Promising Approaches in Prevention and Intervention in Secondary School Settings

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Abstract

Self-injury is not an unusual occurrence in adolescence and thus arises in secondary school settings with some frequency. However, as discussed in this chapter, the complexity of the behavior and the importance of school involvement cannot be underestimated. This chapter begins with a brief overview of the occurrence of NSSI in secondary school students, contextualizing it in terms of its prevalence, functions, stigmatization, and risk and protective factors. The developmental and contextual significance of addressing NSSI in secondary schools will then be highlighted. Following this, a review of the literature surrounding NSSI prevention/intervention approaches within secondary school settings is discussed. Recommendations for NSSI prevention and intervention in secondary school settings will then be organized by level (i.e., primary, secondary, and tertiary). Elements of both prevention and intervention are embedded within each level; specifically, (a) primary prevention/intervention aims to prevent the onset of a behavior through universal intervention; (b) secondary prevention/intervention aims to prevent the onset of a behavior in individuals at-risk; and (c) tertiary prevention/intervention aims to respond to a behavior once it has emerged to reduce its negative impacts. The chapter then concludes by discussing the challenges to NSSI prevention/intervention in secondary school settings, recommendations for navigating such challenges should they arise, and suggestions for future research in this area.

Keywords: NSSI, self-injury, secondary school settings, students, stigmatization, prevention, intervention, adolescence

Case 1. *E.L. is a 16-year-old female who has a history of engaging in self-cutting that spans over three years. She is highly perfectionistic and self-critical. Although she has very supportive family and friends, they are unaware of her self-injury. She is connected to an online self-injury community. She finds self-injury helps her focus and deal with the stress of exams. A friend noticed her cuts and spoke to the school mental health professional about it. However, the student refuses all treatment.*

Case 2. *M.P. is a 15-year-old male who has occasional suicidal thoughts. He feels stressed and hopeless about academics, and feels as though he cannot measure up to family pressure. Out of frustration, he began by banging himself to the point of bruising before exams; this progressed to cutting over time. He refuses treatment due to stigma, stating that his family would be so ashamed.*

Case 3. *A.J. is a 16-year-old nonbinary student. They frequently burnt themself with cigarettes in front of their peers, who did not take it seriously. Subsequently, they attempted suicide and were hospitalized. They have returned to the school while continuing to receive outpatient services. They are withdrawn, appear to be depressed, and continue to burn themself. The parents are unsupportive of their gender identity, and are noncooperative and unavailable. The school mental health professional is having difficulty accessing information from the hospital and is unsure how to proceed.*

Background/Context

NSSI is a common mental health concern among adolescents, both in clinical and subclinical settings, and is linked to a host of negative outcomes (e.g., Biskin et al., 2020; Brown & Plener, 2017; Heath et al., 2016; Walsh, 2012). Among adolescents who engage in self-injury,

the most common methods include cutting, severe scratching, hitting or banging, carving, and burning (Brown & Plener, 2017; Doyle et al., 2015; Garisch & Wilson, 2015). Furthermore, the most common functions of NSSI in adolescence include the downregulation of negative thoughts and emotions, self-punishment, and communication with or influencing others (Brown & Plener, 2017; Cipriano et al., 2017; Taylor et al., 2018) (see Taylor et al., this volume). Despite the prevalence of NSSI in adolescence, this behavior is stigmatized and often misunderstood (Staniland et al., 2020). Its stigmatization may be attributed to the associations between NSSI and mental illness, the self-inflicted nature of self-injury which defies the human instinct of self-preservation, and the wounds and scars that often remain following engagement. Unfortunately, stigmatization and misconceptions surrounding NSSI may serve as barriers to adolescents' help-seeking for this behavior (Hasking et al., 2016; Toste & Heath, 2010), as illustrated by Case 2, whereby M.P. refuses treatment due to stigma, stating that his family would be deeply ashamed of him. In addition to the challenges that adolescents face with respect to NSSI stigmatization and help-seeking, school personnel often express uncertainty and helplessness when it comes to addressing self-injury among their students (e.g., De Riggi et al., 2017; Hasking et al., 2016). Thus, the provision of specific, evidence-informed guidelines for addressing NSSI prevention and intervention in secondary school settings is warranted.

A variety of risk and protective factors for NSSI in adolescence have been documented (See Fox, this volume, and James & Gibb, this volume) and contribute to its elevated prevalence during this developmental period (e.g., Brown & Plener, 2017; Tatnell et al., 2017). Psychological risk factors for NSSI during adolescence include depressive symptoms, high self-criticism, and low self-esteem (Baetens et al., 2015; Tatnell et al., 2017), as reported in Cases 3, 1, and 2, respectively. Demographic risk factors include adolescent age, gender minority status,

and nonheterosexual orientation (Brown & Plener, 2017; Doyle et al., 2015; Liu et al., 2019; Smith et al., 2020). There are notable social risk factors for NSSI during adolescence as well (See Jarvi Steele et al., this volume), such as knowing someone who engages in self-injury; being the victim of bullying; and having experienced emotional, physical, or sexual abuse as a child (Brown & Plener, 2017; Doyle et al., 2015; Garisch & Wilson, 2015; Tatnell et al., 2017). On the other hand, protective factors for NSSI include emotion regulation, high self-esteem, secure attachment, and perceived support in relationships with friends and family (e.g., Garisch & Wilson, 2015; Tatnell et al., 2017).

