Identification and Management of Non Suicidal Self Injury in the School:

Workshop for the REACH team
Tuesday, Feb 5, 2013
1130-1pm

Mary K. Nixon MD FRCPC

Clinical Associate Professor, Dept of Psychiatry, UBC
Affiliate Associate Professor, Division of Medical Sciences, UVic

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For review and discussion:

- What we know about NSSI
- Best approaches in the school setting
- Roles of various personnel and professionals in the school setting
- School policy and protocol surrounding NSSI events in the school
- School based approaches to intervention with students with NSSI
- Some case examples

Defining Non-Suicidal Self Injury

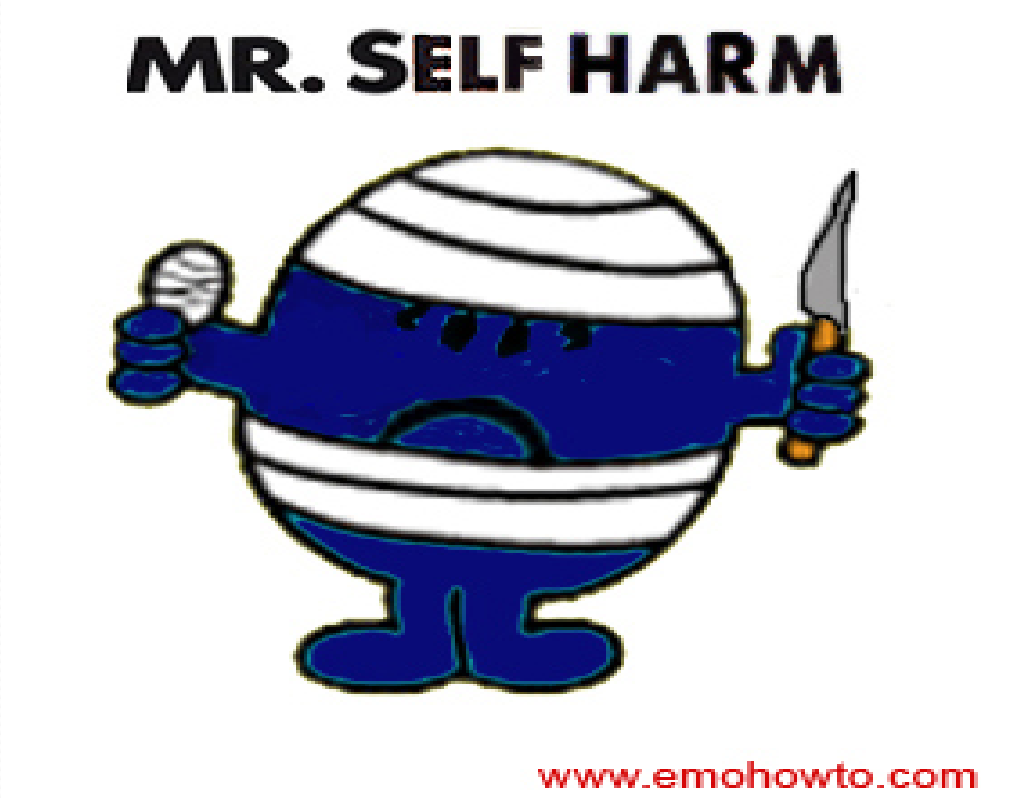
- Purposefully inflicting injury that results in immediate tissue damage
- Without suicidal intent
- Not socially sanctioned within one's culture
- Nor for display
- Occurs within the broader range of non-suicidal self harm behaviors such as minor overdosing, ingesting non ingestible objects etc.

