Acute management of the self-cutter

C. MALONEY, S. SHAH AND D. G. FERGUSON

Department of Accident and Emergency Medicine, Royal Hallamshire Hospital, Sheffield, England

SUMMARY

'Self-cutting' is a specific type of emergency presenting to accident and emergency departments. All cases presenting in Sheffield in a 6-month period were studied. The self-cutter is most often a young, unemployed man: this is the group most likely to cut repeatedly. At least 45% of all cutters had a past psychiatric history, and a quarter of them were judged a high suicidal risk. The seriousness of the physical injury and the suicidal risk cannot be simply correlated.

The crucial part of acute management is the decision about psychiatric referral. As with a complex physical injury, formal assessment must be performed and specialist referral made on that basis.

INTRODUCTION

An estimated 4000 people die by their own hand in England and Wales each year (Office of Health Economics, 1981). A far greater number make suicidal gestures, with a varying degree of intent. Deliberate self-harm is a significant part of the workload of any accident and emergency department. The majority of such acts involve drug overdose. Many, however, are acts of self-cutting, usually of the wrists. Self-cutting is a specific type of emergency presenting to the accident and emergency department: the authors studied its presentation and management in Sheffield over a 6-month period.

METHOD

Sheffield has an accident and emergency department at each of two large city hospitals. The authors looked at all new patients presenting to both between 1 August 1985 and 31 January 1986. For each 'self-cutter' a form was filled by the casualty officer responsible.

Correspondence: Mr D. G. Ferguson, Consultant in Accident and Emergency Medicine, Royal Hallamshire Hospital, Glossop Road, Sheffield, England

This had four elements: basic demographic data, a description of the cut(s), details of management and background, when available, on the patient. Departmental records were regularly examined to pick up all cases, with cross-checking for repeated attenders. The Coroner's office was contacted for news of any fatalities.

RESULTS

Who are the wrist cutters?

In the 6 months, 46 426 new patients were seen between the two departments. Eighty-one of these had cut themselves intentionally, five more than once in the 6 months. Cutters were predominantly male and aged under 35 years (Table 1). Forty-six of them (56·8%) were unemployed.

Most cuts were made at home (78·7%): only rarely was the act a public gesture, usually as part of a florid mental disturbance. The peak time for cutting was 10 pm–2 am (32 cuts). There was no other cluster through the day, but a relative lull between 6 am and noon.

Table 1 Age and sex of self-cutters

	Male (%)	Female (%)	Total (%)
All patients	57 (70·3)	24 (29·7)	81 (100)
Aged 35 years and under	39 (48·0)	16 (19·8)	55 (67·9)
Aged 25 years and under			38 (46·9)

Use of alcohol

The amount of alcohol drunk at the time of a cut was difficult to determine exactly. The authors took a history of the amount taken and usual drinking. In all, answers were given by 51 of the 81 cutters. The patterns for men and women are shown in Tables 2 and 3.

Table 2 Drinking patterns of male self-cutters (no. = 35)*

<i>Amount drunk at time of cut</i>	<i>Usual intake (standard units/night)</i>			<i>Total</i>
	< 6	6–10	> 10	
0	9	1	–	10
< 5	2	–	–	2
5–20	9	7	4	20
> 20	–	1	2	3

* No assessment made for 22 men.

Table 3 Drinking patterns of female self-cutters (no. = 16)¹

<i>Amount drunk at time of cut</i>	<i>Usual intake (standard units/night)²</i>			
	< 6	6–10	> 10	Total
0	11	–	–	11
< 5	2	–	–	2
5–20	1	1	–	2
> 20	–	–	1	1

¹ No assessment made for eight women.

² 'Standard units': 1 unit = $\frac{1}{2}$ pint beer or lager = 1 measure spirits.

Bearing in mind the limitations of the data, there appears to be a difference between the sexes. Most women were sober when they cut, but over 60% of the men, however, had drunk 5 units or more.

The cut

The majority cut their wrists (Table 4; Figs 1 & 2). Of five others, one stabbed herself in the abdomen with a breadknife after a month of depression and heavy drinking. The other four had made trivial cuts to the face and neck. None of the wrist lacerations were life-threatening in themselves. One boy cut a major vein: he had made two other attempts in the previous 2 days (in another city). Seven of the cuts involved tendons: in one of these the ulnar nerve was cut as well. The remainder required little treatment (Table 5).

The psychiatric problem

Five patients came from psychiatric wards and returned after treatment: other cuts, not judged worthy of referral, may have been made there.

