he did not appear psychotic otherwise. Confusingly, Mr. B’s pre-admission symptoms seemed to suggest major depressive disorder, but he was happy in the ICU.

We explored other diagnoses, such as an odd form of OCD and a personality disorder (especially cluster A, given his strange beliefs), though at this point we had too little information for either diagnosis.

We also wondered if Mr. B’s behavior was normal given his strong belief in Catholic penance. Although some sects of the Catholic Church practice self-flagellation and other forms of self-punishment,<sup>1-3</sup> we found no evidence that the church condones or encourages self-shooting. Moreover, Mr. B admitted during questioning that a Catholic clergy member told him shooting oneself is not an appropriate penance.

#### What medication would you start now?

- An antipsychotic
- A selective serotonin reuptake inhibitor (SSRI)
- A benzodiazepine
- No medication

#### The authors’ observations

Mr. B was recovering from major abdominal surgery, was taking nothing orally,

and claimed to feel fine psychologically. Because he was not grossly psychotic and did not endorse anxiety or depression, we decided against medication but recommended a chaplain consult and planned to visit Mr. B daily to gather more history.

We considered Mr. B a low suicide risk—especially while hospitalized—after he said his “need” to shoot himself had dissipated. He also endorsed no suicidal thoughts or other depressive symptoms, and the nursing staff viewed him as pleasant and compliant. We noted this evidence in the chart and continued to reassess him daily.

### HISTORY Dreams, nightmares

Over the next week, Mr. B shares his life story. He says his parents divorced when he was age 5, and around that time he spent approximately 2 weeks in the hospital after being hit by a truck. He considers those 2 weeks a bright spot in an otherwise turbulent childhood because his parents did not fight and he was showered with gifts and attention.

Soon after, Mr. B lived with his mother. When he was 9, he heard his divorced parents arguing during a family gathering and prayed for his own death.

Throughout his childhood, Mr. B dreamed of becoming a priest and a war hero. In his early teens, he attended a church youth program where he and other youths were taught that masturbation is a mortal sin. Through high school, Mr. B’s inability to stop masturbating shook his faith and discouraged him from pursuing the priesthood.

In high school, Mr. B did not use alcohol or drugs and excelled academically but had few friends. After graduating, he enlisted in the U.S. Army and hoped to serve in Vietnam, but basic training became too stressful. The relentless harangues from drill instructors reminded him of his parents’ frequent shouting matches during his childhood.

Approximately 2 weeks into basic training, Mr. B shot himself in the abdomen and injured

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his liver. He underwent laparotomy and cholecystectomy and was discharged from the military. His anxiety dissipated as he recovered, though he later regretted not serving in Vietnam.

Mr. B married at age 44 and was divorced 13 years later. Throughout the marriage, he says, he verbally abused his wife and was emotionally unsupportive. After the divorce, he felt remorse over having mistreated her. His guilt disappeared after he donated his left kidney to an unknown recipient, but the guilt soon returned and drove him to shoot himself a second time in 2005.

Mr. B worked as a special education teacher for 20 years before retiring 4 years ago and has since been pursuing a similar position because he misses going to work. His inability to find a permanent job has led to anxiety, insomnia, increased guilt, and decreased appetite. He says these feelings fueled his desire to shoot himself a third time.

Since his divorce, Mr. B has lived alone and has no family or friends nearby. He feels isolated and is hurt that his family has not acknowledged the cards and notes he sent to them but adds that he did not include his return address on the mailings.

### **FOLLOW-UP** No relief

After 1 week in the ICU, Mr. B is transferred to the surgical ward. His condition is fair and he continues to receive IV antibiotics; analgesics as needed; omeprazole, 20 mg/d, to prevent a stress ulcer; bowel care medications; and ostomy care and education. We continue to visit him in the surgical ward almost daily. He seems to enjoy our visits, during which he openly discusses his past.

Eleven days after admission, Mr. B says shooting himself has not relieved his negative feelings, and his impending discharge makes him feel anxious with some suicidal thoughts. The surgical team delays discharge after Mr. B develops ileus with nausea and vomiting. The trauma team's attending physician prescribes an antiemetic, and ileus re-

### **Box 1**

#### DSM-IV-TR criteria for delusional disorder

- A. Nonbizarre delusions (involving situations that occur in real life) lasting  $\geq 1$  month.
- B. Criterion A for schizophrenia has never been met. (Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional disorder.)
- C. Apart from the impact or ramifications of the delusion(s), functioning is not markedly impaired and behavior is not obviously odd or bizarre.
- D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
- E. The disturbance is not due to the direct physiologic effects of a substance or a general medical condition.

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solves after 4 days. Mr. B then is discharged in stable condition after he denies intention to harm himself.

#### Which diagnosis most closely fits Mr. B?

- a) Delusional disorder
- b) Major depression with or without psychotic features
- c) Personality disorder
- d) Factitious disorder or malingering
- e) OCD

#### The authors' observations

At first we viewed Mr. B's idea of shooting himself to solve his problems as a delusion (*Box 1*), but less than 2 weeks later he denied that his self-injury offered any benefit. Because his original belief was transient, we ruled out delusional disorder and major depression with psychotic features.

