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CASE REPORT



Leaving on a Jet Plane: reflections on working with a patient with complex acquired brain injury secondary to attempted suicide

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ABSTRACT

Objective: Despite indications that patients with Acquired Brain Injury (ABI) as a result of deliberate self-harm have more complex presentations and lower rehabilitation outcomes (Brenner, 2009)¹, there is nominal published literature that considers adjustments to care for these individuals. A multifaceted and emotionally triggering subject, laced with clinical and ethical considerations, the lack of published articles may indicate the complexities surrounding this topic.

Method: This case study reflects on the care of a young man on a specialist brain injury unit who had devastating physical and cognitive disabilities after a significant drug overdose. Because the patient was unable to make informed treatment choices, all medical care was delivered in the patient's best interest amidst questions and doubts about the value of continuing life-saving treatments and escalation plans.

Results: This article is not to defend or challenge the decisions made during this patient's care, but reflects on the complexity and impact of these situations on the patient, the family, and the care team. The patient's father gave permission for this case review publication.

Conclusion: Further investigation is needed to better understand the challenges faced by this population and to determine if bespoke pathways and therapy considerations are necessary to address these specific circumstances.

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Background

In England and Wales, ~1.4 million patients per year attend hospital following head injury; the majority present with mild Traumatic Brain Injury (TBI), however, over 20% present with severe TBI (1). Recovery is a long and necessarily complex process requiring a multidisciplinary team of therapists and medical professionals working closely together.

The most common causes of TBIs are falls in the elderly, and road traffic collisions in the young. However, there is a small group of individuals who sustain brain injury secondary to a suicide attempt. Due to the sub-lethal means through which they sustain their injury, it has been suggested that this population has greater injury severity and poorer outcomes at discharge than those who incurred unintentional injuries (2,3). Rehabilitation for these individuals is thought to be further complicated by pre-existing psychosocial and mental health conditions – around 80% of individuals who die by suicide have a diagnosable psychiatric illness (4,5). Whilst more men die by suicide (75% male (6)), more females attempt suicide (7) and in 2015, female suicide rates had increased in England to their highest levels since 2005 (8). Despite increased literature and awareness around mental health and suicide, there is limited research examining ABI sustained secondary to a suicide attempt. As highlighted in a recent scoping review (9), extensive pre-morbid conditions, severity of injuries, and psychosocial support needs of this population present distinct implications for care; however, *'these individuals are rarely recognized in the literature as a distinct ABI population with*

rehabilitative needs specific to this etiology.' This may indicate the challenges and complexities in how to effectively research this area.

Suicide is a difficult, complex, challenging, and highly emotive subject. Whilst not necessarily dinner table conversation, nearly everyone has an ethical, moral, and philosophical stance on it. The two dominant philosophical paradigms in suicidality are the *Utilitarian* and the *Kantian* perspectives, with beliefs ranging from suicide being noble, an important freedom, a means to put an end to the pain or suffering to self and others, to suicide being unacceptable, morally wrong, an indication of mental illness, a crime, a violation of one's duty to oneself, or an offense against God (10).

Discontinuation of treatment in end-of-life situations is equally challenging and one of the most controversial areas in contemporary bioethics, particularly with regard to life-sustaining treatments (11). Very few countries accept direct termination of life by a medical practitioner; voluntary active euthanasia in which the patient consults and engages the physician to assist with the termination of life is accepted by only a few more. Withholding or withdrawing from treatments is accepted in the context of oncology where a patient declines further treatments, choosing to switch to some form of palliative care. The patient makes the decision to give up some time of life in order to 'acquire' some more 'quality time' – allowing them to prepare to die in a peaceful way. The principles governing these types of medical decisions are very different to the sanctioning of active euthanasia. When considering the

withholding or withdrawal of medical treatment, the care team acts based on the moral principle according to which the patient has a right to decide which therapies they are willing to accept or decline. For a patient with severe brain injury, it is necessary to consider and reflect on behalf of the patient what they would have wanted so an informed decision can be made in their best interest. For the patient with severe brain injury from a suicide attempt, withdrawal of treatment may appear to be the most obvious way to defend the patient from possibly unwanted negative consequences of life-prolonging medical technology, especially when the patient's quality of life has dropped so dramatically. Defining if, how, and when that decision should be made is incredibly challenging.