From: Self –Injury In Youth: The Essential Guide to Assessment and Intervention, Nixon and Heath, 2009

Types of Self Injury/Age of Onset

- Scratching
- Cutting
- Burning
- Self hitting
  - In community samples, the majority self injure once or twice
  - Those who repeat often have multiple methods
- Arms, hands, wrists, thighs, stomach
- Mean age of onset: 12-15 years

Not just a girl thing



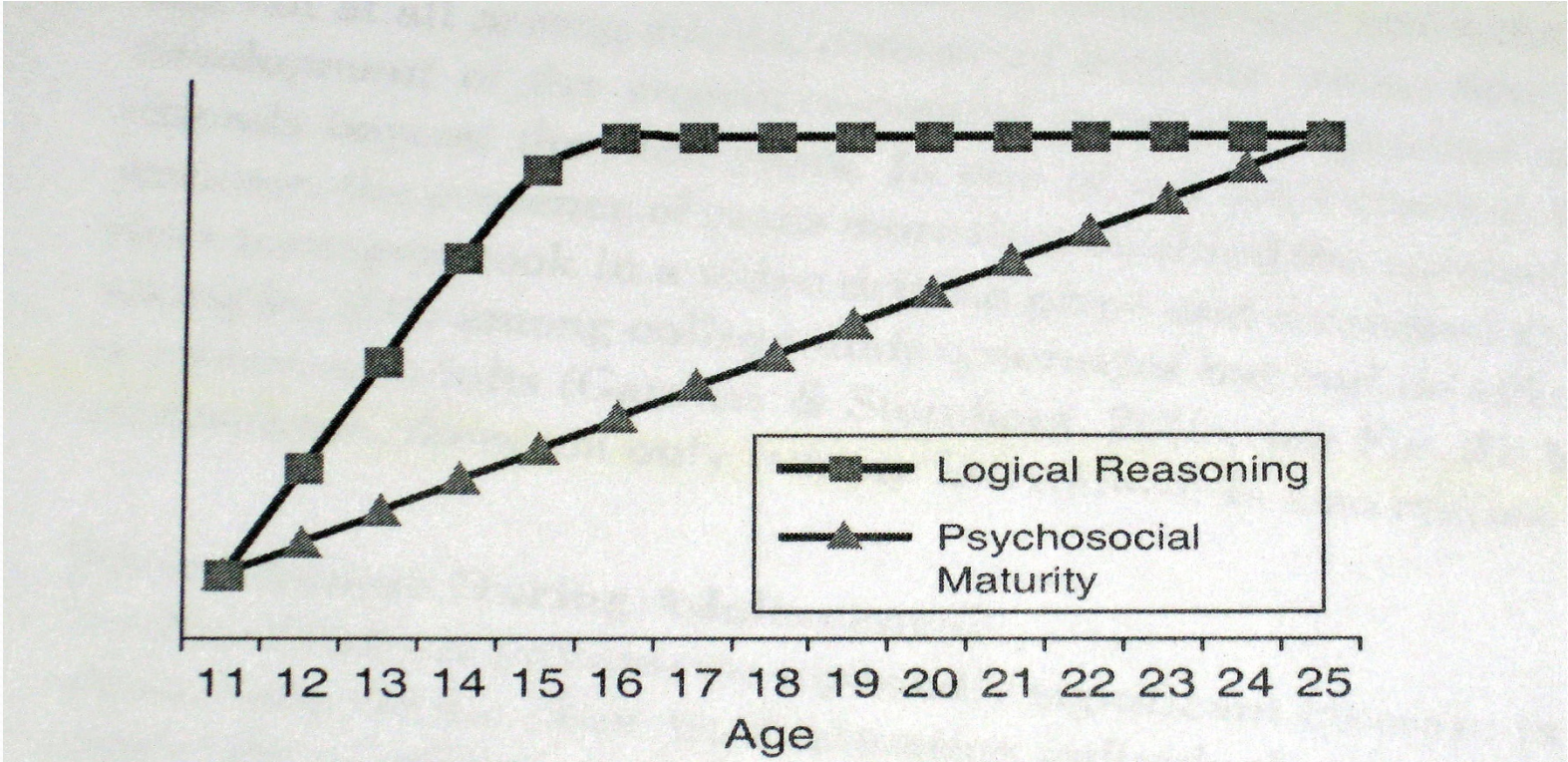


Fig. 1. Hypothetical graph of development of logical reasoning abilities versus psychosocial maturation. Although logical reasoning abilities reach adult levels by age 16, psychosocial capacities, such as impulse control, future orientation, or resistance to peer influence, continue to develop into young adulthood.

