Cutting Contagion in Schools

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References


OUTLINE

Etiology and Epidemiology of Teen Cutting

Risk Factors and Co-Morbidities for Cutting

Established Treatments for Cutting

Phenomenon of Cutting Contagion in Schools

School-Based Cutting Interventions
Question 1

Overall what percentage of teenagers report some form of self injury?

A) 1%
B) 5%
C) 15%
D) 25%
E) 50%
c) 15%
Question 2

What percentage of teenagers with mental health conditions report self injury?

A) 5%
B) 10%
C) 20%
D) 30%
E) 70%
e) 40-80% of adolescent psychiatric patients report self-injury
## Numbers

<table>
<thead>
<tr>
<th>Population</th>
<th>% Reporting Self-Injury</th>
</tr>
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<tbody>
<tr>
<td>All Adults</td>
<td>1-4%</td>
</tr>
<tr>
<td></td>
<td>(1%: chronic and severe self-injury)</td>
</tr>
<tr>
<td>All Adolescents</td>
<td>15%</td>
</tr>
<tr>
<td>All College Students</td>
<td>17-35%</td>
</tr>
<tr>
<td>All Psychiatric Patients</td>
<td>2-20%</td>
</tr>
<tr>
<td>Youth Psychiatric Patients</td>
<td>40-80%</td>
</tr>
</tbody>
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Question 3

Which of the following mental health conditions has the highest rate of self-injurious behavior?

A) Major Depressive Disorder
B) Borderline Personality Disorder
C) Dissociative Disorders
D) Eating Disorders
E) Alcohol Dependence
Answer

b) Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence of Self-Injury</th>
</tr>
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<tbody>
<tr>
<td>Borderline Personality Disorder</td>
<td>70-75%</td>
</tr>
<tr>
<td>Dissociative Disorder</td>
<td>Up to 69%</td>
</tr>
<tr>
<td>Eating Disorders (esp BN)</td>
<td>13-61%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>42%</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>25-33%</td>
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Question 4

What percentage of people who injure themselves have attempted suicide at least once?

A) 10%
B) 20%
C) 40%
D) 60%
E) 100%
Answer

d) 50-85% of people who injure themselves have attempted suicide at least once, and 40% of people have thoughts of suicide while engaging in self-injury

There is a significant literature base linking self-injury with suicidal thoughts and attempts, making self-injury a significant risk factor for suicide
Question 5

Which of the following best describes the course for self-injury in patients with BPD?

A) Continues to increase over the life time
B) Stays relatively stable over the lifetime
C) Decreases over the lifetime
D) Increases and decreases over the lifespan based on environmental/life stressors
Answer

d) Decreases over the lifespan.

A study by Zanarini showed that the rates of self-injury in BPD patients decreased from 80% initially to 28% over the course of 6 years. For other personality disorders a similar trend existed, 16.7% to 1.6% over the same 6 year period.
Course/Outcome

Self-Injury tends to be bimodal with peaks at ages 12-14 and then again 18-19 years of age.

Types of self-injury tend to increase from childhood to the mid-20s and then remain stable through the 6th decade of life.
The vast majority of people who have a lifetime history of self-injury have self-injured < 10 times.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Indicator</th>
<th>Severity/Risk</th>
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<tbody>
<tr>
<td>Number of Types Used</td>
<td>1</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>2-3</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>&gt;3</td>
<td>Severe</td>
</tr>
<tr>
<td>Number of Episodes</td>
<td>&lt;10</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>11-50</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>&gt;50</td>
<td>High</td>
</tr>
</tbody>
</table>
Why Do Kids/Teens Cut?
Many Theories

Cry for Help/Conveying Pain
Expression of Anger/Fear of Harming Others
Tension Relief/Coping Skill
Numbing Pain vs. Feeling Something
Difficulty Expressing/Communicating Emotions
Attempt to Influence the External Environment
History of Abuse/Internalized Self-Loathing
Lack of Social Supports
Greatest Fallacy Is Thinking Teens Who Cut Are “All the Same”
How to Talk About Self-Injury
Questions/Information Gathering

“Where do you hurt?”

