Why Cutters Cut: An Examination of a Growing Trend

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Abstract

Self-Injury (SI) is a growing trend in the world today. More and more people are performing minor to major self-injury, and the rate of occurrence appears to be growing. Unfortunately, due to the secretive nature of self-injury, the problem is likely to be more widespread than studies predict. Individuals bash their heads, beat themselves, burn themselves, and most commonly, cut themselves. Cutting is by far the largest percentage of self-harm, followed by burning. Cutting is often done with razor blades, shaving razors, knives, broken glass, nails, and even tabs from soda cans. While cutting is often seen with other mental illnesses such as Chronic Depression Disorder, Anxiety Disorder, and Borderline Personality Disorder, it is not indicative of other more serious mental issues. Rather, it is most often a solitary issue not relating to any other mental disorders. Cutting is a form of coping with stress or emotional pain, and while extremely effective in doing so, the effects are short lived and the act itself can quickly become an addiction. Various treatment methods exist, but their effectiveness varies as each cutter is vastly different.

Introduction

Can you imagine feeling so lonely that you lock yourself in a bathroom and start slashing at your legs? Can you imagine the only way to cope with physical and sexual abuse is to hurt yourself more than anyone else can hurt you? Can you imagine your emotions being so suppressed that the blood flowing down your arm is your only sense of relief? Can you imagine the only thing you have control over is the ability to hurt yourself? Can you imagine being so anxious about everything and nothing that your only escape is to slowly push a knife into the soft flesh of the inside of your wrist?

Each cutter has his or her own problems and has found the only way to cope is by hurting themselves. Cutting is the only way possible for them to reach out and express the pain they may be going through. In the following essay, the researchers attempt to shed light on who cutters are and why they cut, common myths and misconceptions the public has about cutters, typical behaviors and signs of a cutter, risks and dangers associated with cutting, as well as possible treatment options.

Who tends to cut and why

Understanding what cutting is before one begins to learn who tends to cut and why is incredibly important. Another important note is that cutting is a specific subset of a larger group known as Non-Suicidal Self-Injury, or NSSI. This is often shortened to Self-Injury or SI. Styer quotes Favazza as saying "Self-injurious behavior has been described as the intentional injury of one's body, primarily through tissue damage and without suicidal intent (2006)." This is a broad ranging definition that covers not only socially unacceptable NSSI behavior, such as self-cutting and self-branding, but body piercing and other such decorative modifications as well, even when such

modifications are done to oneself. A common example of this in teenage years is piercing the ears. Although usually done by another individual, often this is done to oneself.

A far better definition is given to us by the International Network for the Study of Self-injury (ISSS) in 2007. Heath, Toste, Nedecheva, and Charlebois provided the ISSS definition below:

> "The deliberate, self-inflicted destruction of body tissue resulting in immediate damage, without suicidal intent and for purposes not socially sanctioned. As such, this behavior is distinguished from: suicidal behaviors involving intent to die, drug overdoses, and other forms of self-injurious behaviors, including culturally-sanctioned behaviors performed for display or aesthetic purposes; repetitive, stereotypical forms found among individuals with developmental disorders and cognitive disabilities, and severe forms (e.g., self-immolation and auto-castration) found among individuals with psychosis (2008)."

This definition, although somewhat laborious, assists in distinguishing an NSSI behavior from socially acceptable acts and from the far more serious acts brought on by those of serious mental illness.

"Current research on self-harm suggests that the rates are much higher among young people with the average age of onset around 12 years old. The earliest reported incidents of self-harm are in children between five and seven years old (Wikipedia, 2008). In a study conducted by Heath, et. al., 70 out of 85 participants reporting a history of NSSI were female. In this study, cutting had the highest rate of occurrence at 65.2%, with severe scratching being a close second with 56.5%. The study also found the highest age range for onset was 14 to 16 years (43.5%) but that 11 to 13 years was also common. The study also found that an onset over the age of 20 was not uncommon (2008). Wikipedia states that "There is no such thing as a typical young person who self-harms. Whilst the best available evidence indicates that four times as many girls than boys have direct experience of self-harm caution is needed in seeing self-harm as a greater problem for young women, since young males may well engage in different forms of self-harm which may be easier to hide

or explained as the result of different circumstances. Research also suggests that no one gender is more likely to use the method of skin-cutting (2008)."