Steinberg, L. (2007).

Risk Taking

- Adolescents engage in more risky behaviour than adults
- Logical reasoning capacity is comparable between teens and adults
- But…
- Psychosocial capacities such as impulse control, resistance to peer influences etc lag behind logical reasoning capacity in terms of matching adult levels

Steinberg, L. (2007). Risk Taking in Adolescence: New Perspectives From Brain and Behavioural Science. *Current Direction in Psychological Science* Vol 16, Number 2, p. 55-58.

Adolescent NSSI and the Internet

- Adolescents group themselves by common interest and behaviour both on and off line
- Whitlock et al, 2006 (*Pediatrics*)
  - 400 self injury message boards, most used by females, 12 to 20 years old
  - Co-morbid issues such as depression, eating disorders and suicide often mentioned on message boards
- Lewis et al, 2011 (*Pediatrics*)
  - 50 character and 50 non-character You Tube sites on NSSI
  - Most highly rated by young females, graphic depictions present esp in non character, some education, none suggest stopping
- Easy access to an abundance of NSSI related content online may ultimately reinforce NSSI as an acceptable/normal behaviour and perpetuate its occurrence in schools and other community settings as a means of group identification

RESEARCH

Nonsuicidal self-harm in youth: a population-based survey

CMAJ 2008;178(3):306-12

Mary K. Nixon MD, Paula Cloutier MA, S. Mikael Jansson PhD

ABSTRACT

Background: Nonsuicidal self-harm includes cutting, scratching, burning and minor overdosing. There have been few studies that have examined the rate of self-harm and mental-health correlates among community-based youth. We performed a population-based study to determine the prevalence of nonsuicidal self-harm, its mental-health correlates and help-seeking behaviour.

Methods: We used data from the Victoria Healthy Youth Survey, a population-based longitudinal survey of youth aged 14–21 in Victoria, British Columbia. The survey included questions about the history, method, frequency, age of onset and

Nonsuicidal self-harm includes behaviours such as self-cutting, scratching and burning, done without the conscious intent to take one's life. Onset typically occurs between 14 and 24 years of age.[1,2] The most common reasons for this type of harm are regulation of affect (e.g., to reduce tension or relieve dysphoric feelings), but reasons may also include self-punishment, interpersonal reasons, sensation seeking and anti-dissociation mechanisms.[3] Factors associated with nonsuicidal self-harm include being female, awareness of self harm in peers, family members who self harm, drug misuse, depression, anxiety, impulsivity, disruptive disorders and low self-esteem.[4,5] Suicide ideation and attempts are more likely to be reported among those with repeated nonsuicidal self-harm.[6]

Method

- 664 randomly selected youth,
  - aged 12 to 18, participated in wave 1 in 2003
- 580 participated in a second wave in 2005
  - self-harm questions were asked

Survey Sample N=568		
sex	n	%
Male	258	45.5%
Female	310	54.6%

Results

Mean age of onset - 15.3, range 10-20

Mean duration – 1.78 yrs

58% stopped (N=50/93)

Have you ever harmed yourself in a way that was deliberate and not intended as a means to end your life? N=568		
	n	%
Yes	96	16.9%
No	472	83.1%

Number of males and females who have self-harmed N=95		
Sex	n	%
Male	23	24.3%
Female	72	75.8%

Which statements best describe the self harm behaviour? (Yes/No)

