Responding to non-suicidal self-injury in New Zealand secondary schools: Guidance counsellors' perspectives

Jessica A. Garisch, Kealagh Robinson, and Marc S. Wilson

Abstract

Schools and school-based mental health professionals play a critical role in responding to adolescent Non-Suicidal Self-Injury (NSSI). However, little is known about the experiences in particular of guidance counsellors responding to NSSI in New Zealand secondary schools. We present here a descriptive thematic analysis of a focus-group discussing the experiences of 14 guidance counsellors working in secondary schools. Counsellors emphasised the key aspects that were important in determining how to respond to student NSSI: the role of confidentiality, disclosure to and involvement of family or whānau, the maintenance of the therapeutic relationship, and the importance of a thorough assessment. Among the wider school staff community, counsellors reported staff misconceptions and discomfort with NSSI, as well as failure to report instances to the NSSI counselling team that school staff had witnessed. We suggest that school communities would benefit from NSSI-specific staff training, as well as a school protocol for addressing student NSSI, and conclude with suggestions for guiding a discussion among pastoral care and senior leadership teams.

Keywords: non-suicidal self-injury, secondary schools, guidance counsellor, qualitative research

Non-suicidal self-injury (NSSI) refers to behaviours that deliberately harm the self and that occur without suicidal intent (International Society for the Study of Self-Injury, 2018), and typically manifests as cutting, scratching, or burning the skin (Whitlock, Eckenrode, & Silverman, 2006). NSSI commonly begins between ages 12 and 14 (Plener, Schumacher, Munz, & Groschwitz, 2015), with approximately 18 per cent of adolescents engaging in these behaviours across the globe (Muehlenkamp, Claes, Havertape, & Plener, 2012). NSSI represents a significant mental health challenge for adolescents. Literature highlights that engaging in NSSI is associated with poorer concurrent psychological wellbeing (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), and subsequently predicts poorer socio-emotional wellbeing (Gandhi et al., 2017; Robinson et al., 2019), and an increased risk of suicide (Guan, Fox, & Prinstein, 2012; Ribeiro et al., 2016).

School staff play a critical role in responding to adolescent NSSI. International research suggests that although the majority of teachers and school mental health professionals respond to self-injury in schools, most report a lack of training in how to respond to and manage NSSI (Berger, Hasking, & Reupert, 2015; Dowling & Doyle, 2017; Duggan, Heath, Toste, & Ross, 2011; Kelada, Hasking, & Melvin, 2017; Roberts-Dobie & Donatelle, 2007). This lack of training is especially concerning because secondary school mental health professionals, and school staff in general, are often the first to discover cases of NSSI (Shapiro, 2008). Within the wider social community NSSI is often seen as attention-seeking and manipulative (Urquhart Law, Rostill-Brookes, & Goodman, 2009), which minimises the seriousness of the behaviour and makes it difficult for young people who self-injure to disclose (Fortune, Sinclair, & Hawton, 2008; Garisch, 2010; Klineberg, Stansfeld, & Bhui, 2013). The response of school

staff on the "front line" is vital to managing stigma, especially as the experience of disclosure/discovery influences the likelihood of young people accessing future support.

There are several international guidelines for responding to NSSI in schools (e.g., De Riggi, Moumne, Heath, & Lewis, 2016; Hamza & Heath, 2018; Hasking et al., 2016; Shapiro, 2008), although the extent to which these are utilised in New Zealand is unclear. There are no national guidelines for secondary schools specific to this concern; often NSSI behaviour is grouped into guidelines for responding more generally to dangerous behaviours such as suicidality and aggression (Collings, 2012; Ministry of Education, 2013). However, NSSI has been substantially differentiated from other risky behaviours (see for example, Muehlenkamp & Kerr, 2010), and thus requires a considered and flexible approach based on a student's presentation and surrounding support systems.

