

Repetetively Cutting Own Oral Mucosa as a Self-Harming Behavior: A Case Report

Esra Alatas¹,
Suheyla Dogan Bulut¹,
Tonguc Demir Berkol¹,
Gazi Alatas²

¹Psychiatrist, Diskapi Yildirim Beyazit Training and Education Hospital, Psychiatry Clinic, Ankara - Turkey
²Psychiatrist, Ministry of Family and Social Policies, Ankara - Turkey



ABSTRACT

Repetetively cutting own oral mucosa as a self-harming behavior: a case report

Self-harm behavior, defined as repetitive and deliberate attempts of harm to self-body without suicidal intentions and resulting in tissue damage, is classified in the text revision of Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV-TR) under the sections of impulse-control disorder not otherwise specified and stereotypic movement disorder which falls under the category of disorders usually first diagnosed in infancy, childhood or adolescence. For DSM-V, a separate classification with the title of non-suicidal self-harm has been recommended and defined separately as personal history of self-harm under the section of other circumstances of personal history under the main category of other conditions that may be a focus of clinical attention. The most encountered form of self-harm behavior starting mostly in adolescence is harming by self-cutting and mostly legs and arms are chosen. Such behavior is generally accompanied with personality disorder, depression, substance abuse. In this article, a case of cutting, a common form of self harm behavior that involves one of the rare parts of the body, oral mucosa is discussed.

Key words: Cutting oral mucosa, impulse control disorder, self-harm

ÖZET

Kendine zarar verme davranışı olarak tekrarlayıcı şekilde kendi ağız mukozasını kesme: Olgu sunumu

Tekrarlayıcı, tasarlanmış bir şekilde, ölüm isteği olmadan yapılan, doku hasarı ile sonuçlanan, kendi vücuduna yönelik girişimler olarak tanımlanan kendine zarar verme davranışı, Ruhsal Bozuklukların Tanısal ve Sayımsal El Kitabının yeniden gözden geçirilmiş dördüncü baskısında (DSM-IV TR) başka bir yerde sınıflandırılmamış dürtü kontrol bozuklukları ve ilk kez bebeklik çocukluk çağı ve ergenlikte tanısı konan bozukluklar içinde basmakalıp davranım bozuklukları başlıkları altında yer almaktadır. DSM-V için intihar niteliği olmayan kendine zarar verme başlığı ile ayrı bir tanımlama önerilmiş ve klinik ilgi odağı olabilecek diğer durumlar bölümünde, kişisel öykünün olduğu diğer durumlar başlığı altında, 'kendine zarar verme öyküsü' olarak ayrıca tanımlanmıştır. Sıklıkla ergenlikte başlayan kendine zarar verme davranışının en çok karşılaşılan şekli kendini keserek zarar verme olup, çoğunlukla da kollar ve bacaklar seçilmektedir. Genellikle kişilik bozuklukları, depresyon, madde kullanımı ile birlikte görülmektedir. Bu makalede kendine zarar verme şekillerinden sıkça görülen kesmeyi, oldukça seyrek görüldüğü bir bölge olan ağız içinde gerçekleştiren bir olgu anlatılacaktır.

Anahtar kelimeler: Ağız mukozasını kesme, dürtü kontrol bozukluğu, kendine zarar verme

Address reprint requests to / Yazışma adresi:
Psychiatrist Esra Alatas
Diskapi Yildirim Beyazit Training and Education Hospital, Psychiatry Clinic, Ankara - Turkey
Phone / Telefon: +90-312-596-2986

E-mail address / Elektronik posta adresi:
esra.alatas@hotmail.com

Date of receipt / Geliş tarihi:
June 17, 2013 / 17 Haziran 2013

Date of acceptance / Kabul tarihi:
August 6, 2013 / 6 Ağustos 2013

INTRODUCTION

Self-harm behavior is defined as attempts of harm towards one's own body, which are carried out deliberately, repetitively, without intent to die and resulting in tissue damage (1).

