

Adolescent Update

"Dissecting the Self-Cutting Phenomenon"

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This issue highlights an area that has been requested many times by the readership. Cutting and carving by adolescents is on the rise and perplexes providers as to how to handle the results. Many have wanted to know whether this equates to a suicidal attempt. Kevin Baszis MD, a second year pediatric resident at St. Louis Children's Hospital provides some insight into this problem, along with Katie Plax, MD, Division Head of Adolescent Medicine at St. Louis Children's Hospital.

The Missouri Council on Adolescent and School Health (CASH) will be meeting again in June to review the work accomplished on a state-wide work plan for adolescent health. This collaborative work and partners were recently highlighted at the National Society for Adolescent Medicine meeting in Boston.

Please continue to give feedback and request new topics of interest to either Patti Van Tuinen or Dr. Lynch.

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Self-cutting is just one of the many practices under the umbrella term of self-harm, or self-mutilation. Self-mutilation is defined as "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent" (Favazza). Self-cutting is the most common form of self-harm. This update will focus on self-cutting, an underestimated and poorly understood phenomenon that appears to be quite prevalent in our adolescent population.

Who are the individuals who self-cut?

One study reports that 7-14 percent of adolescents will self-harm at one point in their lives (Hawton). However, the exact percentage is unknown, due to limits of self-disclosure of a behavior that often carries stigma. Although not as prevalent, males who self-cut are perhaps more concerning; females are more likely to attempt suicide, whereas males are more likely to successfully complete suicide.

What are the risk factors?

The major risk factors for self-cutting include the following: a history of sexual or physical abuse, substance use or abuse, having friends or family members who have engaged in self-cutting, depression, low self esteem, arguments with significant others or family members, anxiety, and impulsivity. Unfortunately the issues that are at the center of most adolescents' lives predispose them to self-cutting. Cutting may be a way to provide temporary relief for depression, anxiety or other painful emotions, likely due to the release of endorphins with self-cutting. Concerns about sexual orientation were found to have a positive correlation with self-harm, and self-harm was found to have an incremental increase with episodes of being drunk and higher consumption of cigarettes and alcohol (Hawton).

There is also a collection of behaviors associated with self-harm that revolves around impulsivity control and risky behaviors. This "syndrome" includes eating disorders, promiscuity, shoplifting, self-mutilation, and substance abuse. One study found females who self-cut were 3.5 times more likely to engage in unprotected sex (Brown).

Self-cutting is not always an entity unto itself; it may be the underlying symptom of a larger disorder, such as borderline personality, posttraumatic stress syndrome, eating disorders, and histrionic disorders.

What are the motives for self-cutting?

Adolescents most commonly self-cut to reduce tension or to punish themselves for perceived wrongs. Other motives are to seek help, escape from life stressors, to show desperation, to cause guilt in family members, or in some cases, to commit suicide, which leads into the next topic.

When to worry about self-cutting as a precursor to suicide?

This is perhaps the most important aspect of evaluating an adolescent who self-cuts. As noted above, suicide is only one of the motives; Hawton states the risk of suicide after deliberate self-harm to lie between 0.24-4.3 percent. Suicide risk factors include being an older teenage male, multiple episodes of previous self-harm, substance abuse, and previous psychiatric admissions. Regarding the attempt itself, red flags should be raised when the self-harm was done in isolation, premeditated, or planned to avoid discovery by family or friends. As noted earlier, these red flags contrast with the episode that is done impulsively to gain attention by alerting family or friends. Self-cutting is done to provide relief from painful emotions, while suicide is often linked with the absence of emotion. The severity of self-injury is not associated with increased suicidal risk.

What to look for?

The obvious warning signs are cuts or scars seen on the wrists or forearms, but other sites of self-cutting are less conspicuous and include legs, feet and abdomen. Some individuals may burn, bite or scratch instead. Wearing long pants and shirts, especially in warm weather, may be another red flag. Blood stains on clothing are another sign to easily screen for.

In summary, self-cutting is a relatively common practice in adolescents, which may not be obvious or suspected in routine encounters with patients. While the act itself is often fairly benign and does not prompt medical attention, the underlying motives and associated disorders may be more concerning. Looking for evidence of self-cutting or mutilation should be part of the complete physical exam. If discovered, more time and questioning should be devoted to motive, mood, and other risky behaviors. Using this screening process, pediatricians health care providers can intervene early and answer this cry from their adolescent patients.

What is the treatment?

Certainly, the best treatment is prevention, but this is not always possible in the adolescent population. Establishing an early rapport and communication line with patients enables the patient to talk more comfortably about these sensitive matters with the primary health care provider. Further treatment options include individual, family, and group therapies. Depending on the comfort level of the practitioner, a multidisciplinary team approach should be used in treating such patients, involving referral to psychology and psychiatry.

In individual cases, cognitive behavioral therapy, anger management and counseling are the initial treatment modality. Cognitive behavioral therapy is helpful especially with comorbid depression. Attempts are made to treat the underlying substance abuse or psychiatric disorder if present. High-dose SSRIs (selective serotonin reuptake inhibitors commonly prescribed drugs for treating depression) can be used to treat uncontrolled cutting (Favazza) along with psychotherapy.

Family therapy may be appropriate when the underlying issue is conflict in the home. Group sessions involving the entire family are helpful to promote communication, role-playing and sharing of feelings. This may also help alleviate denial and concern about the negative stigma of psychological treatment.

School therapy, in conjunction with a counselor or educational psychologist, plays a role if the stressful events lie in the school environment. Educating teachers about the prevalence and symptoms of self-mutilation is also beneficial.

Problem-solving therapy can be done with the individual, the family, or through the school. Steps include identifying the problems, setting goals, tracking progress, dealing with obstruction to progress, and future goal planning or avoidance of situations that provoke stress and depression.

Inpatient therapy is maintained for those who are acutely suicidal or have severe depression/psychosis.

Regardless of the modality chosen, the treatment should be individualized. Screening for this phenomenon falls under the general practitioner's role, but consultation with mental health experts and counseling services are encouraged in order to best treat these patients, with the goal to ultimately heal.

References / Further Reading

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Web Resources:

- American Academy of Pediatrics information on depression and suicide prevention. <http://www.aap.org/healthtopics/behaviormenthlth.cfm>
- TeensHealth - Cutting http://kidshealth.org/teen/your_mind/mental_health/cutting.html
- New Mexico State University, Cooperative Extension Service, "Adolescents and Self-Cutting (Self-Harm): Information for Parents," June 2005 www.cahe.nmsu.edu/pubs/_i/1-104.pdf
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Articles in *Adolescent "SHORTS"* refer to boys and girls. For simplicity, the pronouns "he" and "she" are used interchangeably unless otherwise noted.