The current study sought to investigate and describe how pastoral care workers in secondary schools in the wider Wellington region respond to student NSSI. From 2012 onwards, our research team (the Youth Wellbeing Study) held annual workshops for school mental health professionals and youth workers in the wider Wellington region on youth wellbeing. At our 2013 workshop we facilitated a group discussion focused on the ways in which secondary schools respond to NSSI. Here we analyse the data from this discussion with the aim of providing a descriptive account of the factors pastoral care staff consider when responding to NSSI in schools. The intention is to provide a springboard for further discussion within pastoral care teams regarding their practice.

Method

Participants

Fourteen secondary school guidance counsellors (four of whom were male and 10 female) contributed to a one-hour focus-group discussion. This focus group was recruited from, and took place within, a wider workshop on NSSI. This workshop was attended by 39 people (24 secondary school guidance counsellors, four youth support workers for local youth health agencies, one university counsellor, one youth agency training provider, one health nurse, and one social worker at a teen parent unit; the remainder were research team members), of which 14 research participants contributed to the discussion. Unsurprisingly, given the particular focus on NSSI within the school, only school guidance counsellors chose to contribute to the discussion.

Procedure

An invitation to take part in a free day-long workshop on adolescent wellbeing was extended to all school-based mental health professionals in the Greater Wellington region via Youth Wellbeing Study newsletters and was shared among school-based mental health professionals' personal networks. Several days prior to the workshop, all attendees were emailed a workshop programme which included an information sheet, ground rules for the focus group, and a consent form pertaining to the focus-group discussion presented here. At the beginning of the workshop, attendees were verbally informed about the study, and reminded that participation was voluntary and confidential. The focus-group discussion occurred midway through the workshop day, with participants providing written informed consent prior to the discussion. Workshop attendees who did not wish to take part or listen to the discussion were asked to leave the room for a refreshment break. All workshop attendees chose to give consent to take part in the focus group, although as stated earlier only 14 chose to contribute to the discussion (i.e., the remainder were silent during the discussion). Attendees formed small groups around a central table, with the facilitators standing at the top of the room, and the room was kept closed throughout the discussion, to maintain privacy. Prior to the discussion, the facilitators

reiterated the ground rules for the focus group (i.e., expectations of confidentiality and respect, with one speaker at a time).

A common, long-standing criticism of qualitative research is that interviews (and therefore findings) are influenced by leading questions (e.g., Kvale, 1994). This prompted us to be mindful of ensuring the discussion, which began with the question "Is there a process for managing NSSI in your school?", was participant-led. The participants then discussed the overall topic of responding to NSSI in secondary schools. Given that multiple participants took part in the discussion and in the interest of focusing on guidance counsellors' experiences, the discussion was allowed to flow as directed by the group with minor facilitation and reflection by facilitators. To assist with transcription, the discussion was audio and visually recorded. All identifying information regarding attendees and their affiliated agencies was deleted during transcription and as all workshop attendees had provided consent to take part in the discussion, they were verbally debriefed after the discussion and later sent a copy of the transcript. Ethical approval for this study was provided from Victoria University of Wellington's Human Ethics Committee.

Analytic approach

Data were analysed using thematic analysis, a method for identifying patterns of meaning across a qualitative dataset (Braun & Clarke, 2006; Braun & Clarke, 2013), with the intention of giving voice to guidance counsellors working to manage NSSI in secondary schools within New Zealand.

Using an inductive approach (Braun & Clarke, 2006; Braun & Clarke, 2013), the transcript was read and re-read for data relating to the research question; there was no attempt to fit the data to a pre-existing theoretical framework. However, as researchers we acknowledge that we have been researching NSSI for many years and therefore cannot separate ourselves from the knowledge we have in this area. In this regard, theoretical understandings and approaches to NSSI may have influenced theme-selection. In addition, the participants may have been mindful of existing research and theoretical understandings of NSSI, as these were discussed in the wider workshop, and provided the context within which the research-based discussion took place. Themes were identified using a semantic and realist approach (Braun & Clarke, 2006; Braun & Clarke, 2013). In this approach, participants' language is seen to directly reflect their experience and depict the realities of responding to NSSI within schools. Quotes have been edited slightly for readability. In order to maintain confidentiality, participants were assigned a number in the order in which they contributed to the discussion.