Not defined under a specific title in Diagnostic and Statistical Manual of Mental Disorders fourth edition DSM-IV, it is associated with psychiatric disorders such

as mood disorders, dissociative disorders and borderline personality disorders. While in DSM-IV TR it is placed under the category of "impulse-control disorder not otherwise specified" which is defined as "this category is for disorders of impulse control that do not meet the criteria for any specific impulse-control disorder or for another mental disorder having features involving impulse control described elsewhere in the manual" and under the category of "stereotypic movement disorder"

which falls under the category of “disorders usually first diagnosed in infancy, childhood, or adolescence” (2); in DSM-V it is considered as a new diagnostic category with a separate title of “personal history of self-harm” under the section of “other circumstances of personal history” which falls under the main category of “other conditions that may be a focus of clinical attention” (3).

While self-cutting, constituting 72% of all cases, is the most frequently observed one among repetitive behaviors of self-harm, others line up as burning 35%, hitting to the body 30%, prevention of the healing of wounds 22%, constant scratching of skin 22%, self-inflicted breaking of bones 8% and vaginal tearing 8% (4). In the majority of the cases (approximately 75%) more than one method of harm were used (5). In addition to these, behaviors of removing scabs, the biting and crushing of fingers, hair pulling, acid spilling, and self-biting have also been reported (6). Areas that are most frequently harmed are arms in 74%, legs in 44%, abdomen in 25%, head in 23%, chest in 18%, and genital areas in 8% (4).

Self-harm behavior is a condition often detected within personality disorders, especially borderline, histrionic, and antisocial personality disorder (7). They often co-occur with depressive disorder. Substance abuse, disruptive behavior disorders, anxiety disorders, and bipolar disorders are among other frequent diagnoses (8,9).

Here, we will mention a repetitive self-harm behavior through a case who had self-harm behavior together with symptoms of obsessive compulsive features and anxiety yet does not meet DSM-IV criteria for these diagnosis. Written consent has been obtained from the patient in order to present this case.

CASE

The patient, a 25 year-old married woman with one child, was admitted to our outpatient clinic by guidance of the doctor in charge of her treatment in the emergency room of a private hospital where she went after shearing inside of her mouth.

The patient was born as the first child of a government employee and a housewife. She and her three year

younger brother were grown up together by their parents. She worked as a secretary after graduated from high school. While getting engaged first by her own accord, she wished to separate from her fiancée later but eventually married at the age of 20 with him not to upset her father. She left her city, family, and job in order to begin living with her husband and mother-in-law. The patient's pre-married life does not contain any history of neglect or abuse, and she reported that her family relations was good in this period.

The patient first began biting her mouth in high school due to class-related anxiety. Short time after she married, due to arguments with her husband and mother-in-law, she began to pull at the edge of her lips and cheeks to cut the inner mucosa of her mouth. Realizing that this relaxed her, the frequency of the cutting increased, to a point wherein she felt as though the cutting of even the protrusions of inner lining of her mouth felt by her tongue was necessary. After a few months she bought scissors ranging in size primarily for this purpose. She was obsessed with the layout inside her mouth in the same way she did with the symmetry of objects inside her house. However, she did not organize the furniture every time she was obsessed and even if she did, it did not take much of her time. The patient, who sheared her mouth for 5 years, did so at least 3 times a week, sometimes reaching 5-6 times. While pressing salt onto the wounds in order to stop the bleeding, the increase in pain also had an effect of relaxation. If the bleeding became too much, she referred to a doctor for treatment. Being prevented, arguing with her husband increased her want to cut, and she was not able to stop it despite knowing that she should not do it.

During 6th month of her pregnancy, she was hospitalized and treated in the intensive care unit for 1 week due to the cutting of her wrist and overdosing on medical drugs in a suicide attempt. During this time, a lack of social support increased her behaviors of self-harm. In one instance during her pregnancy, the patient ran away from her home, but was found immediately and taken back to home by the police.

Other than an instance of alcohol use 6 months ago in the form of drinking a single beer a day for a month, there was nothing remarkable in her medical history.

Her family history was also unremarkable.

