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An exploration of the support schools can provide to students with non-suicidal self-injury behaviour.

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Abstract

Non-suicidal self-injury (NSSI) is a behaviour enacted by a significant proportion of children and young people in the UK. Many individuals turn to the behaviour as a coping mechanism and, unfortunately, many schools do not have the guidance or understanding to support these students. Furthermore, many support measures lack sufficient evidence with an NSSI population. In this essay, I will explore NSSI in relation to children and young people, how schools can provide support and the barriers to implementation, to contribute to the NSSI literature supporting education systems, and to demonstrate the need for further research. The first section explores the need to help those at risk of NSSI, the groups at the most significant risk and the aforementioned view of NSSI as a coping mechanism. There is then an examination of four prevention and intervention measures available to schools: adapting the school curriculum; developing school belonging; providing a school policy; and utilising school counsellors. Each is shown to be evidence-based and potentially simple to implement, however, each is insufficient in its evidence of application within an NSSI population. In the final section, there are considerations towards the potential barriers preventing the discussed measures at the individual, school and systemic levels. As a result of these explorations, it is argued that there is an urgent need for greater NSSI research to provide evidence-informed practice.

Non-suicidal self-injury (NSSI), sometimes called self-harm, self-injury or self-mutilation, is the deliberate act of causing harm to oneself by physical injury or placing oneself in a dangerous situation without suicidal intent (Nock & Favazza, 2009). For some schools, NSSI goes unnoticed and undiscussed (Evans & Hurrell, 2016), while many others are becoming aware of the challenges posed by NSSI (Evans et al., 2019). However, many do not feel that they have the knowledge and understanding to support these young people (Simm, Roen, & Daiches, 2010) and fear there are a lack of resources and options to aid schools (Evans et al., 2019).

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Furthermore, many support measures are based on insufficient research (Doyle, Keogh, & Morrissey, 2015). In this essay, I will explore NSSI in relation to children and young people and how schools can provide support. This is to contribute to the emerging literature supporting education systems dealing with NSSI and to demonstrate the need for more research. Initially, this will include exploring the need to support those engaging in NSSI, the populations at highest risk and why young people turn to NSSI. This is followed by examples of prevention and intervention strategies adopted by schools: namely, adapting the school curriculum, developing school belonging, providing a school policy and utilising counsellors. Lastly, there is an exploration into the ongoing barriers towards NSSI support at the individual, school and systemic levels, as well as the argument throughout for the need for greater evidence-informed practice.

Reported rates of children and young people in the UK who engage in NSSI vary considerably, from 3% (NSPCC, 2019) to 15.5% (Morey, Mellon, Dailami, Verne, & Tapp, 2017) and significantly differ depending on the sample population. For example, Sadler et al., (2017) report that NSSI rates for 11- to 16-year-olds were at 3% for those without a mental disorder, compared to 25.5% of those with a mental disorder. There are also concerns that these figures may be on the rise. For girls aged 13-16, between 2011 and 2014, there was a reported 68% rise in NSSI (Morgan et al., 2017). Additionally, the onset of NSSI may be occurring at an increasingly young age. Between 2016 and 2017, 1077 children under 12 were admitted to hospital in England due to self-harm, compared to 669 children of the same age in 2006-2007 (NHS Digital, 2018).

NSSI acts are often categorised into two forms that derive from the work of Spandler (1996). Intrapersonal acts are those that affect the individual directly and include cutting, overdosing and seemingly smaller acts such as picking at skin (MIND, 2016). Interpersonal acts are those that affect or influence other people, such as willingly entering/sustaining an abusive relationship (Fox & Hawton, 2004). NSSI and suicide are often discussed together, and while NSSI is absent of suicidal intention, there is a correlation between them. In a UK study of hospital admission data between 2001 and 2014, young people who engaged in NSSI were 17 times more likely to take their own life. Similarly, Rodway et al. (2016) found that of 130 adolescents who died by suicide between 2014 and 2015, 54% had a recorded history of NSSI. It is important to reiterate that NSSI behaviour has no aim or consideration of suicide; however, the evidence that it is an antecedent to suicide does provide an irrefutable need to treat NSSI with our utmost concern.

A further cause for alarm is the relationship between NSSI and a young person's prospects and wellbeing. Mars et al. (2014) provided self-report questionnaires to 4799 participants in England and found that 24% of those not in education, employment or training at 19-years-old had a history of NSSI at 16-years-old. Furthermore, the same group accounted for 40% of those with depression and anxiety at 18-years-old and 35% of those with substance misuse at the same age. While self-report measures risk a response bias towards perceived desirable answers and rely on the honesty of the participants (Woolfolk, 2016), this method has provided an insight into the detrimental path of NSSI.