There are also a number of risk factors for engaging in NSSI that are specific to the secondary school context. For instance, decreased academic performance and negative attitudes toward school have both been found to positively predict subsequent engagement in NSSI among secondary school students (Baetens et al., 2021). In addition, lower perceived teacher support, a decreased sense of school belongingness, and a more negative peer climate have also emerged as risk factors for NSSI during adolescence (Madjar, Ben Shabat, et al., 2017; Madjar, Zalsman, et al., 2017). All these school-related risk factors likely lead to heightened distress among students, who then engage in NSSI to cope with this distress, as the most commonly reported function of NSSI during adolescence is to regulate negative thoughts and emotions (Cipriano et al., 2017; Taylor et al., 2018). Thus, as is evidenced above, numerous psychosocial and school-related factors may predispose adolescents to engage in NSSI, and prevention efforts should take these risk factors into consideration where possible.

Furthermore, the primary justifications for addressing NSSI prevention and intervention within secondary school settings in particular are twofold. First, addressing NSSI within secondary schools is of great developmental importance (Evans et al., 2019). Adolescence is a

vulnerable period for the onset of NSSI, partly due to elevated levels of impulsivity and emotion reactivity during this developmental period (Brown & Plener, 2017). Accordingly, research has repeatedly documented an average age of onset for NSSI around 14 years of age (e.g., Heath et al., 2009b; Morey et al., 2017), and engaging in NSSI from a young age is associated with a greater frequency of self-injury, the use of more diverse and dangerous methods, and an increased risk of hospitalization (Ammerman et al., 2018), as shown in Case 3. The occurrence of NSSI among adolescents has been of growing concern, with prevalence rates spanning from 10%–20% during this developmental period (Swannell et al., 2014; Tatnell et al., 2017). Engaging in NSSI during adolescence is a significant mental health concern as it has been associated with increased depressive symptoms, anxiety, suicidality, substance use, and engagement in risk-taking behaviors; a higher risk for the development of borderline personality disorder symptoms and impaired psychosocial functioning in adulthood; as well as unfavorable academic outcomes including a lack of school engagement and absenteeism (Biskin et al., 2020; Brown & Plener, 2017; Garisch & Wilson, 2015; Heath et al., 2016; Walsh, 2012). In light of all of these concerns, addressing NSSI prevention and intervention during adolescence is warranted.

Additionally, addressing NSSI prevention within the school setting is of notable contextual importance. Given the proportion of adolescents' time that is spent in school, schools are uniquely well positioned to provide students with strategies and support related to NSSI prevention and intervention (Tatnell et al., 2017; Wester et al., 2018). Particularly given the stigmatization surrounding—and resultant hesitation to seek help for—NSSI behaviors (Hasking et al., 2016; Toste & Heath, 2010), providing psychoeducation and strategies within the school context permits a universal preventative approach, thereby ensuring that this information reaches all students whether they actively seek it out or not. Moreover, the multilevel support that is

available to adolescents within their school is critical to NSSI prevention efforts (Heath et al., 2014; Heath et al., 2020) but is unlikely to be as readily accessible elsewhere. Finally, schools have the opportunity to deliver prevention and intervention programs in large group settings, such as in classrooms and assemblies, therefore providing a more cost-effective means with a broader reach than most clinical and community models of service delivery. Thus, for all of the reasons outlined above, addressing NSSI in secondary school settings is strongly recommended.

Relative to clinical, community, and even postsecondary settings, there is a notable uniqueness to secondary school settings in terms of addressing NSSI. For instance, as illustrated by the diverse cases described at the beginning of this chapter, schools may be expected to provide support (a) for a student who is engaging in NSSI but refuses all treatment yet still needs to be monitored for suicidality, (b) where the demands of the academic setting together with parental expectations may trigger the self-injury, or (c) where the school needs to navigate shared care with a hospital setting. Thus, the school must take on a wide range of roles when responding to such a diversity of experiences, and these settings may face the challenge of responding effectively despite having access to very limited resources relative to clinical and postsecondary settings (Evans et al., 2019). In addition, secondary schools often lack personnel with training and experience in responding to NSSI (De Riggi et al., 2017; Hasking et al., 2016). This is problematic given the frequency with which their personnel might encounter students who engage in NSSI, which is likely to be elevated as a result of rotating classes whereby educators encounter hundreds of students each day, combined with the well-documented elevated prevalence of NSSI during adolescence (Swannell et al., 2014; Tatnell et al., 2017).