N=95		
Type	n (yes)	% (yes)
Self Injury as cutting, scratching, self-hitting, etc.	79	83.2%
Ingesting a substance in excess of the prescribed or generally recognized therapeutic dose	28	31.5%
Ingesting a recreational or illicit drug or alcohol as a means to harm yourself	15	16.9%
Ingesting a non-ingestible substance or object	0	0%
Other	8	9.4%

Frequency and Origin

- How frequently did (does) this self-harm behaviour occur?
  - One occasion only
    - 29%
  - One to three times
    - 33%
  - More than three times
    - 38%
- Where did you get the idea: n=95
  - It was my own idea: 72%
  - Heard about it from my friends: 17%
  - I saw it in a movie or television: 16%
  - I read about it: 12%
  - From family: less than 5%

Affect Regulation and Addictive Aspects of Repetitive Self-Injury in Hospitalized Adolescents

MARY K. NIXON, M.D., PAULA F. CLOUTIER, M.A., AND SANJAY AGGARWAL, M.D.

ABSTRACT

Objective: The incidence of self-injurious behavior (SIB) in adolescent psychiatric inpatients has been reported to be as high as 61%, yet few data exist on the characteristics and functional role of SIB in this population. Because of the repetitive nature of SIB and its potential to increase in severity, features of SIB and its specific reinforcing effects were examined. **Method:** Participants were 42 self-injuring adolescents admitted to a hospital over a 4 month period. Data sources consisted of self-report questionnaires and medical chart review. **Results:** Mean age was 15.7 ± 1.5 years. Reported urges to self-injure were almost daily in 78.6% of the adolescents ($n = 33$), with acts occurring more than once a week in 83.3% ($n = 35$). The two primary reasons endorsed for engaging in self-injury were "to cope with feelings of depression" (83.3%, $n = 35$) and "to release unbearable tension" (73.8%, $n = 31$). Of the sample, 97.6% ($n = 41$) endorsed three or more addictive symptoms. **Conclusions:** SIB in hospitalized adolescents serves primarily to regulate dysphoric affect and displays many addictive features. Those with clinically elevated levels of internalized anger appear at risk for more addictive features of this behavior. *J. Am. Acad. Child Adolesc. Psychiatry*, 2002, 41(11):1333–1341. **Key Words:** self-injury, addiction, affect regulation.

Various terms such as "delicate self-cutting," "self-wounding," "pathological self-mutilation," and "deliberate self-harm" have been used to describe a range of self-injurious behavmonly known as a symptom of borderline personality disorder (BPD) (American Psychiatric Association, 1994).

In a recent study, Briere and Gil (1998) reported adult

Why do you self-injure?
(mean number of reasons 8.2 ±3.8)

• Cope with depression ----------	83.3% (35)
• Release unbearable tension ----------	73.8% (31)
• Cope with nervousness/fear----------	71.4% (30)
• Express frustration ----------	71.4% (30)
• Express anger/revenge ----------	66.7% (28)
• Feel pain in one area, when the other pain I feel is unbearable ----------	61.9% (26)
• Distraction from unpleasant memories------	59.5% (25)
• Punish self for being bad / bad thoughts -----	50.0% (21)
• Stop suicidal ideation/attempt ----------	47.6% (20)
• Stop feeling alone/empty ----------	42.9% (18)

endorsed at least one affect regulation reason	97.6% (41)
endorsed all five affect regulation reasons	40.5% (17)

Co-Occurrence and NSSI in Youth

- Psychiatric diagnoses
  - Mood disorders eg depression, bipolar disorder
  - Anxiety
  - Eating Disorders
  - ADD/ADHD
  - Substance abuse
  - Borderline Personality Disorder

- Abuse
  - Only a modest association exists between childhood abuse and SI (Klonsky et al, 2007)
    - Examined 43 studies and concluded that child sexual abuse could be considered a "proxy risk factor" for NSSI
    - ie child abuse may play a role for some regarding SI but there are many who self injure who have not been abused and many who self injury who have not been abused

Psychological Characteristics and NSSI

(Klonsky and Muehlenkamp, 2007)