Brain injury recovery is in and of itself a multifaceted process due to the confluence of physical, cognitive, and emotional difficulties. This is further compounded by pre-existing psychiatric conditions and the severity of the injuries sustained via means intended by the individual to be lethal (eg: anoxic brain injury from hanging, toxic or metabolic brain injury from deliberate prescription or street-drug overdose). In general, patients with ABI from suicide attempt have poorer functional injury outcomes (eg: physical, memory) when compared with other ABI populations, and there is an increased likelihood of post-injury suicide attempts in those who sustain TBI through attempted suicide compared with those who have TBI through other means (12–15). Generalizing TBI rehabilitative care to this population may not be sufficient to address the needs of these individuals suffering a polytrauma experience (16). There is a 'double hardship' this group faces – they have tried but not succeeded to end their lives, they may now have extensive disabilities, they may have sufficient cognitive awareness to understand and feel this emotionally, and they may have the physical awareness to feel the pain associated with administered interventions. With the burden of mental illness, possible estranged interpersonal relationships and limited psychosocial supports, interdisciplinary care, and rehabilitation support must reflect these needs.

The majority of literature regarding TBI and suicide is considering post-injury trajectories, mood, and suicide attempts. Considerations for the potentially unique rehabilitative needs of this distinct population of injury being caused by attempted suicide is sparse, and primarily addressed in the literature and research from 20+ years ago. This may be indicative of the challenges faced in studying this group, but the lack of commentary does not necessarily indicate a dearth of tailored rehabilitative services and considerations for this population. With more systematic review of this group and their etiology, we may be able to find better and verified ways to support them.

Case study reflection

I can only wonder at the whys and wherefores of the overdose, accidental or intentional, planned or in a moment of despair. But I look into his large blue eyes, I feel my heart breaking for what he might have been feeling, and for what he might be feeling now. Unable to speak, seized by frequent storming, D. lies before me, gazing at me, as his body contorts with dystonic posturing; a sheen of sweat covers

his skin. He closes his eyes as he stiffens. We try to make him as comfortable as possible – splints and bolsters were carefully placed to support his body, so thin and frail I can't help but recall images of a past time. How thin he was before, I don't know. A photo above his bed shows a smiling boy with a rockabilly quiff, surrounded by his friends and bandmates – he was the guitarist. Yes, he was a skinny lad, but this was different. His bones protruded; his hands and feet twisting like a mandrake root.

D. was often asleep when I arrived for sessions. I felt reluctant to wake him, he might need the rest, but maybe he needed the contact too. Standing at his bedside, I would gently touch his shoulder as I talked to him to see if he might rouse. Sometimes he would. As he looked at me, his eyes seemed to smile. I felt he recognized me. Maybe he found some comfort and solace in my presence. The counter transference was palpable – I felt full of maternal protectiveness. I wanted him to know he was not alone. I wanted to help him; I wanted to ease his pain and provide comfort and protection against the despair he may be feeling. Yet I was also caught in my own feelings of helplessness and hopelessness for his situation.

When he was awake, I wheeled his day bed to the therapy room. Framing the sessions with a gentle hello and goodbye song, tempo'd to match his breath rate, I then presented a range of songs and visual stimuli whilst seeking any changes in his facial expression or his eyes. D.'s face appeared to relax as I sang to him, whatever the song. He had been an active musician, playing in bands, writing songs, recording. His musical knowledge and preferences were broad and deep, but his father warned me, 'He loves all music, but *not* Elvis.' I would sing an 'Elvis' song to provoke a different response, but he continued to gaze at me with a gentle smile! I talked to him about the songs, some trivia tidbits, hoping that this might interest him. Throughout the sessions, he would look at me, occasionally appearing to respond to my questions and comments with a blink, nod, or shake of his head.

We introduced various communication tools to further support and facilitate his input. There was a small window of intentional communication – fatigue, pain, discomfort, all impacted his ability to respond to questions and made it hard to assess cognition. I fell back on relying on 'intuition,' guided by his eyes and minimal shifts in his facial expression . . . a muscle release in his brow, his lips, his jaw. When his body contorted in spasm, I would extend vocalizations into low legato tones, with a slow and steady rhythm, humming to absorb, contain, and ease the storm, in hopes of dissipating and dissolving his distress. As the storming passed, his body would release into a depleted stillness, his eyes slowly opening and reengaging with mine. I don't know if my vocalization had helped him, but it had helped me be present with him through the contraction.