Current State of the Empirical Evidence

Despite the timely importance of addressing NSSI prevention and intervention efforts in secondary school settings, this still represents a limited area of research. This section thus outlines previous NSSI prevention and intervention approaches within secondary school settings, several of which include elements relevant across all levels of prevention/intervention.

Currently, there are very few school-based programs that are known to effectively prevent or reduce NSSI behaviors among adolescents (Heath et al., 2014). One of these programs is HappylesPLUS (Baetens et al., 2020), an adaptation of the Happyles program (a school-based program aimed at enhancing general mental health and social connectedness; van der Zanden & van der Linden, 2013) with an added NSSI-focused psychoeducation module. This program was recently piloted with secondary school students and evaluated in terms of its potential effectiveness at preventing NSSI before it has occurred (i.e., at the primary and secondary levels of prevention). Results from this pilot study revealed no iatrogenic effects of the program (i.e., it did not increase NSSI thoughts or behaviors). In addition, following program completion, students reported a reduced likelihood of future NSSI engagement and increased help-seeking intentions. While these results are promising, an important limitation of this pilot study is that it spanned only six weeks, and the program's long-term effects on NSSI-related outcomes remain unknown. Thus, additional longitudinal research is needed to establish the long-term benefits of the HappylesPLUS prevention program.

To our knowledge, the only other school-based NSSI prevention program that has demonstrated efficacy is the Signs of Self-Injury (SOSI) program, created by Screening for Mental Health, Inc. (Jacobs et al., 2009) as an expansion of a widely used school-based suicide prevention program. The SOSI program involves psychoeducation provided to school personnel, focusing on response to student disclosure of NSSI, as well as guidelines for developing school

policy. It should be noted that this program is a tertiary prevention program (i.e., intervening when NSSI has occurred to minimize its negative impacts), rather than a primary or secondary prevention program with the intent of preventing NSSI before it occurs. Furthermore, although initial evaluations of the SOSI program (i.e., Muehlenkamp et al., 2010) in secondary school settings have demonstrated some promise for improving student awareness and understanding of NSSI, it remains unclear whether the SOSI program actually results in increased help-seeking, or decreased rates of NSSI engagement, among students who engage in NSSI.

While there are currently very few school-based NSSI prevention programs, several prevention programs and gatekeeping workshops that target suicidality among secondary school students have also been evaluated, although the generalizability of these findings to NSSI prevention remains unclear. For instance, the Saving and Empowering Young Lives in Europe (SEYLE; Wasserman et al., 2015) study tested the effectiveness of a blended primary and secondary prevention program targeting suicidality among adolescents. Within this study, the universal (i.e., primary) prevention program for suicidality demonstrated the highest level of efficacy at reducing suicide ideation and attempts among students, although the program's potential impacts on NSSI engagement were not evaluated. Moreover, school-based gatekeeping programs, which train school staff to identify students at risk and help them acquire the support they need, have also gained popularity in recent years. For example, Brown et al. (2018) evaluated a gatekeeper training for suicidality, delivered to educators and school-based mental health professionals (MHPs) and found that it was effective at enhancing knowledge and confidence in school staff surrounding suicidality. The adaptation of this suicide prevention approach to NSSI may be worthwhile, particularly in terms of its potential to train school staff to appropriately respond to students at risk for NSSI.

Notably, there has also been an increasing recognition of the need to implement social and emotional learning (SEL) in school settings, in an effort to improve students' emotion regulation, social skills, coping abilities, and overall well-being (e.g., Yeager, 2017). While a variety of SEL-based programs have been developed, the Dialectical Behavior Therapy Skills in Schools: Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A; Mazza et al., 2016) program, which is a SEL-based universal program, is particularly promising for the prevention of unhealthy coping behaviors such as NSSI. DBT STEPS-A is a manualized adaptation of DBT (Mazza et al., 2016) and has been adapted for use in secondary school settings. Its SEL-based curriculum centers on skill-building in the four core areas of standard DBT: emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness (Mazza et al., 2016). While its curriculum was developed to be implemented primarily at the universal (i.e., primary prevention and intervention) level, its manual also includes supplemental guidelines for working with students who might require further support at the secondary or tertiary levels of prevention and intervention (Mazza & Dexter-Mazza, 2019). Although there is currently only preliminary evidence supporting the effectiveness of DBT STEPS-A in secondary school settings and further research is needed to establish its effectiveness at preventing and reducing NSSI engagement among students, it remains one of the most promising approaches for addressing NSSI in schools for a number of reasons discussed below.