Tillotson states that "the key common characteristics of individuals who engage in self-harm are problem-solving deficits, depression and hopelessness. Other characteristics include reduced capacity to regulate emotion, impulsivity, poor interpersonal communication skills, and a limited capacity to offer self-nurture or self-compassion (2008)." Tillotson claimed that experiences in the early development of an individual, such as abuse, lack of a positive role model, damaging environments or relationships, trauma and other negative experiences are often the root cause for the characteristics that may lead one to self-harm (2008). In addition, Tillotson also notes that normal incidents, including "environmental factors such as 'unemployment, financial and housing problems and social isolation' are also noted as associated factors contributing to the development of characteristics of self-harm (Tillotson, 2008)." This puts into perspective that cutting and other forms of self-injury can be influenced by anything, and that no defining characteristics or event cycle that causes cutters to develop a need for cutting.

"A common belief regarding self-injury is that it is an attention-seeking behavior; however, in most cases, this is inaccurate. Most self-injurers are very self-conscious of both their wounds and scars, and go to great lengths to conceal their behavior from others. They may offer alternative explanations for their injuries, or conceal their scars with clothing (Wikipedia, 2008)." The question as to why cutters cut themselves is different for many individuals. Some cutters cut because they are lonely. Some cut as a cry for help. Some cut because they cannot feel anything any other way. Some cut to punish themselves or others, or to feel in control over something since they have no control over anything else. Some cutters have been ritually abused, and have developed a belief that the pain of cutting will allow them to not have to hurt as much no matter what anyone else does to them. Some cannot tolerate their feelings and just want to feel nothing at all, and the act of cutting allows them to go emotionally numb as if the physical pain and blood allows their emotions to bleed out of them. For some, cutting is a release of

tension from general stress and anxiety, and from being overwhelmed. Some just want to disconnect from the world. This is one of the many reasons cutting and other forms of NSSI are so difficult to treat effectively, since even the cutters themselves do not always know why they cut (Styer, 2006).

Myths and misconceptions

The number of cutters appears to have grown over the years and, unfortunately, so has the myths and misconceptions of people who use self-injury as a method to cope. Sadly, most people do not understand the concept behind cutting.

Myth: All cutters have been abused.

The stereotype used to be if someone self-injured, they had been abused. This is not always the case, and many do not have any abuse history whatsoever (Styer, 2006). Cutters tend to come from all walks of life and no one type of person is a typical cutter.

Myth: All cutters are just seeking attention.

"Self injury is not a form of attention seeking. People called "copycat" self-injurers who cut themselves because their friends do it and they find it to be "cool" does exist, however, most do it because they do not know how to cope with their emotions (Styer, 2006)." They have spent most of their lives hidden behind their thoughts and feelings because they never learned how to express themselves. They learned to hurt themselves in order for them to feel better about themselves. No one can hurt them more than they can hurt themselves.

Myth: All cutters are mentally disturbed.

People who self-injure are not usually crazy. As a matter of fact, cutters generally tend to be intelligent, creative, very sensitive and caring individuals who express difficulty

communicating. Cutters tend to use their behaviors to be their voice as a way to cope. Many cutters present very well and are surprised to find that they purposely hurt themselves (2006).

Myth: Cutting is always a suicide attempt.

Self –injury is not a suicide attempt. "The public finds it difficult, as do many clinicians, to understand why people would purposely hurt themselves to feel better. Logically, this does not make sense to most people. If someone purposely cuts themselves, then this act is often logically perceived as a suicide attempt (2006)."

Behaviors and signs

People who cut themselves are applying self-injury to the body. Self-injury is often done in a secretive manner. Some cutters develop strange behavior because they do not want to be identified. There are several ways to detect self-injury and the behavior of those who cut. Self -injury is an act of attempting to alter a mood state by inflicting physical harm serious enough to cause tissue damage to ones body (Lyness, 2007).

The first way to distinguish a cutter is their choice of clothing. Ones who cut will wear clothing that may appear inappropriate to the weather, such as wearing sweaters in warm weather; some cutters wear long sleeves and wrist bands to cover scars. Those who cut themselves sometimes leave no area on the body to cut (Lyness, 2007).

The second sign is the unexplained scars. Most scars appear on the wrists, arms, and legs. Other forms of self -injury which include carving, burning, and biting. Some cutters make cuts so deep that they requires stitches or cases of hospitalization . The third sign is people who cut carry sharp objects such as knives or scissors without a good reason for having such objects . Cutters

often carry non-sterile or dirty cutting instruments such as razors, scissors, pins or even sharp edges of the tab on a can of soda (Tech girl, 2001).