Results

From our findings, three main themes were identified: issues of disclosure, clinical consideration and responsibilities, and school infrastructure and climate. Each theme had associated sub-themes.

Theme 1: Issues of disclosure

Counsellors actively negotiated with their clients about whether to disclose the student's NSSI, and if so, to whom. Prime considerations and/or difficulties in this decision-making process were deciding when to break confidentiality, considerations regarding whether and when to inform or involve family or whānau, and how to maintain the therapeutic relationship. This theme involved balancing concerns regarding students' privacy against the level of risk and the associated need to intervene.

Negotiating confidentiality

Decisions regarding confidentiality were based on the perceived level of risk, counsellor clinical judgement, students' engagement in the counselling process, and determining when, how, and who to disclose to. Counsellors referred to "serious" and "imminent" danger, "professional judgement", the "kind of harm" (i.e., the nature of NSSI and what it suggests about risk), and whether the self-injury was "containable".

> *… mindfulness about serious imminent danger which may be* [when] *making that kind of assessment I think's really important here so getting to know the student … understand a little bit about the circumstance and then perhaps push forward and maybe breach confidentiality if required but you know that's a professional judgement than rather kind of a set of format of ways of dealing with things* (P3).
>
> *… it's a fluid kind of discussion that would go on but I'd certainly unless there's you know serious and imminent danger … and that's apparent from the kind of harm that a young person's turned up with, and again that can be a negotiated thing with me and the dean about how they might manage it if they* [the deans] *came across it first* (P7).
>
> *… make the assessment … depending on what's happening we may or may not talk to the parents. If it's non-suicidal self-injury and it's containable or even beneficial then we may not refer back to the parent or we may do, every case is individual* (P6).

The latter quote from P6 demonstrates how counsellors considered the function of students' NSSI, and the containment of risk, in their decision-making regarding disclosure. In terms of function, this quote considers whether the self-injury is "beneficial"; which refers to how self-injury can function as a self-management strategy to help someone manage intense emotion, or urges. Self-injury may benefit someone in the moment and stop them from engaging in something ultimately more harmful, such as suicide. For some people who self-injure, their injury has an "anti-suicide" function, and therefore engaging in NSSI prevents them from doing something more harmful (Klonsky & Glenn, 2009).

One counsellor suggested that level of engagement was important in determining when to break confidentiality. Where there was unwillingness of the student to engage in counselling the counsellor would likely choose to tell whānau as a matter of course:

> *Engagement makes a big difference. I think that if someone will really engage with me and doesn't want home to know but is prepared to engage in working then I may not tell home but it's such an individual and unique call every single time. I'm making that decision for myself and in league with the nurses usually so that other people in the system know but it's a hard call to make. … I had another circumstance where students came to me to say that one of their peers was cutting they were very concerned … when I met that student she said categorically absolutely not showing you anything and I'm not talking to you about this end of story so under that circumstance I felt, well, if you won't engage with me, I definitely have to speak to your mum …* (P4)

Given the risks associated with NSSI, and the unknowns in an individual's presentation when they don't engage, it would seem expedient to alert whānau or a trusted adult to a student's self-injury.

Unfortunately, this can also backfire, as demonstrated in P4's continuing quote:

> *… when I did* [tell mum] *I was told to mind my own business …* [and she] *said to me, you don't know anything about my daughter and just mind your own business and then rang the principal to have the principal tell me to mind my own business …* (P4)

This quote highlights that counsellors must be prepared for a range of reactions when disclosing a student's NSSI to whānau. The above quotes also illustrate that counsellors are

not working in isolation, particularly when making decisions regarding disclosure and risk management. Counsellors are liaising with senior staff such as deans, the principal, school nurse(s), and colleagues.