Taken together, the empirical evidence to date suggests that a universal, school-based adaptation of DBT may be a promising route for NSSI prevention and intervention in secondary school settings. Additional support at the secondary and tertiary levels of prevention/intervention is also needed for students at risk of engaging in NSSI, including school involvement in effective referral to external supports for students with more intensive needs. Importantly, implementing

programs such as DBT STEPS-A (Mazza et al., 2016) into secondary school curricula requires a careful consideration of the uniqueness of secondary school settings in terms of addressing NSSI prevention and intervention. Specifically, the diversity of students' potential experiences with NSSI should be considered, as should the resource limitations that many schools are faced with (e.g., Evans et al., 2019). Thus, program implementation at all levels of NSSI prevention/intervention should take into account feasibility considerations (e.g., resource limitations) and the sheer diversity of NSSI experiences within secondary school settings, as illustrated by the highly diverse cases presented at the beginning of this chapter.

Prevention and Intervention in Secondary School Settings

In order to effectively develop and implement NSSI prevention programs in secondary school settings, it is paramount that such programs incorporate prevention science best-practice considerations (e.g., Durlak, 1997). In addition, three levels of prevention/intervention should be considered. These best-practice considerations and levels of prevention/intervention are described in detail below.

Prevention Science Best-Practice Considerations

First, programs should be evidence-based, drawing from research and theory on factors contributing to NSSI engagement (Heath et al., 2014), such as emotion dysregulation, distress tolerance, self-derogation, and ineffective communication skills (Brown & Plener, 2017; Cipriano et al., 2017; Taylor et al., 2018). Programs should thus focus on enhancing overall wellness and mental health resilience in the school, while specifically targeting the same skills that have demonstrated effectiveness in treatment for NSSI (Heath et al., 2014). Programs should also be socially and culturally relevant to the target group (Durlak, 1997); in this case, they should be developmentally appropriate for adolescents and should take into consideration the

sociocultural context. Finally, prevention and intervention efforts should be collaborative and multipronged; besides the students themselves, such approaches should involve educators, MHPs, and other school personnel, as well as the families and/or caregivers of students (Arbuthnott & Lewis, 2015; Hasking et al., 2016).

As proposed by Heath et al. (2020), and in line with Cole and Siegel's (2003) comprehensive model, three levels of prevention/intervention should be considered when developing school-wide programs to ultimately reduce NSSI in secondary schools, as each level may be tailored to the experiences and needs of different students. While these levels may be accessed sequentially, whereby a student participating at the primary level may voluntarily choose to seek out further support at the secondary or tertiary levels, the ultimate goal of implementing this model is to have all three levels of prevention/intervention functioning simultaneously within the school. Detailed recommendations for each of the three levels are provided below (see Heath et al. 2020 for further detail regarding each level).

Primary Prevention and Intervention

At the primary level of prevention/intervention, the main goal is to prevent the emergence of NSSI behaviors in all students. To this end, a universal, school-wide approach is optimal wherein the aim is to (a) improve overall capacity for healthy coping, (b) decrease stigmatization, and (c) develop a community of support and help-seeking within the school (Heath et al., 2020), through general stress management and coping skills-building. This universal primary prevention/intervention should be provided to all students in large group settings such as classrooms or assemblies. Importantly, teachings from these "workshops," delivered by school MHPs, should be integrated across multiple stakeholders (e.g.,

family/caregivers, educators, and school administrators) through school, community, and online resource provision.

Provided that the goal of primary prevention/intervention is to decrease the likelihood that students will engage in NSSI, instruction at this level should be relevant to the commonly reported functions of self-injury. For instance, the most commonly reported function of NSSI during adolescence is to regulate intense or recurring negative thoughts and emotions (e.g., Brown & Plener, 2017; Cipriano et al., 2017; Taylor et al., 2018; see Taylor et al., this volume). As such, psychoeducation related to effective coping in order to enhance emotion regulation and reactivity should be a central component of primary prevention/intervention. Another common function of NSSI in adolescence is self-punishment (Cipriano et al., 2017; Taylor et al., 2018). Accordingly, psychoeducation related to fostering self-compassion and the management of self-criticism should be included in these universal workshops as well. Finally, a less common, but nonetheless persistently reported, function of NSSI is to communicate with or influence others (Cipriano et al., 2017; Taylor et al., 2018). Thus, primary prevention/intervention workshops should address effective interpersonal communication as well.

As mentioned earlier, a central goal of these universal workshops is to improve students' overall capacity for healthy coping while actively decreasing stigmatization in the school. Therefore, at the primary level, workshops should have a broad appeal and be contextualized as general stress management and coping skills-building. Numerous healthy and unhealthy coping behaviors should be addressed within these workshops, with NSSI contextualized as merely one example of an unhealthy coping behavior (e.g., Lewis et al., 2019), in order to decrease stigma surrounding NSSI and avoid sensationalizing it. Moreover, information pertaining to help-seeking and help-giving should be embedded in workshops at the primary level of

prevention/intervention. The aim of this approach is to enhance students' willingness to seek help for NSSI and other coping behaviors (which would be beneficial in Cases 1 and 2 where treatment is otherwise refused by the students), as well as to improve students' ability to respond appropriately and supportively to their peers' disclosures of unhealthy coping.