Understanding who engages in NSSI is a challenge that many researchers struggle to overcome. The topic is a difficult area to ethically broach with young people and their families, especially at primary school age (Simm, Roen, & Daiches, 2010). Many studies turn to hospital admission data, though different hospitals collect and record NSSI data differently (Fox & Hawton, 2004) and only an estimated one in five adolescents are admitted to hospital following an act of NSSI (Ystgaard et al., 2009). Despite these ethical and practical challenges, there is a growing understanding of who engages in NSSI and how specific populations are at highest risk.

The onset of NSSI is often found to be around 13-years-old (Morey et al., 2017) and is at its highest rates between 15- and 19-years-old (Marchant et al., 2019). Rates in the primary years are typically much lower (NSPCC, 2019), though rates appear to be increasing within under 12-year-olds (NHS Digital, 2018) and there is comparatively little research into the younger years (Simm et al., 2010). Girls generally have NSSI rates three times greater than boys (Morgan et al., 2017; NHS Digital, 2018). However, Bresin and Schoenleber (2015) argue that the apparent gender differences may be caused by males not wanting to report their NSSI. Similarly, males may not consider their acts as genuine NSSI as typically female NSSI acts, such as cutting (Sornberger, Heath, Toste, & McLouth, 2012), are presented as examples within NSSI studies.

The role of gender arguably has a more considerable influence on individuals who identify as transgender or non-conforming (TGNC). From a sample of 594 children and young people aged 11-19, who identified as TGNC, 84% reported past NSSI behaviour (Bradlow, Bartram, Guasp, & Jadva, 2017). TGNC children are also reportedly 8.6 times more likely to engage in NSSI compared to cisgender children (Aitken, VanderLaan, Wasserman, Stojanovski, & Zucker, 2016). A similar pattern is found within sexual minority youth: estimated rates are three times more than their heterosexual peers (Oginni, Robinson, Jones, Rahman, & Rimes, 2018). These results could suggest a biological component of NSSI risk, however, social experiences (bullying, stigmatisation, etc.) are likely the primary influence (Doyle et al., 2015).

There are a number of correlations between NSSI and social demographics. These include higher incidences for young people in the most deprived areas (Marchant et al., 2019): in looked after children (Wadman et al., 2017); and victims of bullying (Fisher et al., 2012) including cyberbullying (John et al., 2018). Equally, there is a correlation with mental health conditions. Sadler et al. (2017) found 25.5% of 11 to 16-year-olds with a mental health condition had NSSI history, with the rate rising to 34% for an emotional disorder. Depression and anxiety also associate with as high as 40% of individuals who engage in NSSI (Mars et al., 2014). It is important to emphasise that the data in each of these studies is strictly correlational and that it is not possible to infer causation as a result. There are also likely to be many overlapping factors and no one confounding cause (Fox & Hawton, 2004). However, between each of these groups, from biological (depression, etc.) to sociological (deprivation, bullying, etc.), there is a pattern of negative affective states (Laye-Gindhu & Schonert-Reichl, 2005). Consequently, the most significant prerequisite of NSSI appears to be adverse feelings.

From the literature, we can understand who engages in NSSI, but there remain many children and young people within the described populations who do not contemplate the same acts. Why then, do some young people turn to NSSI, while others do not? Research by Smith, Steele, Weitzman, Trueba and Meuret (2015) suggest that self-disgust is the mediating factor between depression and NSSI. Similarly, deficits in self-esteem (Laye-Gindhu & Schonert-Reichl, 2005), problem solving and hopefulness (Fox & Hawton, 2004) appear to explain some of the variation. However, there are undoubtedly examples within these particular populations in which one young person engages in NSSI, whereas another does not. Ultimately, turning to NSSI is a result of a unique set of thoughts and behaviours that are the consequence of the complex interplay of biological, psychological and sociological factors (Doyle et al., 2015). We may know who is more likely to engage in NSSI, but we are far from knowing who will engage in NSSI.

