Observations on Cutting
by Christina Perron

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Abstract: Non-suicidal self-injur is thought of as a disordered emotional coping mechanism. This phenomenon is gaining increasing attention in the psychiatric and lay literature as it often is a harbinger of significant ongoing life stressors, a marker of adverse childhood experiences, and/or a manifestation of psychiatric disease. Dermatologists investigate and treat diseases of the skin and are therefore often privy to a patient's closely guarded stigmata of self-harm. A fourth-year medical student questioned how best to care for this patient population in the outpatient dermatology clinic. A review of the current dermatologic literature proved largely silent on this subject. A dermatology clinic visit may represent an ideal, and under-utilized, opportunity to monitor patients for evidence of self-injurious behaviors and to make note of patients' self-harming thoughts and actions. We suggest dermatologists be prepared to reinforce ongoing behavioral techniques and therapeutic treatment, as well as to identify escalating behaviors and to make appropriate referrals.

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As a fourth year medical student, I am being trained in the arts of observation and listening. Medical students, and most clinicians, attempt to take in as much information about a patient as quickly as possible. Before we expand on the patient's chief complaint or past medical history we are collecting information through a brief visual survey and inspection of the patient. During a month-long fourth-year dermatology elective, this meant a quick visual assessment of the patient's age, skin type, probable medical comorbidities and a myriad of skin lesions. However, as the clerkship progressed, I was surprised to find myself checking patients for the stigmata of self-harm.

One such patient was a 51 year-old single white woman who presented with a many year history of picking perceived facial skin abnormalities using a needle and tweezers. Her picking took place daily. The patient believed she had an underlying acneiform condition. This led her to seek out dermatologic consultation. The dermatologist had previously identified the self-induced etiology of the patient's skin lesions. The patient told us that her picking had a soothing effect.

Further questioning revealed that the patient was a victim of childhood sexual abuse. She was a self-described "cutter" as a young adult and had performed other acts of self-harm

during her adolescence, including dislocating her knee with a hammer in high school. She reportedly informed the physician treating her knee at the time that she had fallen down the stairs. The patient also described a long history of anorexia nervosa.

This patient's exam revealed active facial lesions and older, healed scaring, as well as well-healed thin, horizontal scars on her forearms and abdomen (Figure 1). The stigmata of past and present psychological distress were not new to the dermatologist I worked with, and in fact it seemed to be relatively common finding within his patient population. Although this patient had volunteered her history of cutting on several occasions, self-injury was an incidental finding on an otherwise routine skin exam. Most of these scars were well-healed, suggesting the self-harm was remote, perhaps a closely guarded secret.

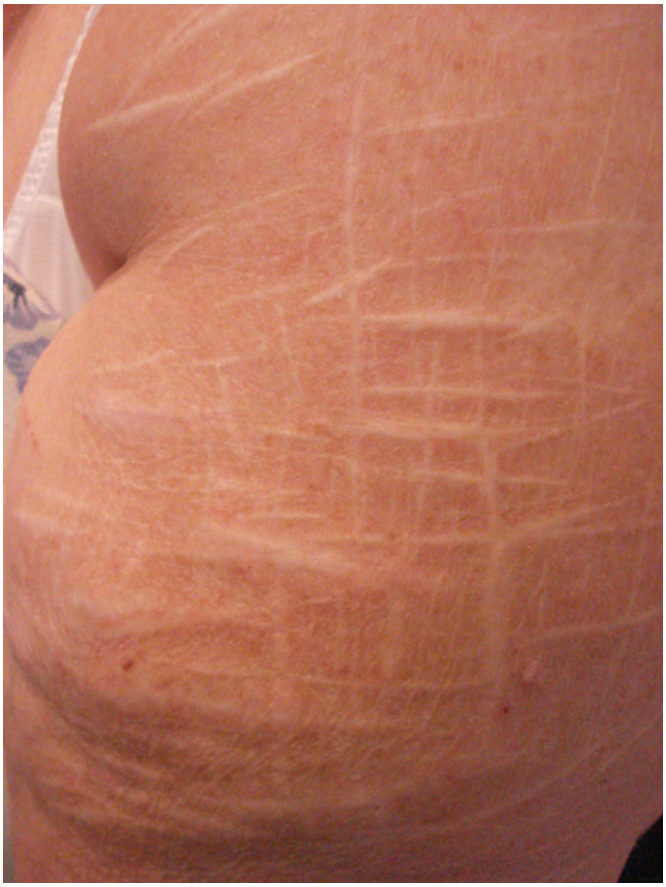

Figure 1: *Well-healed scars on abdomen from self-cutting.* Used with patient's permission

