We’ve got guts: Managing self-harm behavior in a patient with antisocial personality disorder

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Background

Managing patients with extensive history of self-harm behavior in a medical hospital can be challenging for the medical team, staff and the consultation-liaison (C-L) team. We describe a case of a patient without psychosis who presented with self-inflicted abdominal trauma, worsened by ongoing self-inflicted injury during medical admission. The patient was closely followed by the C- L psychiatry service with successful management of extreme self-harm behavior in a level 1 trauma hospital.

Case Presentation

Mr. A is a 42yo male with history of anxiety, depression and opioid use disorder who initially presented to our hospital with reported abdominal trauma from a manual labor accident. Psychiatry was consulted to evaluate for anxiety. It quickly became apparent that the patient’s recall of events leading to abdominal trauma was inconsistent and raised concerns for self-inflicted injury. Early in hospital course, Mr. A expressed frustration with his pain medication regimen and requested increased doses of opioids for pain and benzodiazepines for anxiety. Mr. A’s poor frustration tolerance and coping skills resulted in further self-inflicted injury to the wound with a plastic fork at bedside, followed by a pen days later, and ultimately disembowelment.

After ongoing evaluation, a diagnosis of antisocial personality disorder (ASPD) was given with comorbid opioid use disorder and stimulant use disorder. A behavioral plan was developed and implemented in collaboration with psychology.

Case Presentation, cont

Due to history of depression and anxiety as well as chronic pain and poor sleep, Mr. A was started on amitriptyline 25mg nightly and titrated to 100mg nightly. Limits were set on benzodiazepine and opioid use. The episodes of self-inflicted injury decreased over time with two self-inflicted injuries into the open abdomen early in hospital course followed by another self-inflicted injury 30 days into hospitalization. Mr. A remained hospitalized for over one year due to the extent of his injury and lack of social support. He remained free of associated aggression or behavioral outburst. He underwent successful closure of his open abdomen and was discharged to outpatient follow up.

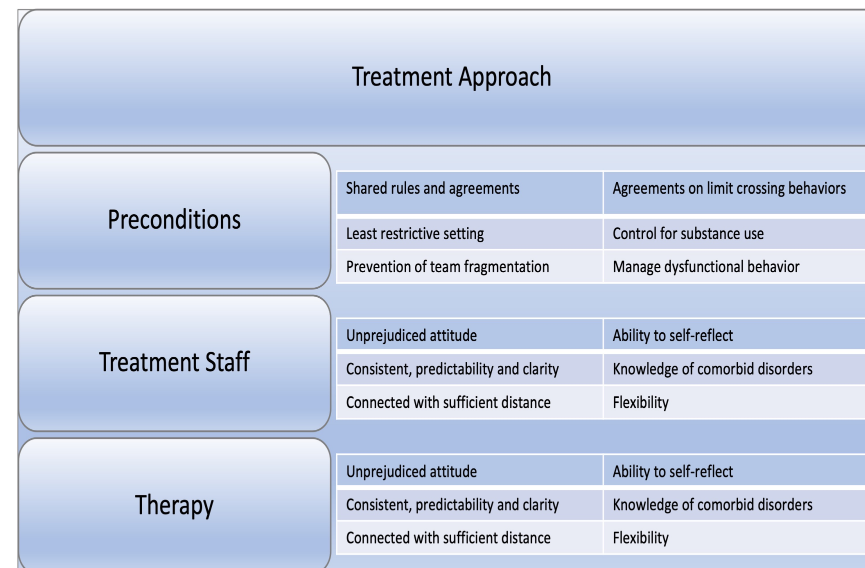

Figure 1: Treatment approach framework

Discussion

Treatment for antisocial personality disorder and other disorders that result in self-injurious behavior can be challenging to treat and particularly difficult to manage during a medical hospitalization. Many studies focus on co-occurring conditions such as substance abuse treatment as there is lack of evidence-based treatment for ASPD. Our team followed a framework (fig 1) similar to L.M.C. van den Bosch et al. Close follow-up by our team was essential in managing Mr. A’s self-harm behaviors. In addition, the surgical team and staff experienced countertransference in caring for Mr. A and liaison work was essential in optimizing his care.

Conclusion

Despite lack of evidence-based treatment for ASPD, utilizing a framework to guide treatment can be effective. Ongoing, consistent follow up by our C-L psychiatry service proved to be the most beneficial in the patient’s care to prevent further self-inflicted injury and improve adherence with medical treatment plan.

References

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