For those children and young people who do turn to NSSI, it is primarily understood as a coping mechanism for the previously discussed negative affect (Spandler, 1996). This coping mechanism can serve many different purposes depending on the needs of the individual (these needs can change, resulting in an individual giving various reasons for their NSSI over time (Klonsky, 2007)). In a qualitative study of young adults, NSSI was described as transferring unmanageable emotional pain into a manageable physical pain and forced their attention away from painful thoughts (Spandler, 1996). The coping mechanism may also satisfy a perceived need for self-punishment (Rodham, Hawton, & Evans, 2004). There is also much attention on the perspective that NSSI behaviours are attention seeking (Fox & Hawton, 2004). However, rather than attention seeking, it is contested that this should be reframed as a coping mechanism that is help seeking and a way to communicate with others (Doyle et al., 2015). In much of the literature, these coping mechanisms are described as maladaptive, however, the recent work of Hasking, Lewis and Boyes (2019) has shown that this unnecessary labelling risks increasing stigma and preventing help seeking. Under each of these coping mechanisms, Laye-Gindhu and Schonert-Reichl (2005) believe there is a temporary transition from the previous negative affect, to increased feelings of relief. In their study, a sample of 424 adolescents showed that while some positive emotions (e.g. happiness) increased marginally during the act, a sense of relief had greater increases during and after NSSI. This study was conducted with a Canadian sample, however, a similar study in England (Rodham et al., 2004) found similar attitudes towards relief. In summary, the act of NSSI provides a coping mechanism that can serve many different purposes, and often elects a sense of relief from the previously present negative affect.

Schools are pivotal to the mental wellbeing of their students as schools are such a considerable part of children's lives (Department of Health and Social Care and Department for Education, 2017). They provide a 'critical window of opportunity to engage at-risk youth' (Hasking et al., 2016, p.36) and enhance a community's understanding of what only a minority may be feeling (Fox & Hawton, 2004). Fortunately, a UK national survey in 2017 (Marshall, Wishart, Allison, & Smith, 2017) indicated the proactive, positive support that schools are providing towards children's mental health. Ninety-two per cent had built a culture of care, and many had promoted positive mental health through regular activities, such as mindfulness (73% of

schools) and support programs (70% of schools). How though are schools specifically supporting the issue of NSSI and what are they able to do? Silverman and Maris (1995) introduced a framework to support suicide prevention, however, the framework and categories provide a similar structure to understanding NSSI support (Robinson et al., 2013). They describe three levels: universal intervention (reducing risk factors and enhancing protective factors for a whole population); selective intervention (targeting high-risk groups for support); and indicated intervention (intervening with those who have NSSI history). To synthesise this framework and apply it within school contexts, universal interventions and selective interventions will be categorised as prevention measures and indicated interventions as interventions (Robinson et al., 2013).

NSSI prevention measures in schools are often overlooked for the more widely studied intervention measures (De Riggi, Moumne, Heath, & Lewis, 2017; Hasking et al., 2016). However, prevention measures offer the opportunity to lessen the requirement for later interventions (Doyle et al., 2015) and can spare a child of the deep negative affect previously discussed. The first example of a preventative measure is the school curriculum. An estimated 87% of state secondary schools already teach sessions on specific issues, such as NSSI (Marshall et al., 2017). Though only 42% of primary schools offer similar sessions, and it is not known how regular these sessions are carried out in secondary or to what standard (Marshall et al., 2017). Furthermore, 47% of teachers in England and Wales reportedly feel there is no time in the current curriculum to teach about NSSI (Evans et al., 2019), and the programme of study for Personal Social and Health Education (PSHE) only introduces NSSI from key stage 3 (KS3) onwards (PSHE Association, 2019). This is unfortunate as curricula that include mental health education can significantly improve students' mental health literacy (Mcluckie, Kutcher, Wei, & Weaver, 2014), mental health knowledge and reduce stigma (Milin et al., 2016). Stigma reduction is particularly poignant regarding NSSI, as some young people report that perceived stigma prevents them from seeking support (Fortune, Sinclair, & Hawton, 2008; Mcandrew & Warne, 2014). For those schools wanting to gain these benefits and make improvements to their curriculum, there is regrettably a severe lack of resources and guidance available. At present, curriculum makers have to craft a curriculum with minimal NSSI guidance and are best suited to reach out to suitable charities, such as YoungMinds (2020) or To Write Love on Her Arms (2020). There is a pressing need to provide curriculum resources to schools and to further the research exploring the benefits of NSSI integration into the curriculum.