For medical students like myself, coursework is largely compartmentalized. Dermatologists specialize in diseases of the skin, not diseases of the mind. Yet it became obvious that dermatologists, during the course of routine skin examinations, become privy to clues of psychogenic disease and distress that few other health care practitioners have the opportunity to observe. I questioned what role a dermatologist, uniquely positioned to assess the stigmata of self-harm, might play in the provision of care to this patient population. I found the dermatologic literature largely silent on this subject.

The International Society for the Study of Self-Injury defines non-suicidal self injury (NSSI) as the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned (ISSS, 2007). Self-injury is primarily thought of as a maladaptive coping method for managing emotions and when present, it likely represents significant distress (ISSS, 2007). Approximately 1 to 4% of adults and 13 to 23% of adolescents report a history of NSSI at some point in their lives (Kock 2009, Jacobson & Gould 2007). As care givers, we must be prepared to consider the entirety of our patient's past medical history in order to come up with a successful treatment approach. For our patient, this meant addressing the stigmata of NSSI (even though these were well-healed lesions) in order to ameliorate her current facial picking. Table 1 lists some of the types of non-suicidal self-injury that can be seen in a clinical setting.

Common Types of Non-Suicidal Self-Injury seen in Clinical Populations
Rubbing; scratching; picking; cutting (most self-injurers cut the extremities or abdomen, not the neck); slashing; gouging; puncturing; applications of heat, acid or caustics; injections of caustics, milk; autoinoculation with infected material, fecal material or blood; sucking; biting; application of suction cups or elastic bands.

Table 1. *Common Types of Self-Injury Seen in Clinical Populations*. Adopted from Koblenzer 1987 and Walsh 2007.

Non-suicidal self-injury is a disorder gaining increased attention in the psychiatric and lay literature. Empirical research suggests that there is currently a trend toward a growing prevalence of self-injury, especially among adolescents and young adults. (Kerr 2010). However, the motivation for self-injurious behavior in patients with and without psychiatric illness is not fully understood and likely varies from patient to patient (Oldham 2006; Stanley 2010). Researcher Barent Walsh suggests that non-suicidal self-injury may be a culture bound syndrome and currently an "epidemic in our country" (Nyus 2012). Walsh suggests there is a bimodal distribution to self-injury and while traditionally self-injury is linked to childhood abuse, especially childhood sexual abuse (Gratz 2006; Yates 2004; 2008), another subset of patients has emerged for whom self-injurious behavior is the "current, most popular expression of adolescent angst" (Nuys 2012). Media outlets such as photos, websites and YouTube videos may be contributing to the rising incidence among adolescents and young adults (Nuys 2012; Tanner 2011). In Yates's 2008 study, participants who engaged in self-injurious behavior were more likely than non-injurers to report having friends who self-injured. Yates suggests that the emergence of self-injury may be a "social contagion phenomenon" maintained by positive reinforcement for the patient such as tension release (Yates 2008). For both types of patients, self-injurious behaviors may produce relief of acute emotional distress and/or provide analgesia due to release of endogenous opioids (Stanley 2010).

Specific psychiatric disorders are associated with higher rates and risk for self-injury. These include: Borderline Personality Disorder, Dissociation and Dissociative disorders, Impulse Control Disorder, Obsessive-Compulsive disorder, eating disorders, major depressive disorder, post-traumatic stress disorder and alcohol dependence (Kerr 2010; Yates 2004; Stanley 2010). However, NSSI may even occur independently of an

underlying psychiatric condition (Whitlock 2010). Anecdotally, patients who self-injure report a sense of numbness and detachment during the act of self-harm. A patient I spoke with in the dermatology clinic described the anxiolytic effects of facial picking, "I would wake up feeling extremely anxious, picking made me feel numb." This same patient disclosed that her dermatologist was actually the *first* health care professional to identify the true nature of her self-injurious skin-picking, and the first clinician to recommend behavioral therapy.