Maintaining the therapeutic relationship

Issues of disclosure were also linked to *maintaining the therapeutic relationship*. The counsellors were aware of balancing issues of confidentiality with establishing and maintaining rapport with students, and were mindful of this when deciding when and how to disclose to whānau:

> *For me* [disclosing] *is a process that is completely transparent, my relationship with my client is paramount, trust is paramount and everything I do I would do it with the knowledge of* [the student] *and let them know if, especially if they're under 16*[i] *the parents are going to be told and we will do this together. There is nothing done behind closed doors and I'd certainly not refer to the dean* [and] *have a conversation that wasn't in front of the student …* (P6)

Decisions around informing parents and/or whānau were sometimes made in collaboration with the student, as a way of maintaining the relationship, ensuring transparency, and information gathering:

> *… One of the things I do with my young people who self-harm … when we first become aware of it, is to have discussions with them about who knows* [about the self-injury] *and who doesn't … to suss out their level of connection with their family, because … I get instances where we've together decided to contact the family, we've done it together, I've done it in front of the child. It's one of the things I do. I* [have a] *phone conversation* [with family] *and you* [the student] *stand there and hear exactly what's been said so there's no "he said she said" but it's an agreement we've reached together… and the kind of situations where we've agreed that actually, no, it's not going to be really helpful for your family to know so we have to build an alternative support team … because it's not allowed to just be me …* (P10)

Again, involving the young person was balanced with the need to ensure safety by developing a support system around the student, whether this be whānau or someone else. The above quote also illustrates counsellors' awareness of the need for additional support, over and above what they routinely offer, when working with students who self-injure. Further, some counsellors were adamant that they would not consider disclosing NSSI to whānau until meeting with the student and finding out more about them:

> *… personally, it just wouldn't occur to me to tell families before I've actually met the student… meet the student and spend more time and find out a little more about the student for myself because I'm not always going to tell home …* (P4)

Several participants had processes in place within their school whereby other staff members would break confidentiality and disclose students' NSSI to whānau, which was specifically framed as a tactic to preserve the therapeutic relationship:

> *… it's the deans and teachers that make that call to the parent and then we're kind of removed … but we're not colluding … we don't want to end in some bind with confidentiality where it's just us and the student and they're refusing to let anyone else in to support …* (P5)

This indicates that level of risk, age (i.e., under 16), an individualised assessment, and transparency are all issues of importance with regard to maintaining the therapeutic relationship and deciding when to disclose and potentially break confidentiality. This is in keeping with the New Zealand Association of Counsellors Code of Ethics (2016, principle 6.2 (a) that school counsellors are bound to uphold and which states "counsellors shall only make exceptions to confidentiality in order to reduce risk".

Considerations when informing or involving family or whānau

Counsellors raised several considerations when informing family or whānau of their child's self-injury or involving them in treatment. These included managing whānau distress, determining whether informing the family could adversely affect the young person's wellbeing, and the capacity of family members to manage this information.

Several counsellors commented on having to manage whānau distress, and that this could make it unclear who their client was, for example:

> *I have had a situation where parents have actually communicated with me about their distress and then it's like "who's my client?". And it got really, really tricky.* (P3)

Some counsellors questioned the utility of telling parents and whether, in some cases, this might place an extra burden on whānau relationships and contribute unnecessarily to the student's distress:

> *I have experience of a woman* [mother] *who was* [like], *"they, they're just attention-seeking, they're not going to kill themselves". It was a really, really dangerous situation … very, very negative, to the point where the child was so completely closed down from everybody to discuss anything for fear that that information would go back to the mother and would make it worse for him …* (P5)

Whānau mental health was also a significant factor, and one that may be unknown prior to disclosure:

> *… I was just thinking of a circumstance where actually I informed a parent and then a couple of days later, she came into school to tell me …* "*I've got really serious mental health issues myself; I've actually had a lot of mental illness.*" *This really upset me … I wasn't to know that the mum actually had mental health issues herself and that she might not manage the circumstances … that's another layer to speaking to families. So what do we know about families? How safe do we know the families always are when we tell them …?*(P4)

On the other hand, counsellors reported that disclosing NSSI to parents/hanau was often experienced as a relief, to both the student and the whānau member(s):

> *… for the most part, sometimes students will say* "*okay it's a relief for you to tell my mum*" *and they'll* [whānau] *say* "*I knew something was going on and knew she wasn't happy* [it's a] *relief to know …*"(P4)