Secondary schools may benefit from referring to the DBT STEPS-A manual (Mazza et al., 2016) in order to develop universal workshops that share relevant psychoeducation and healthy coping strategies to enhance resilience among all students. Although other SEL programs exist, we encourage the use of DBT STEPS-A given its suitability to the reduction of unhealthy coping behaviors such as NSSI in secondary school settings. The teachings of these universal sessions should be integrated across all relevant stakeholders, including educators, MHPs, and other school personnel, as well as the families and/or caregivers of students (Arbuthnott & Lewis, 2015; Hasking et al., 2016). This may be achieved through the development and dissemination of pamphlets, infographics, or emails (see International Consortium on Self-injury in Educational Settings, n.d., for sample resources), should in-person workshops or information sessions not be feasible. Furthermore, educators should be informed of the skills that students are being taught in the workshops and how they may be applicable in the classroom, and parents should be provided with the contact information of a designated person within the school for questions or concerns related to the content being taught in these workshops. This collaborative approach is highly beneficial to the development of a school culture of wellness and will ensure that students feel supported and that a sense of community is developed within the school. Finally, school, community, and online resources and support should be provided to students, such that students may feel equipped to seek help if they find themselves struggling, or to help a friend or peer who may be engaging in unhealthy coping.

Secondary Prevention and Intervention

Additional targeted support may be required for students who are struggling with some aspects of coping or for whom the support and resources offered at the primary level of prevention/intervention are insufficient. Thus, at the secondary level of prevention/intervention, the main goal is to prevent or delay the onset of NSSI behaviors in at-risk students. This can be accomplished through a series of school MHP-led independent small-group sessions (i.e., of up to 15 students) which students would ideally self-select to attend following participation at the primary level, or to which they may be recommended or referred (e.g., by school MHPs or their caregivers; Heath et al., 2020). While the number of sessions held may vary depending upon students' needs and the school's resources, each session should focus on the further development of specific skills and strategies that are known to be potential risk factors or precursors to the emergence of NSSI, and should provide an opportunity for more guided strategy practice than is possible in the universal workshops. Similarly to the universal workshops offered at the primary level, small-group sessions at the secondary level may be structured using the DBT STEPS-A manual (Mazza et al., 2016), as this manual provides detailed group session outlines and may thus be used even by MHPs who are lacking formalized DBT training.

In general, sessions should review the psychoeducational content taught within the primary-level workshops. In addition, given that students who self-select to attend the secondary-level sessions would likely benefit from more practice in coping with difficult situations and/or emotions, an in-depth practice of skills should be embedded within these sessions. Furthermore, discussion periods should be included throughout to discuss daily life application of strategies taught and to problem-solve for anticipated obstacles. Students who attend these sessions would

also benefit from the provision of additional resources for the implementation of the skills taught, as well as to encourage students' overall help-seeking.

Moreover, at the secondary level of prevention/intervention, the primary focus should remain on resilience-building and building students' capacity for healthy coping, rather than on describing and/or exploring less healthy coping behaviors such as NSSI. If a student discloses NSSI engagement at any time during their participation in the primary- and/or secondary-level sessions, they should be offered tertiary support as outlined below. Nevertheless, the three levels of prevention/intervention and the sessions and resources they encompass are not mutually exclusive; as such, students may voluntarily choose to participate in both the secondary and tertiary levels, if they feel that it is of benefit to them. Finally, communication between the school and caregivers is needed at this level of prevention/intervention, taking into account matters of confidentiality as needed, to encourage at-home use of the strategies taught in these sessions.

Tertiary Prevention and Intervention

At the tertiary level of prevention/intervention, the primary aim is to appropriately and effectively respond to NSSI once it has emerged to reduce negative impacts. As described below, an effective response at the tertiary level includes elements such as the development of an NSSI-specific school protocol, widespread knowledge surrounding an appropriate and effective first response to NSSI, the necessity of conducting a risk assessment, and effective referral (Heath et al., 2020).

It can be challenging to identify students who self-injure, particularly since they are often reluctant to disclose and/or seek help for their NSSI (Hasking et al., 2016). This is illustrated in Case 1, whereby E.L.'s supportive family and friends remain unaware of her self-injury. This

reluctance may stem from the anticipated response to disclosure, which is often met with fear, judgment, or horror (Lewis et al., 2019). As such, efforts to identify or confirm the occurrence of NSSI should be managed with extreme sensitivity, as students may find such efforts intrusive or humiliating (Hasking et al., 2016). Ultimately, the identification of NSSI may occur through multiple pathways, including from the student themselves or from a peer, caregiver, or educator who may know or have reason to believe that the student is engaging in self-injury.