During his admission, D.'s father and younger brother visited frequently. They would banter and cajole D., encouraging him to laugh and converse with them. But D. couldn't speak. Occasionally, he was able to slightly move his head to indicate a 'Yes' or 'No.' He couldn't intentionally move his hands, arms, legs, or feet. His father shared how important music was to D. and how he had always preferred playing music over talking.

The occupational therapist (OT) and I arranged to take D. to the Assisted Technology department to see if he might be able and motivated to engage with the eye-harp, a responsive musical program. During the session, he was able to follow the directions necessary to calibrate the eye-gaze, tracking the moving dot around the screen; he then managed to track and complete a musical scale. Whilst slow and requiring facilitated prompts, this was encouraging, and we were optimistic that this might be something he could continue to explore as a way to pursue a meaningful activity as well as facilitating his use of eye gaze for general communication when discharged.

As the days and weeks passed, the dazed bewilderment in his father's eyes gave way to exhaustion. Shattered, he commented, *'I died the day D. died, and he isn't even dead'*. I invited him to join our sessions, during which he would sit still, leaning back against the wall. He mentioned feeling fleeting moments of calm whilst with us, finding a way to be present within a shared space, without having to talk, without pressure. Just being. Just being here with him. He said he was broken and his youngest son—only 14—was now the rock he had come to rely on.

D.'s health deteriorated several times, requiring him to be transferred back to the acute hospital. When physically stabilized, he would return to us; every time, slightly weaker. When his body did move, it was usually the result of neurostorming, as his brain attempted to regulate his nervous system. Sudden spikes in blood pressure, body temperature, and his heart rate lasted for several minutes each time. D. would be administered a range of medications, including morphine to manage and reduce the pain and the effects of the storming. As his oxygen levels dipped, sometimes as low as 70, he was placed on Non-Invasive Ventilation (NIV). He could not eat or drink, so he received nutrition and hydration via a PEG. Despite these obstacles, when he looked at me, his eyes seemed to convey a warm gentle spirit, maybe a little mischievous. It was impossible to know how much he understood or was consciously aware of what was happening, but I felt connected to him.

After D. had returned from a second trip to acute, his dad hung his head in shame; he looked at me and said he wondered if it would be better if we let D. go. I tried to assure him that it was his love for his son that made him question what was happening, what pain D. might be in, and that he was not a bad man for thinking these things.

D. had been deemed incapable of giving informed consent, so all interventions were to be delivered 'in his best interest.' We knew that D. was never going to be able to walk, talk, or play the guitar again. But what would D. have wanted? By the very nature of his injury, D. may have indicated what he wanted. However, most suicide attempts are made impulsively and without a considered decision to die (17). Even if D. had provided a suicide note indicating intentionality, notes are also considered to be written *'in the context of the impulsive decision'*, and consistently contain insufficient information for treating professionals to make a confident and informed judgement about the individual's capacity and wishes (18). As such, a medical team works to provide care and interventions *'in the patient's best interest.'* That a patient has attempted suicide is not, by itself, a basis for concluding that a patient is

not competent, nor can it be interpreted as a clear and consistent indication of wishes. We continued to intervene, treat, and sustain D's life – again, and again, and again.

New technological advances in medicine continue to push our final standing at death's door further and further out. Body parts can be added, removed, and replaced; diseases can be prevented, reversed, and repressed. But interventions come with potential risks and the possibility of subsequent interventions to counteract the first. In a world of increased expectations, where life can be extended indefinitely, there is a weighty responsibility on medical professionals to determine when to intervene and when to stop. With limited research to inform policy and care of patients whose acquired brain injury is the result of a suicide attempt, trying to understand and improve treatment for these individuals feels elusive. When facing uncharted waters, practitioners must draw on their knowledge, experience, and understanding to find new creative solutions to address the situation. The trial with one person may lead to further understanding and success with another person. But threats of litigation, fear of uncertainty, and the range of beliefs around the sanctity of life create a perfect storm of ethical and moral questions that are on one hand, so removed from our day-to-day life, and on the other hand, so fundamental that they rock us to the core.

Whenever there is loss, there is grief. But grief can feel particularly confusing for the parent of a child who has survived a suicide attempt, especially when it has resulted in significant brain injury. I would often bump into D's father. Friendly and appreciative of the staff, he appeared to not know what to do with himself, what to say. He expressed regrets, remorse, bewilderment, frustration, anger, and despair; time had stopped, and he was trapped in a living grief. This wasn't the first time he had lost his son. Custody issues, his son's use of drugs, leaving home without saying where he was going . . . now D's father was caught between his son's lack of life and lack of death. Many parents describe a serious brain injury as a partial death; each new improvement or movement brings an excitement, followed by a mourning for the child who 'used to be'; D's father was carrying a significant burden of 'manifold hardship.'