Several counsellors commented on the utility of informing whānau, stating that this was linked to a reduction in self-injury. Counsellors saw developing whānau capacity and cohesion as an important step in NSSI treatment and resiliency long term; for example:

> *… I have found that… my students that have family awareness* [of NSSI] *I actually have found a reduction in their cutting. Their behaviour improvement is quite significant … I think getting family* [involved] *and helping family be on that* [student's] *team can be really helpful …* (P8)

Counsellors also acknowledged that they are only a "small part of their [the student's] world", and students need a wider, more long-term, support network:

> *The other side of the issue is that we're just a small part of that, their world … hanau, now family, now they're going to be with them for the rest of their life, you know, and so whenever I'm working with kids I'm trying to get them to, we're talking about strengthening those, that engagement with whānau or with their family, not necessarily with parents but with someone.* (P1)

Theme 2: Clinical considerations and responsibilities

Counsellors balanced clinical considerations and responsibilities when considering their role within the school system, and to whom they were accountable, such as other staff, the wellbeing of other students, students who engaged in NSSI, and the wider community. There were several interrelated sub themes that emerged in the group discussion: *conducting a thorough assessment*, *safety of other students*, and *managing overt or public NSSI behaviours*. These are discussed in turn.

Conducting a thorough assessment

The importance of conducting a thorough assessment was seen as pivotal for informing decision-making regarding students' NSSI. Counsellors emphasised that NSSI was a symptom of other underlying psychological issues, and that these needed to be identified to fully understand the behaviour:

> *It's looking at non-suicidal self-injury but that's a coping mechanism for something else … it's sitting alongside anxiety, stress, some other big driving thing … that's* [self-injury] *the solution that the young person's finding and it's our job to assist them to find what the problem is.* (P7)

Counsellors held a well-developed conceptualisation of NSSI. There was discussion of how NSSI is often related to underlying emotional distress (with multiple antecedents), is heterogeneous in form and functions, and requires individualised assessment to progress to treatment.

Counsellors acknowledged a sense of anxiety when working with students who self-injure, and having to be aware of this in their assessment:

> *… I'm not going to do anything till I've spent some time with this kid and get a sense of what's going on because I do think the immediate temptation is that they're cutting themselves, we want them to stop, and it actually may not be helpful, and that's part of the confusion, and I think my own reaction … this boy's cutting himself regularly and I've had to pull back from trying to stop him and realise that actually he's not really doing himself serious harm …* (P9)

Conducting a thorough assessment was seen as important in managing this anxiety, by providing a more accurate sense of risk rather than basing clinical decisions on the counsellors' emotional response to a student's self-injury.

Safety of other students

Risk to other students was a clinical consideration that counsellors raised during the discussion. Counsellors reported that other students could become upset by the self-injury of their fellow students:

> *I had another circumstance where students came to me to say that one of their peers was cutting. They were very concerned, there was lots of blood on paper towels in the bathrooms and definitely signs of cutting … they came to say how upset they were.* (P4)

Counsellors' support was sought from students who had witnessed (or been privy to) their friends' NSSI, and who were struggling to manage their own distress or concern for a friend. Having a friend or family member who self-injures is a risk factor for future NSSI behaviour (Fox et al., 2015; Prinstein et al., 2010), hence friends require special clinical consideration.

Managing overt or public NSSI behaviours

In instances of overt public self-injury, counsellors experienced a tension between supportive and disciplinary responses, which then impact upon decisions around confidentiality and the kind of clinical work that can be done.

