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Case Report

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Suicidal Attempt in a Schizophrenic Patient with a High Level of Expressed Emotion

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ABSTRACT

Schizophrenia is a chronic mental disorder known for distortions in perception and thinking consist of positive and negative symptoms for over six months. Expressed emotion (EE) is an attitude towards a patient with a mental disorder from the individuals surrounding him. EE was predicted as a key element in the relapsing of schizophrenia through criticism, emotional over-involvement, and/or intrusiveness. High-EE environment has always been a known risk factor for relapsing into schizophrenia comparing to low-EE environment. However, in our case, that risk has increased the level of suicidality, as few articles have linked EE as a risk factor to increase suicidality in other mental disorders. We present a case of a young male from eastern reigon of Saudi Arabia with a high level of expressed emotion from the family in the form of emotional over-involvement, better highlighting the importance of family therapy through psychoeducational interventions in managing a schizophrenic patient.

Key words: *Schizophrenia, Expressed emotion, Suicide, Risk factor, Over-involvement*

INTRODUCTION

Schizophrenia is a chronic mental disorder characterized by distortions of perception and thinking [1]. Suicide is an intentional attempt to end one's life [2]. Since 1990, suicide has been one of the top 20 causes of death, and it was ranked 15th in the most recent data [3], accounting for 1.5% of mortality worldwide [4]. In 2019, Saudi Arabia had an estimated suicide rate of 5.4 per 100,000 persons, according to the World Health Organization, and it was higher in males [5]. Expressed emotion (EE) is an attitude towards a patient with a mental disorder from the individuals surrounding him [6]. High EE was predicted as a critical element in the relapse of schizophrenia through criticism, emotional over-involvement, and/or intrusiveness [7, 8]. High-EE environment has a median relapse rate of 48% compared to low-EE environment which is 21% resulting in overwhelming association between EE and relapsing rate [9, 10].

Case report

An 18-year-old male patient arrived at the emergency department in a general hospital in Saudi Arabia with a deep cut wound of approximately 15 cm in length and multiple superficial cuts in the anterior aspect of his neck with heavy bleeding. His vital signs were as follows: temperature of 37°C, heart rate of 78 beats/min, blood pressure of 108/65 mmHg, respiratory rate of 20 breaths/min, and oxygen saturation of 99%. Two units of packed

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red blood cells were transfused, and he was rushed to the operating room for airway securing and neck vessel repair with the performance of a tracheostomy procedure. Toxicology results were unremarkable for any illicit substances except for the presence of benzodiazepine, which was one of his medications during his current intensive care unit admission.

The psychiatry team was consulted; upon the interview, the patient was exhibiting cognitive distortions like memory impairment and being inattentive to communication. However, physical examination revealed no signs of scars, cutting wounds, needle bricks, and skin mutilation in both upper limbs. His parents provided collateral history and reported that at the age of 17, their son was already hearing voices and had aggressive behavior toward the whole family to the point that his siblings would lock themselves during aggressive episodes. As the family strongly believed that it was a demonic possession or a consequence of witchcraft, they initially asked for the help of the local sheik. After weeks of trials with religious methods through multiple sheiks, they finally brought their son to the psychiatric emergency department for consultation, resulting in prescription medications without admission. The parents did not fully comprehend the severity of the mental disorder and the significance of medication adherence to a patient with psychosis, as they continued with the religious methods of treating their son. The psychiatry team recommended starting quetiapine 100 mg orally twice a day; alprazolam 0.5 mg orally once at bedtime; and escitalopram 20 mg orally once at bedtime, with urgent referral to the mental health hospital for admission after being discharged from his surgical condition. After two weeks of hospitalization with continued psychotropic medications, the psychiatrist interviewed the patient and exhibited normal behavioral and thought processing with negative psychotic symptoms and guilt regarding the suicidal attempt. After his mother refused to admit him into the mental health hospital, the patient was discharged and allowed to continue his antipsychotic and Serotonin Selective Reuptake Inhibitor (SSRI) medications at home. A one-week return visit to the psychiatry clinic was scheduled; however, the patient did not show up.

Second admission

One month after his first admission, the patient's relatives brought him to the emergency department due to aggressive behavior two days before his presentation. Prior to his admission, his family needed a second opinion regarding his psychiatric condition; therefore, they sought to consult with another psychiatrist, causing a complete change in his psychotropic medications from two to four prescriptions, which further resulted from the initial decreased medication compliance to altogether withholding treatment. This time, the family agreed to admission into the mental health hospital.

RESULTS AND DISCUSSION

A study conducted in the Eastern region of Saudi Arabia reported that suicide by hanging was the most common method, accounting for approximately 90% of 126 cases, with one case of suicide by throat cutting (0.79%) [1]. A patient with schizophrenia has a 40.8% risk of suicidal attempt at least once in his lifetime, with that risk decreasing to a slightly lower percentage of 39.6% on recurrence [11]. One known risk factor for the relapse of patients with schizophrenia is the high level of EE in the patient's family [7, 12]. In this study, the emotional over-involvement of the family by denying the presence of a mental disorder and holding into a superstitious belief of demonic possession or witchcraft caused a significant delay in patient treatment. Moreover, even after seeking consult from the psychiatry emergency department, the family remained in denial to start the psychotropic medications, resulting in the patient's aggressive form of the suicide attempt. A high level of EE is likely to increase the probability of suicide in a patient with a mental disorder compared with a low level of EE [13, 14]. Psychoeducation, emotional processing, stress reduction, structured problem solving, and cognitive reappraisal are methods of family therapies that need to be delivered by a mental health professional [7]. Psychoeducational interventions must be used in family members and caregivers as early as possible in the first episode of psychosis [15, 16].

CONCLUSION

The high level of EE in a patient's family can have a devastating effect on the patient's well-being, as in this case. Therefore, high EE has a possible risk of increasing the likelihood of suicide; therefore, we urge our fellow psychiatrists to be keen in looking for high EE in their interviews. Subsequently, they must use psychoeducational interventions as early as possible and shift to more complex interventions.

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