Self-injury is an attempt at feeling better, but the cutter usually does not have lasting relief. SI could lead to compulsive behavior; a pattern of behavior that starts as an attempt to feel more in control, but can end up controlling the individual. Often, once can identify a cutter by their behavioral response to an emotional state (Matinson, 1998-2001).

First, cutters intend to isolate themselves from others . Those who engage in self-harm have problem-solving deficits, depression and feelings of hopelessness. Other characteristics include poor interpersonal communication skills; as a result cutters often severely isolate themselves from others.

The second behavioral sign is over or under flowing with emotional issues. Nearly 50% report physical abuse or sexual abuse during his or her childhood. Many self-injurers reports that they were discouraged from expressing emotion, particularly anger or sadness. People who practice self-injury have a tendency to get emotionally overwhelmed. An act of self-harm brings tension back to baseline level. In other words, self-injury reduces emotional discomfort (Matinson, 1998-2001).

Young men who have high rates of self-harm have historically been considered a high risk group for completed suicides. Self harm has increased over the past 20 year. Many cutters who are diagnosed with personality disorder or borderline personality disorder attempt suicide. One out of one hundred people who self harm are likely to commit suicide in one year. Research indicates 20 to 25% of individuals who complete suicide will have engaged in self harm prior to their death (Tillotson, 2008).

Cutters need more psychological intervention research to be effective in reducing the apparent growth of self harm among the general population.

Risks and dangers of cutting

What are the risks and dangers of cutting and self-harming? Some risks and dangers associated with cutting might seem obvious, while others are not so obvious. Some of the most apparent risks include scaring and loss of blood, as a result of cutting oneself. Beyond these examples are more serious risks and dangers including the fact that cutting can become habit forming and thus can create a compulsive behavior. As a direct result of the cutting itself, an individual runs the risk of developing infections, if the instruments used to cut are dirty. Another potential risk of cutting, in cases where two or more people cut themselves together, is the possibility of spreading diseases such as HIV and hepatitis. Although people who cut themselves usually do not intend to injure themselves permanently, cutters can often inflict greater damage to their body than is intended. Should the person cut too deeply, the cutter can cause permanent damage to muscles and tendons (Teens Health, 2007). Another danger to people who cut themselves is a lack of appropriate treatment in an emergency room and hospital setting, which includes negative attitudes by hospital personnel, which serves to reinforce the low self esteem, which is common in individuals who self-injury themselves. Finally, the greatest risk to people who cut themselves is the potential to commit suicide. Approximately one quarter of individuals who commit suicide have committed self-injury, such as cutting, within the year preceding the suicide (Broadhurst & Gill, 2007).

Treatment

Treatment for people who cut themselves varies upon each individual. Since cutters do so for different reasons, counselors must first talk to the clients and diagnose from fact." While various diagnoses have been found to co-exist among clients who self-injure, very little is known about the diagnoses or psychological symptoms related to self-injury, specifically among clients who reside in the community and are seeking outpatient services by mental health professionals. Studies have been conducted on inpatient settings only and treatment for outpatient clients is still unknown since treatment can be difficult without close observation. Cutters have a higher risk of cutting again especially if placed in confinement. As mentioned previously, cutters are not crazy, they have poor coping methods to relieve stress and have found cutting as a stress relief. Two of the most common treatments for cutting, would be a behaviorally based treatment and a cognitive based treatment.

"Behaviorally based treatment methods include behavior modification, problem-solving, behavior-substitution, and relaxation.(Trepal, 2007)" Researchers have found that cutters respond best when they are given tools that mimic the effects of cutting, without actual tissue damage. "Specifically, one researcher mentioned the use of Dialectic Behavior Therapy (DBT), an approach that provides clients with problem-solving strategies while using validation strategies to encourage use of newly learned behaviors. In addition, clients work on the ability to communicate and enhance relationships with others (Trepal, 2007)." Since communication is where they lack the confidence, counselors have found it necessary to allow the cutters space and allow the cutter to open up at their own pace. Any quick judgment with or without anger can send the cutter back to the beginning, with little to no self-esteem.

Another researcher also suggested behaviorally based methods, using reinforcements to increase adaptive forms of coping and problem-solving, while using negative reinforcements to decrease the use of self-injury. Some suggest implementing self-soothing strategies using relaxation and imagery to help a client be able to control, stop, and manage unwanted or intense emotions, including a behavioral plan to identify triggers, stopping points, and physical cues to self-injury. "Clinicians discussed replacing cutting with non-damaging alternative methods that provide the same stimulus to clients who self-injure until the underlying reasons for the behavior can be found. For example, they suggested that if a client tends to stop self-injuring when seeing the blood on his or her arm from cutting, then have the client use a red marker on their arm to simulate the red aspect of blood; or if they like the sensation that burning creates, suggest they use an ice cube or toothbrush to rub on their skin to experience a similar sensation without causing tissue damage (Trepal, 2007).” These methods have proven to help some but are not necessarily helpful to everyone who cuts.