The first step in being prepared to respond to students who engage in NSSI involves the development, distribution, monitoring, and routine evaluation of an NSSI-specific school protocol (also see Baetens et al., this volume) that provides clear guidelines on effective and appropriate first response to NSSI engagement among students (De Riggi et al., 2017; Hamza & Heath, 2018; Hasking et al., 2016). This protocol should clearly outline the roles and responsibilities of all school personnel and establish a designated MHP to coordinate case management for students who self-injure (e.g., to conduct suicide risk assessments, make necessary referrals) as well as to provide school-wide staff education around NSSI (Hasking et al., 2016). Additionally, it should provide guidelines for when caregivers of students are to be informed of their child's NSSI (Hasking et al., 2016), as will be described later in this chapter.

It is important to note that the first response to a disclosure of NSSI will play a critical role in the student's future help-seeking behavior (Toste & Heath, 2010). All school personnel must understand the importance of a supportive, empathic, and nonjudgmental demeanor when responding, as implicitly or explicitly communicating judgment or disgust can exacerbate internalized stigma, thwart help-seeking, and reinforce NSSI (Hasking et al., 2016; Lewis et al., 2019; Toste & Heath, 2010). Validating the student's feelings or thoughts associated with the NSSI is also important (Hasking et al., 2016). If NSSI is identified by, or disclosed to, nontrained

staff, the staff member should recommend that the student seek help from the school's designated MHP. If the student refuses, the staff member must notify the MHP themselves but should communicate to the student that they are initiating this support as part of the school protocol and because they are concerned for the student's well-being (De Riggi et al., 2017). Although it may be challenging for the MHP to build rapport with the student, this rapport is integral to building a therapeutic alliance, and MHPs should therefore approach first conversations with students in a calm, patient, and supportive manner.

Once an appropriate first response to NSSI disclosure has been made, an assessment of risk by a school MHP is necessary. Risk assessments should include sensitive inquiries about any suicide ideation, the age of onset and duration of the NSSI, the frequency of engagement, the number of methods used, the potential need for medical attention, and the reasons behind the NSSI (Westers et al., 2016). For some students (i.e., certain low-risk students), school-based NSSI intervention will be sufficient; for others (i.e., certain high-risk students), external support may be needed in conjunction with school-based support (Hasking et al., 2016; Toste & Heath, 2010).

If a student is of legal age to refuse treatment, it is not unlikely for them to do so (as demonstrated by two of the three cases described earlier, wherein the students had refused all treatment), particularly out of fear of being asked to stop engaging in NSSI altogether or to share emotional details underlying their engagement (Heath et al., 2020). It should be communicated that the goal is simply to learn additional coping strategies which may be used in moments of distress, rather than immediately halting NSSI, and that they will not be forced to stop this behavior or commit to treatment. School personnel, caregivers, and peers need to be aware that as students learn healthier coping and their NSSI diminishes, there should not be excessive focus

on “recovery” or NSSI cessation. NSSI recovery is often nonlinear, and schools may have either a primary or supportive role in this process depending on the needs and preferences of the student, as well as on the resources available within the school.

NSSI in Secondary Schools: Summary of Recommendations

In summary, a review of existing approaches to NSSI prevention/intervention among adolescents suggests that school-based interventions should (a) be offered universally to all students, (b) be collaborative and multipronged, incorporating school personnel and caregivers at every level, (c) encompass three levels of prevention and intervention to respond to the diversity of NSSI experiences that is likely to be encountered in a secondary school setting, and (d) be evidence-based, drawing particularly from SEL-based skills building programs such as DBT STEPS-A (Mazza et al., 2016) and incorporating modules on mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness.

Challenges to NSSI Prevention and Intervention in Schools

There are a number of challenges that are unique to addressing NSSI prevention/intervention in secondary school settings. Three examples of such challenges are outlined and recommendations are provided.

Response to Wounds or Scarring

Another challenge in schools is the demonstration of an appropriate response to wounds or scarring. Schools are often concerned that viewing scars or wounds can be triggering for vulnerable students. Although there is evidence that viewing fresh wounds carries a likelihood of being triggering (Baker & Lewis, 2013), research has suggested that choosing to stop concealing one’s scars can be very therapeutic and an important step in recovery (Lewis, 2016; Lewis & Mehrabkhani, 2016). The school’s response should thus differ depending upon whether fresh

wounds or scars are revealed (Hasking et al., 2016). It is recommended that fresh wounds should be kept concealed to prevent potential infection, and it should be explained to students that there is some evidence that the sight of wounds by those who may be still struggling with their recovery around NSSI can be triggering. On the other hand, as previously noted, a student's choice to stop concealing scars can be a positive step toward recovery (Lewis, 2016; Lewis & Mehrabkhani, 2016). Nevertheless, school MHPs should have a sensitive and compassionate discussion with the student that involves acknowledging that this is the student's choice and may be a positive step for them, but also discussing the potential negative consequences that may arise (e.g., intrusive questions, negative comments, and bullying) and how these potential challenges may be addressed, as well as how the student can be supported in facing such challenges.