During her mental state examination, she displayed actions appropriate to her age and maturity, adequate self-care, a willingness to communicate, and gave proper answers to the questions asked to her. She displayed dysphoric moods and anxiety. There were no indications of hallucinations or delusions. She exhibited obsession and compulsion for the symmetry and organization of her household. Nevertheless, this did not meet the DSM-IV diagnosis for an obsessive-compulsive disorder. The administered Minnesota Multiphasic Personality Inventory (MMPI) test did not display anything remarkable either, other than obsessive features and symptoms of anxiety. Her physical and neurological examinations were considered to be normal. Her biochemical and hormonal test results were within normal limits.

According to the criteria of the DSM-IV, the patient diagnosed with not otherwise classified impulse control disorder and was prescribed 20 mg of escitalopram a day to reduce anxiety, and given weekly individual therapy sessions. At the end of the third week, her anxiety symptoms lessened and her actions of self-harm decreased to twice a week. At the end of the second month, her self-harm was reduced to only a single instance per 10-15 day period, though not ending completely. At the end of the third month of the treatment, the patient displayed self-harm only 2-3 times a month, and stopped coming to follow-up sessions. In the 6th month, the patient was invited to the clinic, she reported that because her condition was improved, she did not come to follow-up visits, and although she continued her medication sometimes she did not take her prescription, and the clinicians were informed that she only displayed signs of self-harm during extreme events of tension. Revising her diagnosis to "Personal History of Self-Harm" according to DSM-V, was deemed suitable.

DISCUSSION

Behaviors of self-harm mostly start during adolescence, especially between the ages of 13-19 (3,10). They are more frequently seen among those of

lower socioeconomic class, singles, and women. Self-harm behavior has been reported to be seen at a rate of 1% within society, but can reach up to 12% among teenagers and young adults (11,12). The results of a national study involving teenagers admitted to outpatient psychiatry clinics showed similarly that, intentional self-harm behavior was seen in 50% of them, and that it was more common among girls than boys (13).

Self-harm behaviors generally occur after instances of high levels of anxiety and when alone, and there is a tendency to hide the scars. These behaviors have been reported to be used more as a way of reducing high levels of anxiety by transforming it into physical pain than being done out of some manipulative intent (14). Past or continuing events of physical or sexual abuse and separation anxiety in early stages of childhood have been said to play a role (15), the reason of the behavior was tried to be explained as a way to punish themselves, or control the extreme events of tension they experienced (16).

In our case also, self-harm behaviors began during adolescence, and increased due to further negative life events. The patient did not mention any history of neglect or abuse in childhood. It is believed that self-cutting provided a relaxation from pressure arising from the inability to adapt to the environment or intolerance (17).

The behavior of self-harm includes repetition of self-harm behavior, feeling of tension before self-harming, experiencing relief, enjoyment and pleasure together with physical pain, trying to hide the evidence of self-harm and blood because of embarrassment and fear of social stigma (4). In our case, self-harm behaviors increase along with adverse living conditions, she reduces internal tension by self-harming, afterwards regrets what she has done, exhibits the behavior when alone, and tries to find solutions through practices such as pressing salt onto her own wounds.

Among cases of those admitted for self-harm behavior, 15% of them are readmitted into the hospitals in one year, and more than 5% of them attempt suicide during the 9 year period (18). Displaying self harm behavior is a strong predictor of possible suicide

attempts. The risk of suicide is especially high during the first 6 months of self-harm, but the risk still exists after 6 months (19).

Self-harm behavior is divided into different groups in different classifications. Taiminen et al. (20) handled it in two groups based on the level of severity. Major self-harm, including the instances such as eye removal, amputation of genital organs or an extremity, is more often seen in psychotic disorders or major sexual identity disorders. Minor self-harm on the other hand includes behaviors like cutting of the skin, burning, stabbing with pins, letting off blood, self-biting, hair pulling, and the self-induced breaking of bones.

Favazza (7) considered self-harm in three groups. 1- Major self-harming: including permanent bodily damage such as eye amputation and castration 2- Stereotypical self-harm: such as repetitive head striking as seen in Tourette Syndrome and mental retardation, and self-biting and 3- Superficial/middle self-harm: cutting skin, burning oneself, and hair pulling, etc.