A further NSSI prevention measure focuses on enriching a sense of belonging; the psychological need to create and maintain relationships (Olcoń, Kim, & Gulbas, 2017). In the literature exploring suicide, Joiner (Joiner Jr, Van Orden, Witte, & Rudd, 2009) hypothesised that thwarted belongingness, a feeling of loneliness or segregation, increased the risk of suicidal ideation. The thwarted belongingness theory was supported by Olcoń et al. (2017) who found a correlation between rejection behaviours in schools (e.g. bullying or feeling unsafe) and increased suicidal behaviours. The NSSI literature reports similar findings. In Young, Sweeting and Ellaway's (2011) longitudinal school-based study of 1698 pupils, from age 11 to 19, there was a 15-18% increase in the likelihood of NSSI or suicide-risk for the young

people with low school engagement (reduced engagement included attending a religious school in which the students did not share the same beliefs). Fortunately, there are a range of evidenced prevention measures that can support a greater sense of belonging in schools: writing a regular gratitude journal (Diebel, Woodcock, Cooper, & Brignell, 2016); creating adult to adolescent mentoring sessions (Sanders & Munford, 2015); ensuring a range of accessible extra-curricular activities for all pupils (Fredricks & Eccles, 2005); or supporting pupils to share their feelings, values and experiences to build relationships with peers and adults (Dunleavy & Burke, 2019). However, these measures have not been knowingly tested with an NSSI population. Subsequently, specific NSSI research is required to bridge this gap.

Schools often allocate more time to NSSI interventions than prevention measures, particularly in secondary schools (Evans et al., 2019), despite school staff favouring prevention measures (Simm et al., 2010). This may be due to the perception that NSSI interventions are more useful then prevention measures (Evans et al., 2019) and that NSSI behaviours are often only addressed once they arise (Simm et al., 2010). Irrespective of a school's view of interventions, a fundamental component of their approach to intervention measures is their NSSI policy. Much of the research in this area is conducted within the Australian education system. It has shown that many school staff are dissatisfied with their school's NSSI policies (McAllister, Hasking, Estefan, McClenaghan, & Lowe, 2010) and that there is limited research supporting the development of NSSI policies (Berger, Hasking, & Reupert, 2015). To explore what a highly-valued policy may look like, Berger et al. (2015) implemented an NSSI policy into 18 secondary schools across five Australian states. The policy was based upon previous research and addressed many teacher and school staff needs, including NSSI identification, student referral systems, conditions requiring immediate medical attention and the roles and responsibilities of different staff members (for the full policy, see Berger et al., 2015). Forty-eight school staff then completed a questionnaire on their opinions of the policy: 83% felt it addressed their needs, and 82.2% recommended the policy. A year later, the study informed a comprehensive position paper that provided clear guidelines for creating a school's NSSI policy (Hasking et al., 2016). The guidelines include many of the previously discussed policy components while discussing more holistic elements, such as how parents and the community interact with schools. Unfortunately, there is no published research exploring the application of this policy, nor is there comparative research within a UK context.

Within a policy, there may be a signpost to counselling, a measure reported as the most useful form of NSSI intervention by school staff (Evans et al., 2019). The Department for Education (2016) define a counsellor as a professional who allows young people to 'explore, understand and overcome issues in their lives which may be causing them difficulty, distress and/or confusion' and 'to create a greater awareness and utilisation of their personal resources' (p.6). Counsellors may also provide training and resources to other staff (Townsend, Gray, Lancaster, & Grenyer, 2018) and communicate with outside mental health services (Harris & Jeffery, 2010). In 2015, an estimated 70% of UK secondary schools provided counselling, compared to 52% of primary schools (Harland et al., 2015). Unfortunately, there are suggestions that school counsellors have only moderate NSSI knowledge and lack of NSSI training (Duggan, Heath, & Toste, 2011). Similarly, a qualitative study of NSSI experiences in

Ireland showed that school counsellors felt they need more time, training and support regarding NSSI behaviour. If UK counsellors are experiencing similar levels of need, they may be unable to provide one of the most valued support options to young people: someone they can talk to and receive advice. Fortune et al., (2008) asked pupils from 41 English secondary schools what could help young people at risk of NSSI. The most popular response (28% of respondents) was for young people to have someone to talk to and provide advice. At present, there is little UK research exploring the role of counsellors and NSSI support. However, the Department for Education (2016) provided ‘Counselling in Schools: a blueprint to the future’ a guidance document that offers wide-ranging advice on implementation and features of an excellent counselling service. Such features include that ‘all staff, parents or carers, pupils and school partners are aware that a school-based counselling service is being offered’ and that ‘there are clear referral, including self-referral, procedures in place’ (p.27).

