Case Report

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A Case of Autokabalesis

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Abstract

Autokabalesis is a method of severe deliberate self-harm (DSH) involving jumping from a height. It has been presented in a study that this form of attempting suicide was done predominantly by single, young unemployed males. Also, it appears that patients who have acted in this dangerous manner had serious psychiatric disorders. In this article a fascinating case of a patient who developed psychosis due to his increased anxiety egodystonic related thoughts with paedophilic context which led him to a serious suicidal attempt. The difficulties in managing this case in a trauma ward by different teams are discussed. The challenges and the ways that could be used to overcome this in one of the busiest London hospitals.

Keywords: Autokabalesis; Self-harm; Suicide; Psychiatric disorder

Introduction

Autokabalesis is a method of severe deliberate self-harm (DSH) involving jumping from a height [1]. It has been presented in a study [2] that this form of attempting suicide was done predominantly by single, young unemployed males. Also it appears that patients who have acted in this dangerous manner had serious psychiatric disorders [3]. In New York [4] where it was examined this kind of violent behaviour towards self between the years 1990-1998, it was demonstrated that the majority of deaths were above the age of 65. Joyce and Fleminger [5] pointed out that 4% of all deaths by suicide were from an Autokabalesis.

Case Report

The aim of this case study is to examine the antecedents of a serious suicidal attempt of a 47-year-old professional man, following a thirty feet jump from a motorway bridge and the management of the ensuing medical and psychiatric complications. The patient was managed at Royal London Hospital (RLH) which is one of the four major trauma centres in London and is the base of the helicopter emergency service (HEMS).

Following his suicide attempt, he sustained typical skeletal injuries-lumbar spine (L4), calcaneal and metatarsal fractures. The fractures were treated conservatively, with casts and a spinal brace; the estimated time for discharge from hospital was two months.

Management

He was referred to psychiatry liaison team for an assessment of his mental state and on-going risk management. This was a difficult assessment in a demanding trauma ward complicated by the lack of privacy, the nature of the information divulged and his lack of mobility. It was his first presentation to mental health services with no previous psychiatric history.

He reported paranoid psychotic symptoms, biological symptoms of depression four months prior to the attempt and feelings of guilt due his paedophilic tendencies. He had a sexual relationship with a 12-year-old boy when he was 21 and continues to experience sexual urges towards minors which he felt unable to function and be in control of his daily life.

He reported delusional beliefs about monitored by the internet provider, persecutory ideas while driving and delusions of reference. The working diagnosis was of a schizoaffective disorder and Paedophilia. The treatment was initiated with olanzapine 10 mg and citalopram 20 mg with a very good effect. His psychiatric notes were kept in private from the general orthopaedic ward medical notes and were only discussed by the psychiatric liaison team in view of potential bias in treatment offer by the rest of the teams as it could potentially affect the quality of treatment given to this patient.

The patient agreed to engage in long term psychotherapy due to his egodystonic thoughts and sexual fantasies with minors and he was subsequently referred to Portman and Tavistock Clinic for psychotherapy.

Discussion

Interesting enough the World Health Organisation reports that the most important risk factor for suicide is a prior suicide attempt [6]. Suicides are a global phenomenon and 79% of

them occur in low- and middle-income countries [6]. Is paramount to identify ways of preventing suicides and suicidal attempts. An ample multisectoral suicide prevention strategy is the least to say essential.

Conclusion

This case raises important issues for the liaison psychiatry of self-deliberate self-harm. His management required stabilisation of his mental state and sedation to enable bed rest and further enabling conservative treatment of physical injuries which was complicated by his concerns that medical and nursing staff would punish him for his paedophilia. His psychiatric follow up was hindered by his residual physical disability.

Further an interesting point that arises for discussion and consideration in a more ethical and fundamental understanding is if the psychiatric liaison notes should be kept in private and to be used only by the liaison staff in view of potential bias in treatment offered.

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