Some of Mr. B's symptoms suggested OCD, including thought-related anxiety that is relieved after performing an action—in his case shooting himself. Whereas obsessions and/or compulsions occur daily

### Clinical Point

Patients whose delusional beliefs are transient probably do not have a delusional disorder

**Box 2****DSM-IV-TR criteria for factitious disorder**

- A.** Intentional production or feigning of physical or psychological signs or symptoms.
- B.** The motivation for the behavior is to assume the sick role.
- C.** External incentives for the behavior are absent.

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**Clinical Point**

If the patient is troubled by beliefs that are overvalued yet nondelusional, an SSRI could help

in OCD, Mr. B would perform the action and then feel fine for months to years before his anxiety resurfaced. Also, he did not consider his thoughts wrong or obtrusive.

Although Mr. B experienced some depressive symptoms and anxiety just before discharge, we were hesitant to diagnose major depression because his symptoms appeared tied to situational factors. He also did not fit a particular personality disorder, although he showed characteristics of:

- cluster A (odd ideas, solitary lifestyle)
- cluster B (self-harm, narcissistic tendencies)
- and cluster C (avoiding his relatives, dependence on others to meet his needs).

We could have diagnosed personality disorder, not otherwise specified, but we were unsure whether personality explained his pathology or if his personality characteristics warranted diagnosis.

Mr. B's intentional production of physical symptoms strongly suggested malingering, but we instead diagnosed factitious disorder because he was clearly motivated to play the sick role despite lack of a secondary gain (*Box 2*). The patient admitted causing the gunshot wound and clearly connected his subsequent emotional relief with both his positive childhood experience in the hospital and his satisfaction after donating a kidney.

Researchers have tried to distinguish between factitious disorder and other types of self-harm. Claes and Vandereycken<sup>4</sup> would consider Mr. B's behavior "self-mutilation"

rather than factitious. Turner calls DSM-IV-TR criteria for factitious disorder nebulous and says that lying about symptoms or their origin should be a necessary criterion.<sup>5</sup> If so, then Mr. B's condition might fit no DSM diagnosis.<sup>6</sup>

**How would you treat Mr. B?**

- a) Medication
- b) Pastoral counseling
- c) Insight-oriented therapy
- d) Supportive therapy

**The authors' observations**

Although Mr. B's diagnosis remained elusive, he needed a treatment plan before discharge to prevent another shooting and save his life.

We first considered psychotropics. Because Mr. B's beliefs did not appear delusional, an antipsychotic would not be a useful first-line treatment. Nor would a benzodiazepine help Mr. B at this point, especially since we did not diagnose primary anxiety.

Although we did not diagnose a major depressive or anxiety-spectrum disorder, we felt an SSRI such as citalopram could help. According to some investigators, SSRIs might benefit patients with overvalued ideas that are not as persistent as delusions.<sup>7,8</sup>

Additionally, we felt supportive therapy could help Mr. B establish a therapeutic relationship with a provider to whom he could turn during future crises. Should Mr. B contemplate self-harm, the therapist could suggest medications, hospitalization, or other interventions. We also recommended pastoral counseling to increase his support within his faith.

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## Related Resources

- Feldman MD, Eisendrath SJ, eds. *The spectrum of factitious disorders*. Washington, DC: American Psychiatric Press; 1996.
- Sutton J, Martinson D. Self-injury Web site: What self-injury is. [www.palace.net/~llama/psych/fwhat.html](http://www.palace.net/~llama/psych/fwhat.html).

### Drug Brand Names

Citalopram • Celexa  
Omeprazole • Prilosec

### Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

## OUTCOME Another shot?

Before discharge, we start citalopram, 10 mg/d, and schedule a follow-up appointment within 2 weeks. We also suggest that Mr. B:

- move into an apartment near his outpatient doctors
- get involved with the local Catholic community to build his support network.

When we contact Mr. B 2 months later, he says he discontinued citalopram because he felt no benefit from it. At his initial appointment with a psychiatrist, he denied depressive symptoms and was not scheduled for ongoing therapy. He has not spoken with clergy or other local church members because “I know they would say God has forgiven me.”

Mr. B calls his recent hospitalization upsetting because “I did not get the attention I wanted.” He endorses no immediate plan to shoot himself but voices concern that when his physical problems resolve, he might shoot

himself in the liver—as he had done 40 years ago—to bring himself full circle. “There’s still something attractive about this,” he says.

### The authors’ observations

Patients with factitious illness commonly refuse mental health treatment.<sup>9</sup>

We feel Mr. B needs frequent ongoing appointments in a medical clinic where doctors can provide sufficient attention to counter his persistent self-harm urges. Regular appointments with a primary care physician—regardless of whether Mr. B is medically ill—could help him feel supported.

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## Clinical Point

If a patient with factitious illness refuses post-discharge psychiatric treatment, consider referral to a primary care physician

## Bottom Line

Nonsuicidal self-injurious behavior can result from a range of psychopathologies. To narrow the differential diagnosis, determine if the patient has long-term fixed beliefs, major depressive symptoms, disordered personality characteristics, obsessive-compulsive traits, or a desire to play the sick role. Combination medication and psychosocial therapy can help, depending on which symptoms are present.