The final section of the essay will explore some of the barriers that could prevent the implementation of the discussed intervention and prevention measures. The first set of barriers are at the individual level, specifically, staff thoughts and feelings. There are reports that staff feel fearful and inadequate to support NSSI behaviours (De Riggi et al., 2017; Dowling & Doyle, 2017) and that teaching children about NSSI could cause imitation behaviours (Evans et al., 2019; Simm et al., 2010). It appears that this fear of social contagion is warranted, with research evidencing that social contagion can influence NSSI behaviours (M. K. Nock, Prinstein, & Sterba, 2009; Ross, Heath, & Toste, 2009). Similar concerns caused the Information Commissioner’s Office (2020) to provide new guidelines to social media companies to take responsibility for the content that could influence NSSI behaviour. However, the literature on suicide education shows that a good education can support many more young people than those at risk of imitation (Robinson & Calear, 2018). Equivalently, similar concerns in the past (education on drugs, sex, etc.) have become rationalised and integrated into the national curriculum (Simm et al., 2010). It is hoped that these concerned thoughts and feelings could be alleviated through thoughtful, quality NSSI training and supervision. However, once again, there is no research evidencing whether such training would successfully change existing perceptions of NSSI.

At the school level, some educational settings are failing to notice and prioritise NSSI. In Evans and Hurrell's 2016 systematic review of qualitative research, there was a reoccurring perception that NSSI is a problem that occurs elsewhere and not at the participant’s school. Similarly, some NSSI behaviours are misattributed as other forms of behaviour. Simm et al. (2010) provide the example of a teacher recalling a primary school pupil pulling their eyelashes out and presuming that it was misbehaviour. Schools are also often structured to decrease the role of teachers and other ‘front line’ staff. NSSI behaviours are regularly seen as a challenge to be faced by external experts or by the senior leadership team, minimising the need for involvement and awareness from all staff (Evans et al., 2019; Simm et al., 2010). This failure to notice or engage with NSSI may contribute to NSSI being insufficiently prioritised in schools (Evans & Hurrell, 2016; Evans et al., 2019) and the subsequent lack of NSSI training (Berger, Hasking, & Reupert, 2014; Dowling & Doyle, 2017; Evans et al., 2019) which is often poorly received (Evans et al., 2019). For schools to combat these barriers requires a reflective

practice and for schools to honestly question how they are currently noticing, prioritising and supporting NSSI behaviour. Although, if schools are not already prioritising and noticing NSSI, there may be no emphasis in a school to take such action. It is the role of research to bring this need to schools.

Lastly, at the systemic level, are the barriers of government and research. Schools may have no means to influence this systemic level directly, but by highlighting these barriers, there are hopes for greater awareness and a general contribution towards the need for change. At present, there are no expectations to teach about NSSI in the primary curriculum and only a minimal inclusion of NSSI in the PSHE curriculum from KS3 onwards (PSHE Association, 2019). This is despite calls for the government to take more of an initiative to address NSSI since 2010 (Simm et al., 2010) and calls to provide more significant financial support for NSSI measures (Dowling & Doyle, 2017). The UK government must improve its NSSI initiatives if it is to support schools and those children and young people at risk. A similar need for development is within the NSSI research field. As discussed repeatedly throughout this essay, there are considerable gaps in the literature and a pressing need for additional research. As well as the gaps already mentioned, there is limited qualitative research exploring how schools support those with NSSI behaviours (Evans & Hurrell, 2016) and almost no research examining the understanding and experiences of primary school children (Simm et al., 2010). This absence of research considerably contributes to the lack of research-informed prevention and intervention measures in the UK (Evans et al., 2019) and until addressed, will force theoretical solutions to a present and significant problem.

In conclusion, this essay has explored NSSI in relation to children and young people and argued for the need for significantly greater research to inform support measures and to overcome barriers to implementation. A significant proportion of children and young people in the UK are at risk and are turning to NSSI as a coping mechanism. Schools have the opportunity to implement a range of accessible, achievable and necessary prevention and intervention measures, including the ability to adapt the school curriculum, develop school belonging, enhance a school policy and support the role of counsellors. Each of these measures are evidence-based, however, there is a lack of evidence showing the application of each measure within an NSSI population. Furthermore, schools will face a range of barriers to implement such measures at the individual, school and systemic levels, while potential solutions to these hurdles require more research. In sum, there is considerable need for greater research in the field of NSSI support. It is hoped that such research will inform better practice, remove barriers and ultimately support some of the most vulnerable children and young people in the UK.

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