The second form of treatment is cognitive behavioral therapy (CBT), where the clients realize the connection between their thoughts and beliefs and how it influences emotion and behavior. Cognitive behavior therapy is a short-term intervention with the aim of solving current problems and modifying dysfunctional thinking and/ or behavior (Beck 1995.)

“In terms of cognitive maintenance, the functions of self-harm are to facilitate compensatory strategies to overcome the identified characteristics and skills deficits. It is widely accepted that self-harm is used as a coping strategy to provide distraction or as a method of managing emotion, discomfort or negative cognitions, or to communicate distress (Richardson 2004). Self-harm may also highlight a need for care, or provide an opportunity to offer self-care in an environment where care needs are not met (Tillotson, 2008).”

Every cutter has beliefs in their minds that have enabled them to cope with daily living. Fundamental beliefs reflect the individual's sense of self, the world and others, and are known as the "powerhouse driving urges to cut (Kennerley, 2004). They provide the underpinning motivation to consider self-harm as an option more generally--for example: 'I am bad, I deserve to hurt' (Kennerley 2004)." Cutters of this nature tend to reinforce signs of depression and hopelessness, therefore, compounding existing problems (Tillotson, 2008)."

Facilitating beliefs allow cutters to make excuses in order for them to continue the behavior. This behavior goes along with the ideas in their heads and allows the unthinkable acts to continue. Facilitating cognitions, which may include negative automatic thoughts and or predictions, are described as: "I can't tolerate this feeling and there is no other way to deal with it (Kennerley 2004)." Reduced problem-solving abilities, impulsivity, poor interpersonal communication skills and a limited capacity to self-nurture and offer compassion may reinforce facilitating beliefs as an individual has a limited range of coping methods available at the time of self-harm. Without facilitating, permission-giving beliefs the urge to engage in self-harm would not be fulfilled and behavior would not occur, therefore, these cognitions offer a seal of approval that links cognition and behavior.

Reactions to self-injury enable such cognitions and behaviors to be maintained. Cutters cut because they already feel like they are bad people and that the only way they can cope are by cutting themselves. Any negative reactions given to the cutters can only reinforces what they already feel to be true. Although most people do not understand why cutters cut, it is important that judgment not be placed and or anger be displayed in front of the person whom is cutting. This can only reinforce the fact they feel cutting is the only way to deal with their feelings.

Flashbacks and intrusive recollections of incidents of self-harm or of other difficult memories serve as triggering events for further validation of fundamental beliefs. Intrusions, ruminations and memories prove to be distressing for the individual. When people have demonstrated reduced problem-solving skills and a limited capacity to self-nurture, options for managing these recollections may be limited.

However, the key to helping this group lies with assisting discovery of the individual function of self-harm, discovery of the underpinning belief system and identification of beliefs about the consequences of self-harm (Kennerley 2004), therefore, determining future vulnerability.

Counselors must consider the characteristics and functions of cutters in order to provide the best treatment. Interventions are appropriate when dealing with depression and hopelessness since they are at a higher rate of hurting themselves once again. These conditions must be handled by the appropriate professional. Researchers have found cutters who are in a structured environment may offer more pleasure for the client without causing them to act out for the time being. Cutters have to relearn what they know in order to stop the insanity. Cognitive restructuring, via Socratic dialog and thought diaries, may assist in overcoming maintenance-level cognitions that may contribute to depression and hopelessness. Alongside this the concept of problem-solving may be helpful and may impact on impulsivity as the ranges of coping options are increased. Affect tolerance and cognitive work concerning self-nurture would appear to be beneficial and could be achieved with the use of modified thought diaries as noted in Paul Gilbert's 'compassionate minds' work (Gilbert 2005) and through role-play.

These interventions may initially be directed at maintenance-level cognitions. However, underpinning cognitive constructs--i.e. schematic/core beliefs--could prove to be obstacles to the

resolution of maintenance problems. An idiosyncratic formulation informed by the cognitive model, incorporating cognitions, emotions, behaviors and biology as well as environmental and social factors, would appear to be essential in providing maps for understanding. This would be useful both for client and therapist, and assist intervention. More general therapeutic skills such as genuineness, empathy and warmth and providing a safe and open environment, including consistency in approach, will prove to be paramount in engaging this client group while maintaining a structured, time-limited focus in which to support the individual to make necessary changes.