- Negative emotionality
  - More frequent and intense negative emotions
- Deficits in emotion skills
  - Difficulties with their experience, awareness and expression of emotions
- Self derogation
  - Self critical, self directed anger

Risk Factors for NSSI

- Axis I psychiatric disorders
  - Mood disorders
  - Anxiety disorders
  - Psychotic disorders
  - Eating Disorders, among others…
- Axis II disorders
  - Borderline PD
  - Developmental disability
- Adverse childhood experiences
  - Neglect/abuse
  - Loss
  - Attachment/parenting problems
  - bullying
- Self derogatory beliefs
- Emotional dysregulation
- Non-heterosexual orientation

Suicide Behaviour and NSSI in Youth

- 50% of a community based sample had a hx of a suicide attempt (Muehlenkamp and Gutierrez, 2007)
- 70% of inpatients (Nock et al., 2006)
- 73.8% of inpatients and partial hospitalized patients (Nixon et al., 2002) with repetitive SI, at least one SA in past 6 months
- Self injurers who are more likely to attempt:
  - More repulsed by life
  - Have greater amounts of apathy
  - Are more self critical
  - Fewer connections to family members
  - Less fear re suicide

  (Muehlenkamp and Gutierrez, 2004 and 2007)

Case Example

- M.J. is a 13 yo girl having difficulties in school
- Missing school periodically then would return to class
- Tried to keep up with her homework but was unable to manage her courseload
- Teacher noticed one day when reviewing her assignment that she had an extension on that she had fresh cuts on the inner aspect of her wrist
- M.J. looked away when it became apparent that the teacher had noticed and then excused herself from the meeting

What to do?

- Teacher asks themselves:
  - “What should I do with that information?”
  - “Did her parents know about the behaviour?”
  - “How long has this been going on for?” “If I did not bring this to someone's attention, would something more serious happen?”
  - “What are my responsibilities as a teacher?”

M.J. and her school counsellor

- The teacher decides to meet with the school counsellor to discuss his/her observations
- School counsellor offers a meeting with M.J. “to see how she is doing”
- Teacher continues to support academic difficulties and feed forward any pertinent information
- School counsellor meets with M.J. to explore how she is doing/feeling/psychosocial stressors/and any concerns she has to determine next steps, if M.J. is willing

Teacher training

- Schools are busy but….teachers may be the first to recognize a problem
- Teachers need basing information and a route for action, if necessary

Some basic approaches for school staff

- Be open to listening in a non-judgemental way
- Understand that NSSI may be a means to deal with difficult emotions and/or stress and/or communicate distress and also may be difficult to stop once started
- The teacher's role is to feed forward and/or assist the student in accessing a trusting person to talk with as a first step
- Teachers are a collaborative member of a team
  - They can provide important information regarding academic difficulties, issues with peers, changes in previous level of functioning
- Help dispell myths and misunderstandings re NSSI

An example of a School Response Protocol

- Response to NSSI
  - All staff should have training and information about NSSI and any protocols so that responses are consistent and appropriate
- Referral
  - School personnel who learn of NSSI in a youth should consult with a school based mental health professional regarding next steps
  - maintain a chain of supervision, as required
  - feed forward important information to the consultant

School Protocol (continued)

- Assessment and Engagement (a delicate balance)
  - School based or related professional does a risk assessment for both suicide and NSSI
    - Standard Suicide Risk Assessment
    - “How I Deal with Stress Questionaire” for NSSI
  - If there are concerns of a physical nature, eg deepness of cuts, a medical referral is necessary and issues regarding parental involvement will need to be discussed
  - Dependent on that other referrals will be made and parents may be contacted
    - Low risk suicidal and non-suicidal youth will be triaged differently than higher risk

Engagement

- Importance of the role of the “first responder”
  - Non-judgemental
  - Respectful curiosity regarding NSSI
  - Importance of open ended questions to start

School Counsellor: Some key areas to consider

- Psychosocial stressors
  - Peers
  - Family
- Basic mental health assessment
  - Depressive symptoms
  - Anxiety symptoms
  - Risk taking behaviours
- Risk Assessment
- Parental contact if deemed necessary

How I Deal with Stress (HIDS)

- Useful screening tool for assessing coping skills and exploring possibility of self injury without overtly suggesting it

Heath, N. and S. Ross. (2007). *How I deal with stress*. Unpublished measure.