NSSI Online Activities

Research has demonstrated that adolescents who self-injure are more likely to seek peer, rather than professional, help (e.g., Doyle et al., 2015). As such, internet use, and specifically the use of social media, has increased in recent years for discussion and help-seeking surrounding NSSI (e.g., De Riggi et al., 2018), as illustrated in Case 1 at the start of this chapter. In fact, one third of youth with a history of self-injury reported online help-seeking for NSSI (Frost & Casey, 2016). While NSSI online activities may be beneficial for decreasing social isolation, encouraging recovery, and providing a platform for emotional self-disclosure, they also have the potential to be harmful. Specifically, NSSI online activities may trigger urges to self-injure and provide social reinforcement of the behavior, as well as ideas for concealing NSSI (De Riggi et al., 2018; Lewis & Seko, 2016; Murray & Fox, 2006). Furthermore, some websites display content such as images and videos that may cause distress or trigger urges to self-injure, and

while certain websites provide trigger warnings for such content, others do not (Duggan et al., 2012). In any case, it appears that the majority of NSSI-related online searches are primarily seeking supportive, recovery-oriented information (Swannell et al., 2010), and thus have a positive underlying motivation.

Recommendations for secondary schools in responding to NSSI online activities are as follows. First, an open discussion of students' online NSSI activities should be incorporated into the tertiary level of school-based NSSI prevention/intervention programs (Berger et al., 2017). MHPs can provide guidance regarding appropriate websites and/or discussion forums for NSSI (Swannell et al., 2010), in an effort to steer students away from potentially harmful websites. Finally, as part of the tertiary intervention discussed earlier, schools should help adolescents become aware of the potential benefits and risks associated with online activities and/or online NSSI disclosure (Christofides et al., 2012), helping them to become informed consumers of digital supports rather than simply recommending that they stay offline.

Social "Contagion" (Influence)

Although frequently referred to as social "contagion" (see Jarvi Steele et al., this volume), we do not endorse this terminology as it is stigmatizing in its disease-based connotation; thus, we will henceforth refer to this construct as social influence. Social influence may be defined as the presence and spread of behavior (i.e., NSSI) in at least two people in the same group within a short period of time (Rosen & Walsh, 1989) or a significant number of individuals engaging in NSSI within the same group (Walsh & Rosen, 1985). As noted earlier, the increased use of social media, particularly among adolescents, may serve to normalize NSSI by disseminating instances of it to a large number of individuals in a short period of time. Social influence has also been suggested to increase when NSSI serves a social or interpersonal

function (Jarvi et al., 2013). In fact, individuals who self-injure largely report learning about NSSI through peers and/or some form of media (Heath et al., 2009a; Hodgson, 2004). Thus, the social influence of NSSI has been proposed as a potential reason for its rising prevalence (White Kress et al., 2004) and has been identified as an ongoing concern in schools (Toste & Heath, 2010; Wester et al., 2018).

Recommendations for secondary schools in responding to the potential social influence of NSSI are as follows. First, tiered NSSI prevention/intervention approaches, as outlined in this chapter, have been identified as central to preventing and/or diminishing social influence of NSSI (Wester et al., 2018). Specifically, preventing the onset of NSSI behaviors before they occur, as is the goal at the primary level of prevention/intervention, can effectively eliminate the possibility of social influence. At the secondary level, the social influence of NSSI may be reduced through the targeted instruction of healthy coping strategies within small-group sessions. Any group discussions of coping behaviors should be contextualized within a healthy/unhealthy coping framework, as group discussions that are centered on NSSI may be triggering, exacerbate social influence, and should thus be avoided (Wester et al., 2018). Nevertheless, despite past recommendations to reduce social influence by avoiding or prohibiting all discussions surrounding NSSI in schools (e.g., Walsh, 2012), this is no longer recommended (e.g., Hasking et al., 2016). However, discussions surrounding NSSI should take place on an individual basis (Wester et al., 2018). Importantly, these discussions should include information about the potential harm in supporting or encouraging self-injury within peer groups.

Informing Caregivers

For secondary schools, helping caregivers respond productively to their youth's NSSI is a vital part of effectively addressing it (Arbuthnott & Lewis, 2015; Whitlock et al., 2018).

However, a challenge for schools involves knowing when, and how, to involve caregivers in a discussion of their child's self-injury (Berger et al., 2013). MHPs must carefully weigh the adolescent's risk profile along relevant legal and clinical obligations (Hasking et al., 2016). Moreover, MHPs in schools have a duty to break confidentiality and notify a students' caregiver of their NSSI when the student is at risk for suicidality (Lloyd-Richardson et al., 2015). Otherwise, MHPs should use clinical judgment while relying on school protocol and professional order guidelines. Notably, they should take into account what is known about the student, the family, and how they are likely to react to NSSI disclosures (Hasking et al., 2016). When feasible, the student should be actively involved in decision-making; this might include obtaining their consent to contact caregivers, allowing the student to be present when caregivers are informed, and being actively involved in decisions regarding treatment (Hasking et al., 2016; Whitlock et al., 2018). Finally, caregivers should be provided with support and information when notified of their child's NSSI. Specifically, MHPs should help caregivers navigate first conversations by encouraging them to know what to expect in terms of the NSSI recovery process, and understanding and addressing safety concerns (Whitlock et al., 2018). It may also be beneficial to encourage caregivers to seek informal or formal support for themselves, in order for them to feel adequately supported throughout their efforts to support their child.

