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Self-Cutting Behaviors in Adolescents

Kathryn R. Puskar, RN, DrPH, CS, FAAN

*Professor, University of Pittsburgh School of Nursing
3500 Victoria Street, Room 415
Pittsburgh, PA 15261
(412) 624-6933 fax: (412) 383-7293
email: krp12@pitt.edu*

Lisa Bernardo, PhD, MPH, RN

*Associate Professor of Nursing
University of Pittsburgh
School of Nursing Pittsburgh, PA 15261
lbe100@pitt.edu
(412) 624-7637*

Mary Hatam, MSN

*Instructor, UPMC Shadyside School of Nursing
Motor Square Garden
5200 Baum Boulevard
Pittsburgh, PA 15206
(412) 623-0048
hatamr@alltell.net*

Samantha Geise, RN

*Psychiatric Nurse, Western Psychiatric Institute and Clinic
5519 Wellesley Avenue Apartment 10
Pittsburgh, PA 15206
(412) 519-9050*

Jeanne Bendik, RN, BSN

*South Side Are School District
Middle/High School Nurse
4949 St. Rt. 151
Hookstown, PA 15050
jfb@sssd.k12.pa.us.*

Beth R. Grabiak, MSN, CRNP

*Graduate Student Researcher
University of Pittsburgh School of Nursing
Room 415
Pittsburgh, PA 15261
brg2@pitt.edu
(412) 657-8139*

Young people, aged 7 to 24 years, present to the emergency department for self-harm behaviors relatively frequently, with 225 ED visits per 100,000 annually.¹ Self-harm is a complex group of behaviors that involves conscious decisions to mutilate or hurt oneself in the absence of suicidal intent.^{2, 3} Adolescents who harm themselves are more likely to have been exposed to stressors, such as intimacy problems or peer conflicts, that affect their resilience and their ability to cope.⁴ They also may have a higher incidence of family problems and trouble in school.⁴

Other factors associated with self-harm include existing mental illness (eg, depression), impulsivity, conflict regarding sexual orientation,⁵ or a sense of hopelessness.⁶

One self-harm behavior, self-cutting, is impulsive and provides instant, though temporary, relief from stress. Some adolescents report that they engage in this behavior “to stop bad feelings,” “to feel something, even if it is pain,” “to get attention,” and “to avoid something unpleasant that [they] do not want to do.”⁷ According to Kumar, Pepe and Steer, patients may engage in self-cutting partially to alleviate symptoms of negative affect, such as anger, anxiety, or depression⁸ (Table 1).

Self-cutting Behavior

Adolescents who self-cut commonly engage in this behavior in a solitary environment, so the behavior never comes to the attention of health and social services and frequently is kept from parents or caregivers.⁹ The forearms, wrists, ankles and lower legs may be the areas of choice for self-injury because they are easy to cover and hide from family members and peers.^{3, 9} The self-cutting behavior then may continue without interference.³ On the other hand, adolescents with borderline personality disorder have been known to engage in self-cutting in a public situation as a means of getting attention.

Many adolescents claim that they discovered this coping skill by accident, but once they found that it worked for them, they continued using it.⁸ Self-cutting is extremely addictive, so the majority of self-cutters continue the behavior throughout adolescence and even into adulthood, depending on how much time passes until psychiatric intervention.

Emergency Treatment of Adolescents with Self-cutting

Adolescents may present to the emergency department with self-cutting injuries as their chief complaint, or the triage or primary nurse may discover evidence of self-cutting on a secondary assessment. Upon completion of their health evaluation, the ED nurse assesses the adolescent to determine if the injury was a suicide attempt or a self-cutting episode. If the injury was a suicide attempt, suicide protocols should be implemented, according to ED policy. If the injury was a self-cutting episode, the nurse then questions the adolescent about the self-cutting behavior.

Emergency nurses need to be empathetic in their approach to self-cutters. As one interviewed adolescent said, “Look at the individual, not the harm. Look at the person beyond the scars. Scars are not important; the person who did them is important.”⁹

Staff may assess the frequency of the self-cutting attempts by examining existing scars or wounds in various stages of healing. This assessment includes differentiating between abuse by another person versus self-cutting or self-harm. Questions about the cuts, the length of time that self-cutting behavior has been used, and how the self-cutting is accomplished are appropriate when asked with a non-judgmental attitude.

While awaiting treatment in or disposition from the emergency department, sharp objects, needles, and other items should be secured to prevent the adolescent from harming himself or herself. Wound treatment is straightforward and includes cleaning the wounds, suturing, if necessary, and administering tetanus prophylaxis, as indicated. Consultation with an adolescent psychiatrist or mental health professional is warranted.

Long-term Care and Outcomes

Patients may be discharged to an inpatient psychiatric unit or to home with close psychiatric follow-up. Treatments may include group therapy, individual therapy, medication (eg, antidepressants), or stress reduction and management skills.³ If the patient is discharged to home, instructions to the caregiver should include advice on how to make the environment safe for the adolescent, (ie, the caregiver must remove or lock up all items that could have the potential to break the skin).

The long-term prognosis for adolescents with self-cutting behaviors is poor because this behavior is extremely difficult to treat. Because it is a learned coping skill that feels effective to the cutter, adolescents are resistant to change it. Even with inpatient treatment, an estimated 40 to 60% of adolescents continue to self-injure.⁷ Nevertheless, behavioral interventions may have an impact on a small proportion of adolescents who perform self-cutting.

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Table 1
Characteristics of adolescents with self-cutting behaviors

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- Common anatomic sites: arms, wrists, ankles, lower legs³
 - Other sites: abdomen, inner thighs, feet, under arms³
 - Tools used to self-cut: knives, razors, fingernails, paperclips, pins, tacks, and glass^{3, 8}
 - Location: often in a solitary environment (eg, bedroom)⁹
 - Frequency: at least once a week^{8, 9}
 - Most prevalent among adolescent females³
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