Tables 6 and 7 show the pattern of psychiatric referral and its outcome. In total, 20 of the 81 cutters were judged as a high suicidal risk—almost 25%.

Table 4 Choice of site for self-cutting

	<i>No. of cutters</i>
Wrists/forearm alone	72
Wrists/forearm and other site	4 (all to trunk, superficial)
Neck/face	4
Abdomen	1
Total	81

Figs 1 and 2 Self-inflicted wounds to the wrist.

Table 5 Physical management of wrist cuts

	<i>No. of patients</i>
No treatment	9
<i>'Simple' treatment</i>	
Cleaned and dressed only (including 'Steristrips')	35
Sutured	21
Tendon repair in department	2 (extensor tendon) 1 (palmaris longus)
Specialist referral for tendon repair	4
Left before receiving treatment	4
Total	76

Table 6 Psychiatric referral

No referral made	18 (4 own discharge)
Admitted for physical problem (no acute referral)	11
Continuing as psychiatric in-patient	5
Acute psychiatric referral	47
Total	81

Table 7 Outcome of psychiatric referral

Discharged	6
Home, with out-patient appointment	24
Admission	17

Was the degree of physical injury related to perceived suicidal risk? One of the cuts was life-threatening—an abdominal wound with peritonitis. One more involved a major vein. Both were judged, on other grounds, to be of high intent. The remaining 79 were minor injuries. Classifying them as ‘deep’ (beyond skin and fat) and ‘superficial’, the authors compared management (Table 8).

No clear correlation was demonstrated between depth of cut and need for intervention. Clinically, there were many cases of a negligible wound with high intent: suicidal risk cannot be judged by the seriousness of the cut.

Table 8 Psychiatric management of the cutter in terms of depth of injury*

	<i>Depth of cut</i>	
	<i>Superficial</i>	<i>Deep</i>
Acute admission	11	6
Psychiatric follow-up	10	14
Discharge by psychiatrist	4	2
Discharge (A & E)	12	2

* Four patients took own discharge.

Eleven were admitted for other reasons.

Five psychiatric patients returned directly to their wards.

Previous psychiatric problems

Seven people were judged psychotic when they cut, two presenting for the first time.

Of 63 patients who gave a past history, 35 had seen a psychiatrist before: six of these were still in treatment. Nineteen cutters were known to have done it before, only 14 of whom admitted psychiatric contact in the past. Fourteen of these repeated cutters were men.

Thus, of all our cutters, 44% were *known* to have had past psychiatric treatment. Many of the others may also have had problems in the past.

DISCUSSION

Women make suicidal gestures more often than men (Hawton & Catalan, 1982). The typical self-cutter has been said to be the young, attractive, single female who repeatedly attacks her wrists (Simpson, 1976): a conclusion drawn from psychiatric in-patients. Our experience does not bear this out. A community-based study (Clendenen & Murphy, 1971) confirms our picture. The typical self-cutter is a young male. It has been seen further that he is often unemployed, with an increased likelihood of having made a previous cut. A strong correlation between employment and the suicidal gesture has been established on a far larger sample of men (Platt & Kreitman, 1984): self-cutting may be expected to be on the increase.

Acute management

The physical injury is often trivial. If complex, management is that of trauma of any other cause. The difficulties lie with diagnosis and assessment.

Often the nature of a cut is not admitted. It may be claimed accidental or to have been inflicted by others. The story may be implausible or not fit the features of the wound. Self-inflicted cuts are often multiple, initially tentative, and there may be scars from previous attempts. A companion may give an accurate history.

In Sheffield, all overdoses are admitted as hospital policy but self-cutters are not. Physical seriousness of the attempt is easily assessed for a cut but, as has been seen, this cannot be correlated with suicidal intent. The crucial decision for the casualty officer is whether to make a psychiatric referral.

Assessment of suicidal risk in the accident department has been discussed elsewhere (Gardner *et al.*, 1982; Kessell, 1985), and guidelines issued by the Department of Health and Social Security (DHSS, 1984). Treatment and disposal based on the initial assessment by the casualty officer, and without psychiatric referral, is now officially acceptable.

It is suggested that the possibility of self-cutting should be borne in mind with all unusual presentations of lacerations. Each known cutter requires careful psychiatric assessment by the accident and emergency staff, who must then decide to refer, as with any complex physical problem. The temptation to correlate the seriousness of the injury and degree of psychiatric illness or suicidal intent should be resisted.

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