Music had been an integral part of D.'s and his father's lives. His father said he hadn't picked up his bass since D.'s . . . his voice would trail off. He perked up to tell me what a talented musician D. was, how he could play anything that he wanted . . . how D. was a far more natural and gifted musician than he was, D. lived and breathed music. They had played together, and they had played in different configurations. He was so happy to know that D. was receiving 1:1 music therapy, seeing how calm D. appeared in the sessions. I suggested that his father consider playing music for himself. He was not ready to do that. Maybe in the future, he will consider playing music again, as a way to celebrate his son rather than as an untouchable token preserved in his honor.

D. was discharged from our care after six months and transferred to a long-term care ward. Shortly thereafter, he was observed to be deteriorating. There were discussions about transferring him back to the acute hospital, however, because deterioration was so rapid, this did not

happen. Unfortunately, his father and brother arrived after D. had made his final departure.

When I found out about D.'s death, I felt both incredibly sad and relieved. D. had finally been relieved from his mental and physical pain. I wondered if we had done right by him with the initial resuscitation and subsequent interventions, or if we had actually prolonged his spiritual and physical pain in a suspended purgatory. I took solace in the moments that we had shared, when his eyes and face appeared to smile at me, and he seemed to say, 'It's OK'. I listened to one of his preferred songs, *Leaving on a Jet Plane*, and thought of how the lyrics echoed D.'s various departures that his father had shared with me. I also wondered if this third and final loss was what was necessary for his father and brother to start living again.

Final reflections

The Mental Capacity Act (2005) states that if an individual has capacity, they have the right to consent to and refuse any medical treatment, even if this will result in death. When considering a patient's capacity to make a decision about medical treatment, a competent decision to refuse treatment does not need to be rational per se, nor does it need to be based on common societal beliefs, however, the patient's reasoning must be internally consistent and follow logically from any starting premises (19). When the patient does not have capacity to consent to hospitalization, a Deprivation of Liberty Safeguards is requested by the hospital and authorized by the local authority, ensuring that the least restrictive practice is being applied.

Unexpected accidents and injuries do not give the individual the luxury of advanced care planning, and if the patient is unable to communicate, interventions are administered in the patient's best interests. In a recent report by the Marie Curie Palliative Care Research Centre (20), 70% believe their preferences around death and dying should take priority over the wishes of their next of kin or their doctor's advice; however, despite nearly 90% of respondents agreeing that planning for end of life was essential, only 14% of people had formally done so.

Identifying with, understanding, and acting through the patient's perspective and in their best interests is further obscured with ABI. Death is often considered to be a failure of medical treatment. Even with the smallest chance of success, a novel, or invasive treatment may be worth trying, even if it may lead to increased pain and suffering as a result. Withdrawing or refusing treatment when knowing this will result in death is a decision that is never taken lightly, but I can't help but wonder whom were we keeping D. alive for . . . for him, for his family, for ourselves, or for something else?

With the advancements in medical technologies (e.g. resuscitation techniques, surgical procedures, the artificial ventilation, hydration, and nutrition), increasing numbers of people are being kept alive with prolonged disorders of consciousness. When the injury is the result of suicide attempt, patient care often becomes conflated with complicated family emotions—the integrity of parenting and/or

spousal relations shaken; the desire to do everything and anything possible to extend the life of a loved one, or the desire, and ensuing guilt, to end life so as to not see their loved one suffer further. The medical, therapy and care teams working with patients and families in an already challenging environment, may be further affected by the situation. As such, this appears to be an area gravely under-studied, in part due to the patient's inability to consent to research participation, and lack of ability to reliably report on their experience, but an area that requires significant input to provide informed guidance to reduce complications, provide appropriate interventions, and help families through their prolonged bereavement process.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethics Statement

This reflective case study was reviewed and discussed with the therapist's supervisor and consultant medical director. The patient's father read and provided verbal consent for the publication of the article.

Data availability statement

This reflective case study does not incorporate data other than that which has been externally sourced.