> *Our person who was actually handing out … blades to junior school intermediate kids, and he was a sick child and did have a psychiatrist … between us* [as a counselling team] *we had to manage what was discipline and what was not … public displays were not acceptable. If he wanted to self-harm at home as a release that was different—what he did in private was different. What he did in public was not acceptable and that we had to put up those boundaries in place for the safety of the, of others … hence the discipline element that was in there as opposed to the help that he was getting …* (P5)

Hence there were clinical decisions made regarding placing certain overt self-injurious behaviours under the domain of disciplinary management (public displays of NSSI; behaviours that could be interpreted as inciting others to self-injure), which were not under the same domain of confidentiality as private NSSI and were seen to have potentially different underlying functions i.e.: "*at home as a release is different*". Previous research has indicated that public NSSI is generally seen as "attention-seeking", less genuine, and less deserving of support than private NSSI (Gilbertson & Wilson, 2008). The perceptions of public NSSI as unacceptable, perceived as attention-seeking, geared towards provoking a reaction, whereas private NSSI being considered as a release, as identified by the above research participant often influenced the counsellors' responses, and those of other school staff involved with students:

> *… we had a person who from a staff point of view was* [using] *attention-seeking behaviour and would deliberately put razor blades in his mouth in front of the teacher in the classroom to provoke a reaction. So consequently, although* [they]*referred him to us, it was dealt with as a disciplinary thing by senior management and in that sense our input was limited, you know. We could only work with the person at this level and make referrals for him but really because of the way in which he was displaying his self-injury it was so public and so "look at me chur"*[ii] *that the teacher had to respond … in that particular case it ended up being dealt with as a disciplinary thing even though it got referred to us …* (P5)

Overt public NSSI was also described as requiring an immediate response from the classroom teacher, with follow-up "restorative" conversations:

> *… just last week with an art year nine class and the lesson to the whole class is that there are, you know, a lot of sharp* [tools] *and the teacher said no accidents, please, and … this young woman really just ran with it to the point where she went up* [to] *the teacher and went across her hand* [with a sharp implement] *and* [the teacher] *took her out, immediately dressed it and … it got reported on* [the intranet site for recording students' functioning] *and followed* [up] *as a discipline … there'll be, you know,*

> *restorative chats … the teacher will have with her about, you know, what were you hoping to achieve by that …?* (P7)

When NSSI was public, there was a different approach to disclosure. Counsellors reported that in the case of public NSSI they would readily tell parents, as the information (regarding their child's self-injury) was already public.

> *… it's out there … everyone knows … it's really important the school actually does tell the parents so it's not other parents telling them or kids telling them so that … the school is seen to at least be aware of what's going on and having real care and concern …* (P6)

Theme 3: School infrastructure and culture

Counsellors were frustrated by school infrastructure and the culture regarding NSSI. The sub-themes identified were *staff misconceptions and discomfort regarding NSSI*, *informal responses and training regarding NSSI*, and *failure of other staff to report NSSI to the pastoral team*. Counsellors were confronted with managing other staff members' perceptions of mental health (e.g., NSSI as attention-seeking), and willingness to follow processes when confronted with student mental health issues (in this case, NSSI).

Staff misconceptions and discomfort regarding NSSI

Counsellors reported that school staff would occasionally refer to self-injury as "attention-seeking", despite having been presented with information to the contrary and they felt that this was an unhelpful way of understanding the behaviour.

> *I was quite dismayed when Marc [research team leader, last author Marc Wilson] came to the school*[iii] *because we'd talked about it and I was quite dismayed to hear one of them [school staff] say something like NSSI was attention-seeking behaviour. I thought to myself "we've had these discussions I don't know how many times". (P2)*

Another counsellor said that the way staff talked about students who self-injure as attention-seeking was negative and enabled the deferral of responsibility to the student (rather than encouraging support):

> *… they* [staff] *see it as a "well, we just ignore it". It's a way of putting it down to the student rather than—"well, let's respond to it" and help them find other ways of getting attention and in a less damaging way. It's a putting down of the student to me that … that's what I hear in their voices.* (P7)

This labelling of NSSI as attention-seeking was seen by another counsellor as reflective of other staff members' discomfort with the topic:

> *I just wonder if it reflects staff personal discomfort, that negativity, and not knowing how to cope with it really …* (P3)

Informal responses and training regarding NSSI

When asked whether there was a specific process or protocol for responding to NSSI in schools, attendees unanimously reported that there was not. Most often, there was an informal process for responding to NSSI, with staff either going directly to the counselling department, or letting whānau know of the self-injury and then referring it to the counsellor. The level of involvement of teachers and management staff appeared to vary between schools and was at least partially dependent on staff comfort and their relationship with the counsellors. When a policy was referred to, it was not specific to NSSI:

> *… not a specific process for NSSI, but a process for managing events of self-harm, or harm, or potential risk, or violence, or students who people are worried about for whatever reason. There are guidelines of referring to the counsellor and assessment and possibly to contact home … nothing specific.* (P1)

> *We actually do have policy in school and every year at the beginning of the year the principal and the dean stand there and tell the whole staff that if they have concerns about students—whether it's depression, if it's something about suicide attempts or non-suicidal self-harm—they must refer to one of us* [pastoral care team]. (P5)

The process for responding to NSSI appeared to be amalgamated with the process for responding to other behaviours related to risk.

Counsellors usually provided informal guidance to school staff around reporting NSSI to whānau and how to respond to cases of NSSI.

> *My deans, I talked to them about it and said, "look, don't do this if you don't feel comfortable and come and talk to me and we can, you know, work through it together", but they seem quite comfortable* [about reporting home regarding cases of NSSI] *because they do keep it as quite factual.* (P3)

Hence the counsellors would keep in mind staff levels of comfort when considering staff members' roles in responding to NSSI, and this would be discussed on a case-by-case basis. Counsellors commented on the importance of building and maintaining a trusting relationship with staff, to assist with this process:

> *I think, if there were safety issues then our deans are pretty tuned-in to our kids and they're pretty aware of most of those kids at risk, and so I kind of trust their judgement of the situation.* (P3)

Counsellors also reported experiencing occasions where they could not trust staff to report cases of NSSI when necessary, as discussed below.

Failure of other staff to report NSSI to the pastoral team

Several counsellors recounted situations in which staff had chosen to keep cases of NSSI to themselves and had attempted to support the student on their own.

> *… some people in the past have kept it* [student NSSI] *to themselves and then it's got dangerous, and then it's suddenly been like a hot potato thrown in our direction. "Why the hell didn't you tell us six months ago?"* (P5)

This was explained by another counsellor as reflecting staff intentions to be helpful, but that ultimately this behaviour was outside most teachers' area of expertise and competence.

> *… there are some individuals who like to feel like they're helping and there may be stuff in their own background with their own children; "Ooh, I can really help this child, I know something about this", and of course every case is different—this is not your child* [but] *somebody else's. But some of them get hooked into that, and before they know it it's become too big for them to handle … they get frightened and then pass it on, but in the meantime you know you could have been doing some work with* [the student] *to help them.* (P6)

One counsellor said that responding to NSSI also included responding to any safety risks for teachers, too; and this included cases where teachers did not tell the pastoral care department about student NSSI as early as they perhaps should have.

> *… it's a safety thing for teachers because I've had the same experience as you've had where teachers have held on to something that's got too big and … then they throw it our way and it's kind of far out, you know, we should have known about this a long time ago.* (P1)

Discussion

Responding to NSSI in secondary schools is a complex endeavour, and participants' responses in the focus group indicate that counsellors are required to attend to needs within the school community at various levels, including the self-injuring student, other students and school staff, as well as parents and whānau.

Issues of confidentiality and managing disclosure were common experiences. Counsellors were mindful of maintaining their relationship with students, while also acknowledging that the risk of harm associated with self-injury may necessitate breaking client confidentiality. Considerations regarding disclosure involved ensuring adequate support for the student, ascertaining students' engagement in therapeutic intervention (with lack of engagement indicating greater need to disclose to whānau), and the nature of the self-injury (e.g., public NSSI required disclosure to whānau). School guidance counsellors do not work in a vacuum and have multiple relationships to consider when making clinical decisions. Having close ties with academic staff, and solid relationships with senior staff and the wider pastoral care network (e.g., nurses, deans, the principal), was presented as vital to supporting counsellors in their roles.