Over the course of my month-long dermatology clerkship it became clear that non-suicidal self-harm is common. It was also clear from our literature review that few patients are questioned about the antecedents of their NSSI, even though it can be an indicator of both psychopathology and adverse life experiences. It is necessary to address, and not ignore, these stigmata with an unbiased and respectful line of inquiry. The dermatologist (and indeed all health care practitioners) should try to understand the functions and severity of self-injury with the same level of interest as he or she would a surgical scar, healing wound or developing infection (Kerr 2010), maintaining a nonjudgmental and dispassionate response to the patient's disclosures (Walsh 2007). The therapeutic approach of detached concern will likely allow the dermatologist to make recommendations for finding alternatives to self-harm or to provide resources and referrals to outside care-providers if warranted. In the case of the 51 year old woman with pathologic skin-picking and stigmata of NSSI, the dermatologist recommended the patient try a behavioral strategy to keep her face further than her arms length from a mirror ("mirror amputation*"). Over the course of the office visit, the dermatologist also validated the patient's therapeutic relationship with her counselor and psychiatrist and sent along his office notes to the mental health providers in order to maintain continuity of care for his patient.

Dermatologists are in the unique position of seeing patients with regularity over a long period of time for their skin conditions. Therefore, the dermatologist is poised to address new evidence of self-injurious behaviors and/or to monitor the status of the patients self-harming thoughts. The dermatologist (and, indeed, all care givers) should be prepared to reinforce techniques and therapeutic outlets that have helped the patient to stave off self-injurious behavior in the past. If warranted, the dermatologist (in the same way as a primary care physician) will be able to refer to and/or reconnect the patient with behavioral health services (Kerr 2010).

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APPENDIX

Some helpful full-text references include:

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References Specific to PEDIATRIC Population

The Scope of Nonsuicidal Self-Injury on You-Tube http://pediatrics.aappublications.org/content/early/2011/02/21/peds.2010-2317.abstract

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Inside a Cutter's Mind: Understanding and Helping Those Who Self-Injure by Earl Henslin and Jerusha Clark

Treating Self-Injury, First Edition: A Practical Guide by Barent Walsh

Self-Multilation: Theory, Research and Treatment by Barent Walsh

Bodies Under Siege: Self-Mutilation, Nonsuidical Self-Injury and Body Modification in Culture and Society by Armando R. Favazza

The Lived Experience of Violation by A. L. Kirkengen

Self Mutilation Opposing Viewpoints, Edited by Mary Williams

Novels:
The Solitude of Primary Numbers by Paulo Giordano

The Tender Cut: Inside the Hidden World of Self Injury by Patricia and Peter Adler

Stopping the Pain: A Workbook for Teens Who Cut and Self Injure by Lawrence E. Shapiro

The Tenth Circle by Jody Picoult

Skin Game: A Cutter's Memoir by Caroline Kettlewell

Articles:
The Poverty Clinic – by Paul Tough in the New Yorker
Self-Injury: An Interview with Barent Walsh, Ph.D. – by Christy Matta for Psych Central Online at *http://blogs.psychcentral.com/dbt/2010/09/self-injury-an-interview-with-barent-walsh-ph-d/*

Film:
The Black Swan
Girl, Interrupted
Act to Prevent Self-Injury, a DVD/ prevention program for high schools in collaboration with Screening for Mental Health of Wellesley, MA by Barent Walsh

Websites:
National Self-Harm Network. http://www.nshn.co.uk/

Hidden Hurt: Domestic Abuse information. http://www.hiddenhurt.co.uk/self_harm.html

International Society for the Study of Self-Injury http://www.isssweb.org/

Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults http://www.crpsib.com/

Self-Help Website: self-injury.net Designed as an online community for self-help, designed by a "cutter" patient. From the Website description: "this website was made to let self-injurers know that they are *not* alone and to help their friends and family learn more about self-injury and how it affects their loved one."

Current Controversies in Dermatologic Literature
A 2009 *Psychocutaneous Medicine* Journal article, “Self-Induced Skin Lesions: A Review of Dermatitis Artefacta.” Suggests patients presenting with Dermatitis Artefacta, particularly those with nonsuicidal self-injury are self-harming for the sole purpose of assuming the sick role.