References

1. NICE. Head injury briefing paper. 2014 [accessed 7 May 2024]. <https://www.nice.org.uk/guidance/qs74/documents/head-injury-briefing-paper2#:~:text=Each%20year%2C%201.4%20million%20people,to%20hospital%20with%20head%20injury.>
2. Brenner LA, Carlson NE, Harrison-Felix C, Ashman T, Hammond FM, Hirschberg RE. Self-inflicted traumatic brain injury: characteristics and outcomes. *Brain Inj.* 2009 Dec;23(13–14):991–98. doi:10.3109/02699050903379362. PMID: 19891537.
3. Kim H, Colantonio A. Intentional traumatic brain injury in Ontario, Canada. *J Trauma.* 2008;65(6):1287–92. doi:10.1097/TA.0b013e31817196f5.
4. Bryan CJ. The 90% statistic', rethinking suicide: why prevention fails, and how we can do better New York: Oxford Academic; 2021 Jun 1 [accessed 7 May 2024]. [https://doi.org/10.1093/med-psych/9780190050634.003.0003.](https://doi.org/10.1093/med-psych/9780190050634.003.0003)
5. Mann JJ. A current perspective of suicide and attempted suicide. *Ann Intern Med.* 2002;136(4):302–11. doi:10.7326/0003-4819-136-4-200202190-00010.
6. Office for National Statistics. Suicides in the UK: 2018 registrations. 2019 [accessed 7 May 2024]. <https://ons.gov.uk>.
7. Craig R, Fuller E, Mindell J. Health survey for England 2014: health, social care and lifestyles London: NatCen Social Research; 2015 [accessed 7 May 2024]. <https://content.digital.nhs.uk>.
8. Office for National Statistics. Suicides in the United Kingdom: 2015 registrations. 2016. accessed 7 May 2024] <https://hons.gov.uk>.
9. Higgins C, Rooney K, O'Connell B, Waldron B, Linehan C. Attempted suicide leading to acquired brain injury: a scoping review. *Brain Inj.* 2020;34(2):160–70. doi:10.1080/02699052.2019.1686771. Epub 2019 Nov 1. PMID: 31674208.

10. Alonzo D, Gearing RE. Suicide assessment and treatment: empirical and evidence-based practices. 2nd ed. New York City (NY): Springer Publishing Co; 2018.
11. Reichlin M. On the ethics of withholding and withdrawing medical treatment. *Multidiscip Respir Med*. 2014 Jul 16;9(1):39. doi:10.1186/2049-6958-9-39. PMID: 25057360; PMCID: PMC4107538.
12. Klonoff PS, Lage GA. Suicide in patients with traumatic brain injury: risk and prevention. *J Head Trauma Rehabil*. 1995;10(6):16–24. doi:10.1097/00001199-199512000-00005.
13. Oquendo MA, Harkavy Friedman J, Grunebaum MF, Burke A, Silver JM, Mann JJ. Suicidal behavior and mild traumatic brain injury in major depression. *J Nerv Ment Dis*. 2004;192(6):430–34. doi:10.1097/01.nmd.0000126706.53615.7b.
14. Kuipers P, Lancaster A. Developing a suicide prevention strategy based on the perspectives of people with brain injuries. *J Head Trauma Rehabil*. 2000;15(6):1275–84. doi:10.1097/00001199-200012000-00007.
15. Singhal AB, Topcuoglu MA, Koroshetz WJ. Diffusion MRI in three types of anoxic encephalopathy. *J Neurological Sci*. 2002;196(1–2):37–40. doi:10.1016/S0022-510X(02)00019-9.
16. Parmelee DX, Kowatch RA, Sellman J, Davidow O. Ten cases of head-injured, suicide-surviving adolescents: challenges for rehabilitation. *Brain Inj*. 1989;3(3):295–300. doi:10.3109/02699058909029642.
17. Hall RCW, Platt DE, Hall RCW. Suicide risk assessment: a review of risk factors for suicide in 100 patients who made severe suicide attempts. *Psychosomatics*. 1999;40(1):18–27. doi:10.1016/S0033-3182(99)71267-3.
18. Barr W, Leitner M, Thomas J. Self-harm or attempted suicide? Do suicide notes help us decide the level of intent in those who survive? *Accident Emerg Nurs*. 2007;15(3):122–27. doi:10.1016/j.aen.2007.04.005.
19. Stewart C, Biegler P. A primer on the law of competence to refuse medical treatment. *Australian Jaw J*. 2004;78:325–42.
20. Nelson A, Bryne A, Carson-Stevens A, Longo M, Sivell S, Islam I, Price D, Graham-Wisener L, Dempster M, Newman A. Public attitudes to death and dying in the UK. London, UK: Marie Curie; 2021.