Recommendations for Future Research

Despite the prevalence of NSSI in secondary school settings, to date, very few school-based programs have demonstrated efficacy at preventing and/or reducing NSSI behaviors among adolescents (Heath et al., 2014). Therefore, there is a need for future research on NSSI prevention in secondary school settings to rigorously evaluate existing school-based prevention programs across all three levels of prevention/intervention (e.g., Baetens et al., 2020;

Muehlenkamp et al., 2010), particularly in terms of their long-term efficacy at preventing NSSI and promoting greater levels of help-seeking in secondary school students at risk. In addition, we have proposed that a multipronged approach as well as prevention science best-practice considerations should be incorporated into prevention programs to optimize their efficacy (Arbuthnott & Lewis, 2015; Durlak, 1997; Hasking et al., 2016). Future research should thus consider evaluating NSSI prevention/intervention programs on the basis of their inclusion of these proposed essential elements. Finally, there is also a need to continue developing, distributing, monitoring, and evaluating the effectiveness of NSSI-specific school protocols that support students across all three levels of care.

Conclusion

Although addressing NSSI prevention/intervention in secondary school settings is of paramount developmental and contextual importance, school personnel often feel ill-equipped to respond to this rising mental health concern. This challenge is further exacerbated by a lack of research empirically evaluating school-based NSSI prevention/intervention programs. Specifically, there is evidence to suggest that existing programs can be implemented in a manner that is feasible in schools (e.g., Mazza & Dexter-Mazza, 2019), although at this time, they have not been rigorously evaluated. Nevertheless, the provision of education and information surrounding NSSI can serve as a beneficial foundation for addressing its incidence in secondary school settings, and may even be similarly impactful as implementing comprehensive prevention programs. Schools are uniquely positioned to respond to adolescents' NSSI and to pioneer for the destigmatization of this coping behavior; they may take on a number of highly important roles in their students' journeys with NSSI, as outlined below.

Case 1. Resolution: *Despite refusing treatment, E.L. participated in her school's universal prevention program, attending sessions at the primary and secondary level, and completed regular check-ins. As a result, her coping abilities improved and her self-injury decreased.* Analysis: E.L.'s case highlights the importance of having primary and secondary interventions available for those who decline intervention for self-injury but would benefit from learning healthier coping.

Case 2. Resolution: *M.P. took part in class-wide primary-level activities to learn better emotion regulation skills. His self-injury decreased over time as a result, and his suicidality is monitored on an ongoing basis through check-ins with the school counselor.* Analysis: Similar to E.L., albeit for different reasons, M.P. benefited from the primary program and, over time, was more open to considering the secondary-level groups. The use of safety/wellness check-ins also ensured that changes in suicide risk were being monitored. M.P.'s case highlights the challenges of involving caregivers without a well-considered evaluation of the potential benefits and drawbacks.

Case 3. Resolution: *The school struggled to collaborate with A.J.'s hospital care. Liability issues around risk level continued and were never fully resolved. Ultimately, the student dropped out of high school and is still in and out of the hospital.* Analysis: A.J.'s case is illustrative of the continued difficulties in coordinating care between hospitals and schools. The need for school MHPs to be well informed and proactive in working to establish the needed collaboration for supporting students as they transition back to the school is critical.

Summary

There is a notable uniqueness to secondary school settings in terms of addressing NSSI prevention and intervention. Central to being able to effectively respond to students who engage

in NSSI is the development, distribution, ongoing monitoring, and routine evaluation of an NSSI-specific school protocol that clearly delineates the roles of all relevant stakeholders. Furthermore, while the ultimate goal is to prevent NSSI, early intervention (i.e., once NSSI has been disclosed) is also imperative, but neither can occur without the involvement of educators, MHPs, and other school personnel, as well as the families and/or caregivers of students. Therefore, school-based NSSI prevention programs should be collaborative and multipronged, in addition to incorporating prevention science best-practice considerations. Additionally, three levels of prevention/intervention should be incorporated in NSSI prevention programs (i.e., primary, secondary, and tertiary), with each level being uniquely tailored to the experiences and needs of different subsets of students. To date, there is a lack of research rigorously evaluating the immediate and long-term effectiveness of NSSI prevention programs in secondary school settings. Nonetheless, the provision of evidence-informed, NSSI-focused psychoeducation can serve as an important first step for addressing its occurrence in secondary school settings. While the implementation of a universal, school-wide approach to NSSI prevention is the ultimate aim, every effort to reduce stigmatization around NSSI and improve the school response can have a notable impact on all members of a secondary school community.

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