Teaching staff were described as sometimes having an emotional reaction to NSSI and at times being judgemental in their stance, such as seeing NSSI as an attention-seeking behaviour. Research indicates that people who self-injure are highly sensitive to, and vigilant about, criticism and rejection from others, particularly in relation to the self-injury, and may expect to be stigmatised (Fortune et al., 2008; Harris, 2000). These factors can lead to shame and withdrawal from available support. It is important that school staff respond in ways that are sensitive to the risk of reinforcing shame or negative self-attributions, while remaining low-key and unflustered. The research literature describes a "low-key, dispassionate demeanour" (Walsh, 2014, p. 84) as the ideal approach when an individual displays their NSSI, and training in this regard could be very beneficial for all secondary school staff.

There was unanimous agreement among participants that they did not use any specific protocol for managing NSSI in their schools, nor did they mention using any specific assessment instruments. Yet, international guidelines for managing NSSI in schools are readily available (Bubrick, Goodman, & Whitlock, 2010; Hamza & Heath, 2018; Hasking et al., 2016; Hasking et al., 2019; Shapiro, 2008), and the importance of using them emphasised across the literature (e.g., Kelada, Hasking, & Glenn, 2017; Whitlock et al., 2018). For example, Shapiro (2008) discusses a self-injury protocol for school nurses. This protocol includes direct referral to the school mental health professional(s) following disclosure of self-injury, determining the severity of harm (i.e., whether suicidality is present, or whether the self-injury is low lethality), and ideas for what to communicate to parents upon disclosure, such as explaining that self-injury is not usually about suicide. These are likely to be useful for staff training, to encourage consistency in responses to disclosure, and a means of sharing the workload of school counsellors.

Several limitations of the present research also require consideration. Many of the workshop attendees chose not to contribute as participants to the discussion, but rather only

listened to the conversation. This self-selection may be because several attendees were not working in secondary schools (e.g., their background was working in youth services) and they therefore may not have felt qualified to discuss the issue of responding to NSSI in schools. In addition, several of the counsellors knew each other well, and so may have felt more comfortable discussing the topic in front of their peers than those who were not as familiar with colleagues who were present. Alternatively, attendees may have chosen not to contribute for fear of being judged negatively, particularly if they worked at a school with a different process for responding to NSSI than that described by others present. This may have led to a more homogenous response than if all attendees had been willing to contribute their thoughts. However, every attempt was made to create a safe environment for contributions. The discussion was also time limited; more discussion may have elicited greater depth of conversation.

In conclusion, the secondary school guidance counsellors who participated in this research tended to take a holistic client-centred view of responding to NSSI. They prioritised their clients' safety and the therapeutic relationship, while acknowledging the limitations and potential pitfalls of working therapeutically within a school setting. Currently there is little, or no training offered to secondary school staff in Aotearoa New Zealand regarding NSSI, despite the high prevalence of this behaviour and its link to negative health outcomes. Further research is needed to illuminate which resources or training programmes might be introduced and prove effective in New Zealand schools.

We conclude this article by offering some reflective questions to stimulate discussion among school pastoral care staff on how to best manage NSSI within school environments:

> **1.** In responding to NSSI in your school, what do you think is done well, and where do you see room for improvement?
> **2.** Are there specific people within your school context who you enlist for support when responding to student NSSI? What support do they provide?
> **3.** Would an NSSI-specific management protocol be helpful in your school? Who would be the key people involved in responding to student NSSI, and what would their role(s) be? What are the barriers to implementing a protocol?
> **4.** How is NSSI perceived among staff at your school? Is this perception(s) helpful? What would it be like to have explicit conversations about these perceptions, and the consequences they may have (e.g., on student willingness to disclose; on readiness of staff to respond appropriately to student NSSI)?

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*(Note that references providing guidelines for responding to NSSI in school contexts are marked with **).*

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[i] Sixteen is the age at which a young person is legally able to consent (or refuse to consent) to health decisions, including who they involve in their care.

[ii] 'Chur' is slang commonly used by young New Zealanders, usually meaning "'thank you", "wow", or as an expression of the target being very cool. Here the speaker is using reported speech in order to convey the attitude of the student she's referring to, who was implying "look at me, I'm really cool".

[iii] The research team regularly leads professional development workshops for school staff about non-suicidal self-injury and adolescent wellbeing.