In another classification, self-harm is divided into

two groups; culturally accepted harms (e.g. Piercing, tattooing, cauterization), and socially unaccepted harming behaviors. Actions not accepted by societal norms are further divided into subsections of major, stereotypic, compulsive and impulsive self-harm. While major, stereotypic, and compulsive harms are causes of frequent psychiatric visits, compulsive and especially impulsive self-harm behaviors are very common also in general population.

In the treatment of self-harm, treating only the main disorder and considering the self harm as a sign of or accompany to a main disease consequently expecting a recovery in self harm due to the treatment of the major problem may cause unexpected results.

By giving additional emphasize on self-harm behavior, requirements to end such behaviors should be specified and studies need to be conducted with patience. Despite all these, there is still a need for developed treatment approaches for self-harm behavior, effectiveness of which are supported by studies.

REFERENCES

1. Feldman MD. The challenge of self-mutilation: a review. *Compr Psychiatry* 1988; 29:252-269.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Publishing 2000.
3. American Psychiatric Association. *Desk Reference To The Diagnostic Criteria From DSM-V*. Washington, DC London, England: American Psychiatric Publishing, 2013; 372.
4. Favazza AR. Repetitive self-mutilation. *Psychiatr Ann* 1992; 22:60-63.
5. Langbehn D, Pfohl B. Clinical correlates of self-mutilation among psychiatric inpatients. *Ann Clin Psychiatry* 1993; 5:45-51.
6. Ghaziuddin M, Tsai L, Naylor M. Mood disorder in group of self-cutting adolescents. *Acta Pedopsychiatry* 1992; 55:103-105.
7. Favazza AR. Self-injurious behavior in college students. *Pediatrics* 2006; 117:2283-2284.
8. Olfson M, Gameroff MJ, Marcus SC. National trends in hospitalization of youth with intentional self-inflicted injuries. *Am J Psychiatry* 2005; 162:1328-1335.
9. Portzky G, van Heeringen K. Deliberate self-harm in adolescents. *Curr Opin Psychiatry* 2007; 20:337-342.
10. Pattison EM, Kahan J. The Deliberate Self-harm Syndrome. *Am J Psychiatry* 1983; 140:867-872.
11. Roberts-Dobie S, Donatelle RJ. School counselors and student self. *J Sch Health* 2007; 77:257-264.
12. Suyemoto KL, Kountz X. Self-mutilation. *Prev Res* 2000; 7:1-4.
13. Sacarcelik G, Turkcan A, Guveli H. The prevalence of deliberate self-harm behavior and its association with sociodemographic features in patients referred to secondary care psychiatric clinic for adolescents and young adults. *Düşünen Adam The Journal of Psychiatry and Neurological Sciences* 2011; 24:253-264. (Turkish)
14. Skegg K. Self-harm. *Lancet* 2005; 366:1471-1483.
15. Rosenthal RJ, Rinzler C, Walls R. Wrist cutting syndrome: the meaning of gesture. *Am J Psychiatry* 1972; 128:1363-1368.
16. Roy A. Self-mutilation. *Br J Med Psychol* 1978; 51:201-203.

17. Brunner R, Parzer P, Haffner J. Prevalence and psychological correlates of occasional and repetitive deliberate self-harm in adolescents. *Arch Pediatr Adolesc Med* 2007; 161:641-649.
18. Owens D, Horrocks J, House A. Fatal and nonfatal repetition of self-harm: systematic review. *Br J Psychiatry* 2002; 181:193-199.
19. Cooper J, Kapur N, Webb R. Suicide after deliberate self-harm: a 4-year cohort study. *Am J Psychiatry* 2005; 162:297-303.
20. Taiminen TJ, Kallio- Soukinen K, Nokso-Koivisto H. Contagion of deliberate self-harm among adolescent inpatients. *J Am Acad Child Adolesc Psychiatry* 1998; 37:211-217.
21. Schoppmann S, Schröck R, Schnepf W. 'Then I just showed her my arms . . .' Bodily sensations in moments of alienation related to self-injurious behaviour. A hermeneutic phenomenological study. *J Psychiatr Ment Health Nurs* 2007; 14:587-597.