HOW I DEAL WITH STRESS

Please begin by completing the following information:

Age: _____ **Sex:** ❑ Male ❑ Female

What **languages** do you speak at home? ❑ English ❑ French ❑ Other (please specify): _____

Country of **permanent residence** ❑ Canada ❑ USA ❑ Other (please specify): _____

Country of **birth** ❑ Canada ❑ USA ❑ Other (please specify): _____

Young adults have to deal with a lot of stress. In a recent survey, young adults said they used the following list of strategies to help them deal with problems. We are interested in knowing if you have also used any of these strategies to help you deal with stress.

Please read each item and indicate whether you:

never used this strategy (0)
used this strategy **only once** (1)
used this strategy a **few times** to cope with stress (2)
frequently used this strategy to cope with stress (3)

➢ Please note that some items are printed in **bold**. If you answer that you have used a bolded strategy (once, a couple of times, or frequently), please fill out the follow-up questions at the end of the survey.

1. Try not to think about it	0	1	2	3
2. Spend time alone	0	1	2	3
3. Go out	0	1	2	3
4. **Talk to someone**	0	1	2	3
5. Try to solve the problem	0	1	2	3
6. Do something to keep myself busy	0	1	2	3
7. Say to myself it doesn't matter	0	1	2	3
8. Listen to music	0	1	2	3
9. Exercise	0	1	2	3
10. Play sports	0	1	2	3
11. Read	0	1	2	3
12. Go shopping	0	1	2	3
13. Eat	0	1	2	3
14. Stop eating	0	1	2	3
15. Drink alcohol	0	1	2	3
16. Hit someone	0	1	2	3
17. Get into an argument with someone	0	1	2	3
18. Do drugs	0	1	2	3
19. Smoke	0	1	2	3
20. **Do risky things**	0	1	2	3
21. **Physically hurt myself on purpose**	0	1	2	3
22. Cry	0	1	2	3
23. Sleep	0	1	2	3
24. Pray or engage in other religious	0	1	2	3
25. Online gaming				
26. Other: _____	0	1	2	3

"Physically hurt myself on purpose"

Please fill out this questionnaire if you answered that you indicated that you have used this strategy.

Please circle any way that you have intentionally hurt yourself (*without suicidal intent*):

1. Cut your wrists, arms, or other areas of your body
2. Burned yourself
3. Scratched yourself, to the extent that scarring or bleeding occurred
4. Banged your head against something, to the extent that you caused a bruise to appear
5. Punched yourself, to the extent that you caused a bruise to appear

How old were you when you first hurt yourself on purpose? _____

When was the last time you hurt yourself on **purpose?**

_____

How many years have you been hurting yourself on purpose? (If you are no longer doing this, how many years did you do this before you stopped?) _____

Think of the longest period in which you engaged in self-injury (this could be in days, months, or years). How long was this period?

_____

Has this behaviour ever resulted in hospitalization or injury severe enough to require medical treatment?

_____

Have you ever hurt yourself with the intent to kill yourself? ❑ **Yes** ❑ **No**

How many times have you hurt yourself on purpose throughout your life? (circle one)

One time

2 to 4 times

5 to 10 times

11 to 50 times

51 to 100 times

More than 100 times

Another Case example

- Mary, 14 year old, grade 9 student
- Lives at home with her mother and younger sister
- Mary and her sister were physically, verbally and emotionally abused by their father
- One month ago, he uttered death threats to his 2 daughters, police were called and he was arrested and removed from the home; restraining order in place
- The school had been notified regarding the family and the recent very stressful events in order to support Mary and her siblings

- Mary had been doing well academically although lately her grades have slipped
- While meeting with her math teacher for extra help, her teacher noticed she had a bandage on her right wrist.