Conclusion

As cutters face life on a daily basis, they have found that cutting is their only hope. They have learned to hold in their thoughts and feelings and are unable to communicate with others regarding their feelings. Researchers have found that these people are not crazy, nor should they be locked up for life. While there are some typical behaviors and signs, these are not always effective indicators of self-injurers. Unfortunately, due to the highly secretive nature of cutters, fueled by their desire to remain undetected, cutters often use non-sterile implements posing serious health risks. Treatment is a difficult process that is highly individualistic.

Resources for Cutters and other Self-Injurers

S.A.F.E. http://www.selfinjury.com/

ASHIC http://www.selfinjury.org/

The Preteen Alliance http://forum.lpfch.org/

Emotions Anonymous http://www.emotionsanonymous.org/

http://www.palace.net/~llama/psych/injury.html

http://www.recoveryourlife.com/

http://www.selfinjuryhelp.com/

http://www.coolnurse.com/self-injury.htm

http://www.youngwomenshealth.org/si.html

http://recoveryissexy.com/stopping-self-injury-self-help/

References

Alderman, T. (1997). The scarred soul: Understanding and ending self-inflicted violence. Oakland, CA: *New Harbinger Publications, Inc*.

Beck J (1995) Cognitive Therapy: Basics and Beyond. *Guilford Press.*

Broadhurst, M & Gill, P. (2007). Repeated self-injury from a liaison psychiatry perspective. *Advances in Psychiatric Treatment*. The Royal College of Psychiatrists.

Cameron, L. (2003). Challenges for ELT from the expansion in teaching children. *ELT Journal, 57*, 105 – 112.

Clarkin, J., Widiger, T., & Frances, A. (1983). A prototypic typology and the borderline personality disorder. *Journal of Abnormal Psychology*, 92, 263-275.

Demchak, M. A., & Halle, J. W. (1985). Motivational assessment: A potential means of enhancing treatment success.

Gilbert P (2005) Compassionate Mind Worksheets and Handouts. *Mental Health Research Unit, Kingsway Hospital, Derby*.

Heath, L., Toste, J., Nedecheva, T, and Charlebois (April 2008). An examination of nonsuicidal self-injury among college students. *Journal of Mental Health Counseling*, 30/2 pp 137-156.

Kehrberg, C. (1997). Self-mutilating behavior. *Journal of Child and Adolescent Psychiatric Nursing*, 10, 35-40.

Kennerley H (2004) Self-injurious behaviour. Oxford Guide to Behavioural Experiments in Cognitive Therapy. *Oxford University Press.*

Linehan, M. M. (1987a). Cognitive-behavioral treatment of borderline personality disorder. *Guilford Press*.

Lyness, D. (2007). Cutting. *Teens Health*. Retrieved May 29, 2008 from http://www.kidshealth.org/teen/your_mind/mental_health/cutting.html

Masters,A. (2007). Persistent methods of education. *ELT Journal, 77*, 95 – 102.

Milnes, D., Owens, D., & Blenkiron, P. (2002). Problems reported by self-harm patients: Perceptions, hopelessness, and suicidal intent. *Journal of Psychosomatic Research*, 53, 819-822.

Styer, D M (December 2006). An understanding of self-injury and suicide. (Disease/Disorder overview). *The Prevention Researcher*. , 13, p.10(3). Retrieved June 02, 2008, from http://find.galegroup.com/ips/start.do?prodId=IPS

Tillotson, K. (Feb 2008). Is cognitive behaviour therapy useful for people who self harm? *Mental Health Practice*. , 11, 5. p.28(4). Retrieved June 02, 2008, from http://find.galegroup.com/ips/start.do?prodId=IPS

Trepal, H,Wester, K.(2007). Self-injurious behaviors, diagnoses, and treatment methods: What mental health professionals are reporting. *Journal of Mental Health Counseling*,29(4),363-375. Retrieved June 2, 2008, from Research Library database. (Document ID:1378470341).

Wikipedia (2008)Self-Injury. *Wikipedia*. Retrieved June 02, 2008, from http://en.wikipedia.org/wiki/Self-injury

Yang, L. J. (2003). Combination of extinction and protective measures in the treatment of severely self-injurious behavior. *Behavioral Interventions*, 18, 109-121.