ALWAYS screen for SI

Ask about Types of Injury, Onset, Place of Body, Severity/Extent of Damage, Functions of Self-Injury, Frequency, Repetition

Screen for Co-Morbid Mental Health Conditions

Screen for environmental stressors and abuse
## Therapeutic Approaches

<table>
<thead>
<tr>
<th>Psychodynamic Psychotherapies</th>
<th>Cognitive-Behavioral Psychotherapies</th>
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<tbody>
<tr>
<td>Transference-Focused Psychotherapy</td>
<td>Manual Assisted CBT</td>
</tr>
<tr>
<td>Mentalization-Based Therapy</td>
<td>Dialectical Behavior Therapy</td>
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Phenomenon of Cutting Contagion in Schools
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Definition: clusters of cutting behaviors within a school setting, beware of using term “trend” or “fad”

Youth may be cutting at younger ages (middle school)

Increase in male cutting behavior
Phenomenon of Cutting Contagion in Schools

Cutting may spread through:

- Direct observation of cutting (bathroom)
- Seeing cut marks on other students
- Social media or other communication
- Often close friend group → student body
Ethical Dilemma

Patient/Student Confidentiality and Privacy

Adequately Addressing Safety Concerns

Avoiding Reinforcement of Cutting Behavior Through Increased Attention
Micro vs. Macro

Individual + Group → Safe School
When assessing individual students with self-harming behaviors, the task is two-fold:

(1) Performing a risk assessment
(2) Behavioral assessment strategies
Assessment and Interventions with Potentially Suicidal Patients

**High Risk**
- Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.
- Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgement
- Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits

**Moderate Risk**
- Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt
- Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed
- Evaluate for psychiatric disorders, stressors, and additional risk factors
- Consider (locally or via telemedicine):
  1) psychopharmacological treatment with psychiatric consultation
  2) alcohol/drug assessment and referral and/or
  3) individual or family therapy referral
- Take action to prevent the plan
- Encourage social support, involving family members, close friends and community resources. If patient has therapist, call him/her in presence of patient.

**Low Risk**
- Patient has thoughts of death only; no plan or behavior

Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and collaboration with other providers. Make continued entries in tracking log.
Patients who exhibit cutting behaviors and are in the Low to Moderate Risk categories do continue to need regular monitoring by a school counselor.

Whether or not to refer a teen who is not in acute danger to a mental health counselor may depend on the available resources in your community.
Two Useful Tools

1) Functional Behavior Assessment (FBA)
2) Behavioral Chain Analysis (DBT)
Functional Behavior Assessment

New Mexico Public Education Department: Conducting a Functional Behavioral Assessment
http://www.ped.state.nm.us/RtI/behavior/4.fba.11.28.pdf
ABC Analysis

Antecedent  Behavior  Consequence  Function
ABC Analysis

Behaviorists are trained to always ask, “What is Driving the Behavior?”

This includes:
- What happens immediately preceding behavior?
- How is behavior carried out?
- What is the immediate consequence?
- What is the longer term function?
Many Theories

Cry for Help/Conveying Pain

Expression of Anger/Fear of Harming Others

Tension Relief/Coping Skill

Numbing Pain vs. Feeling Something

Difficulty Expressing/Communicating Emotions

Attempt to Influence the External Environment

History of Abuse/Internalized Self-Loathing

Lack of Social Supports
DBT Chain Analysis

Reacting Behaviors

Vulnerability

Trigger

Responsive Behaviors

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Guidelines for a Behavioral Chain Analysis

1) Describe the specific **PROBLEM BEHAVIOR** (example cutting or a suicide attempt)

   A) Be very specific and detailed. Avoid vague terms.

   B) Identify exactly what you did, said, thought, or felt

   C) Describe the intensity of the behavior and other characteristics of the behavior that are important

   D) Describe the problem behavior in enough detail that an actor in a play or movie could recreate the behavior exactly
Guidelines for a Behavioral Chain Analysis

2) Describe the specific **PRECIPITATING EVENT** that started the whole chain

A. Identify the environmental event that started the chain. Always start with some event in your environment, even if it doesn’t seem to you that the environmental event caused the problem behavior. Here are some possible questions to get to this:

1) When did the sequence of events that led to the problem behavior begin? When did the problem start?

*The night before*

2) What was going on at the moment the problem started?

*I was washing the dishes when my mom criticized me for missing a dish*

3) What were you doing, thinking, feeling, and imagining at the time?

*Thinking my parents hate me and I may as well end my life*

4) Why did the problem behavior happen on that day instead of the day before?

*Because my parents were not being nice to me*
Guidelines for a Behavioral Chain Analysis

3) Describe the **VULNERABILITY FACTORS** happening before the precipitating event. What factors or events made you more vulnerable to a problematic chain? Areas to examine include the following:

a) Physical illness, unbalanced eating or sleeping, injury: 
   *tired from staying up on the weekend*

b) Use of drugs or alcohol, misuse of prescription drugs

c) Stressful events in the environment (positive or negative):
   *on and off relationship with boyfriend*

d) Intense emotions, such as sadness, anger, fear, or loneliness

e) Previous behaviors of your own that you found stressful
4) Describe in excruciating detail the **CHAIN of EVENTS** that led up to the problem behavior.

What exact thought (or belief), feeling, or action followed the precipitating event? What thought, feeling, or action followed that? What next? What next?
Guidelines for a Behavioral Chain Analysis

5) What were the **CONSEQUENCES** of this behavior? Be specific. How did other people react immediately and later? How did you feel immediately following the behavior? How about later? What effect did the behavior have on you and your environment (could be positive or negative or both)?
Guidelines for a Behavioral Chain Analysis

6) Describe in detail different **SOLUTIONS** to the problem

   a) Go back to the chain of your behaviors following the prompting event. Circle each point or link where, if you had done something different, you would have avoided the problem behavior.

   b) What could you have done differently at each link in the chain of the events to avoid the problem behavior? What coping behaviors or skillful behaviors could you have used?
Guidelines for a Behavioral Chain Analysis

7) Describe in detail a **PREVENTION STRATEGY** for how you could have kept the chain from starting by reducing your vulnerability to the chain.

8) Describe what you are going to do to **REPAIR** important or significant consequences of the problem behavior.
Vulnerability: Conflicts with boyfriend and best friend; impaired sleep.

Prompting event: Father refused to grant a previous request; mother criticized her dishwashing.

Links: 
Emotion: Sadness.
Thought: “No one loves me any more.”

Consequences: 
Negative reinforcement: Experienced emotional relief.
Positive reinforcement: Mother and boyfriend lavished her with love and affection after suicide attempt.

Problem behavior: Suicide attempt/Planned harm herself with razors.

FIGURE 8.2. Behavioral chain analysis of Jessica’s suicide attempt.
FIGURE 8.3. Solution analysis of Jessica’s suicide attempt.

Vulnerability:
Conflicts with boyfriend and best friend; impaired sleep.

Provide didactic instruction on sleep hygiene

Prompting event:
Father refused to grant a previous request; mother criticized her dishwashing.

Teach skills:
Mindfulness, distress tolerance.

Links:
Emotion: Sadness.
Thought: “No one loves me any more.”
Conduct
(1) exposure to sadness and
(2) cognitive restructuring.

Consequences:
Negative reinforcement:
Experienced emotional relief.
Positive reinforcement:
Mother and boyfriend lavished her with love and affection after suicide attempt.

Explain principles of reinforcement to client and family members.
Obtain commitment to practice reinforcing prosocial behaviors and extinguishing maladaptive behaviors.
Macro

School-wide policies to help deter cutting contagion
Hypothetical Case

You are the primary mental health provider of a large public high school’s school-based mental health center. The district superintendent has asked for your recommendation for a protocol around a recent increase in cutting behavior in the student body.

What would be your first course of action?
Hypothetical Case

You hold a meeting to gather more information from the teachers, who identify a core group of approximately 4-5 students with cutting behaviors. Teachers note that most of these students are friends or acquaintances. The teachers aren’t sure how to address this in the classroom.

How would you instruct teachers to approach this in the classrooms? What would you do with the students?
Hypothetical Case

You decide to call the students in one by one to maintain their personal confidentiality. You screen the students for suicidality and also call the family to request a meeting with the family.
Hypothetical Case

While your initial efforts result in a lull in cutting activity for several months, the cutting seems to expand again, only this time involving up to 15 students. A meeting with the teachers is called again in which teachers now relate that all involved are not friends and from different social circles.

What practices might you consider to deter cutting behavior in the school, and to be able to identify students who are truly at risk for suicide?
Actual Suggested Solutions from School Officials

Consensus toward sensitive individual interviews rather than group interviews

Avoid general or public announcements

Act quickly and identify social networks

Immediate head to toe nurse checks (notify parents prior to doing so)
Actual Suggested Solutions from School Officials

Any cutting which is on display must be covered

Public Health vs. Student Autonomy

Covering prevents spread of infection

Sharing razors → order labs and rule out diseases such as HIV/HCV

“Quiet time” away from peers when studying to allow for “de-stressing” but really to deter reinforcement from peer attention. Could backfire with students cutting because they want to get away from class (why a behavioral assessment is essential)
Actual Suggested Solutions from School Officials

Remind students that bringing any sharp object to school is against the law and could be considered bringing a weapon to school.

School law enforcement personnel can deliver this message to students and parents, but again try to avoid a general assembly/address.

Providing a sharp object to another student with the knowledge that it could be used for harm is highly punishable.
Actual Suggested Solutions from School Officials

The challenge for all of us is to remain empathic, supportive, and on the alert for students at high risk for serious self-harm.

All students with cutting behavior need to be screened for self-harm (have a plan in place in the event that more students are screened than you had anticipated).

Try to do a needs assessment in the community to insure there are enough providers for students endorsing self harm.
Any other thoughts/suggestions? Questions???

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