School Based Approach to NSSI

- School Assessment of NSSI
  - Teachers, librarians, team coaches, support staff may be the first to notice NSSI
  - Essential all staff be knowledgeable about and aware of NSSI
  - Studies have shown that teachers feel uncertain about how to react and manage NSSI (Best 2006, Heath, Toste, &Beettam 2006)

School Assessment of NSSI

- Teachers need to know how to react when they become aware that a student is self-injuring
- The relationship a teacher develops with a student may create the atmosphere such that the student first shares their NSSI behaviour with their teacher

What teachers need to know

- From Leiberman, Toste, and Heath, 2009
  - Know it is ok to talk about the behaviours
  - Listen in an open and nonjudgmental way
  - Know the risk factors and warning signs of NSSI and that they may or may not always be apparant
  - Upon observing concerns, discuss with a school professional and/or refer student
  - Know that they can't stop the behaviours – their role is to identify and refer

Mary

- Mary's teacher wasn't sure if she should say anything about the bandage, so she did not address this with her
- It wasn't until one of Mary's friends shared her concerns about Mary's NSSI with a teacher that Mary was referred to see the school counselor

Role of school based professionals

- Educate teachers about NSSI
  - High prevalence of the behaviour in youth(14– 20% in school aged youth in North American populations)
  - That it isn't necessarily a sign of psychopathology but rather an attempt to cope
  - Help teachers to feel more comfortable addressing NSSI, not dismissing it as trivial, manipulative or attention seeking
  - Help them to recognize the warning signs and how to identify a youth who is self-injuring – and what to do

Warning signs of NSSI in school

- Student who is self-injuring tells a friend who then tells an adult in the school
- Expressions of NSSI in creative work at school (writing, artwork)
- Observing cuts or scars on limbs
- Continually wearing long sleeves despite warm weather
- Possession of sharp objects (razor blades)

Mary

- School counselor met with Mary who was initially reluctant to talk about her NSSI
- Once Mary felt comfortable and not judged negatively by the counselor she opened up about her NSSI
- Mary reported she had been cutting for about 3 months

School Counselor Assessment

- Level 1 Assessment
  - Suicide Risk
  - Physical injury
  - Common co-morbid mental health issues and risk behaviours

Mary

- Mary admitted she may have started cutting because some of her friends that she hangs around with on weekends are also engaged in self injurious behaviours
- Mary said that cutting helped to “release feelings I keep inside”

Mary

- Mary tells the counselor that cutting is her way of coping with difficult feelings and she denies that she has any suicidal thoughts
- Mary feels comfortable enough to show her cuts to the counselor who deems them to be superficial and not in need of any immediate treatment
- The counselor feels that there is the beginning of a positive alliance and they agree to meet again in one week

Mary

- At the second visit with the school counselor, Mary is visibly upset
- Mary tells the counselor that her boyfriend broke up with her over the weekend and that she had been cutting more frequently and more deeply because she was very upset
- She felt hopeless and could see no point in living
- Mary related that she wanted to die and had a plan to overdose as she felt worthless and useless

Mary

- The school counselor concluded that Mary was at high risk so she contacted the school psychologist (or equivalent) for help
- The school psychologist followed the protocol established within their school board

Mary

- He contacted Mary's mother to tell her about Mary's suicidality and his plan to contact the local children's hospital for direction
- He contacted the Intake services of the local children's hospital to access their Urgent Care Clinic

Mary

- Following discussion with the Intake services, the psychologist was directed to have Mary brought to the hospital's Emergency Department for further assessment as it was deemed she could not wait for an outpatient appointment

School Board Protocols

- Creating formalized linkages between a School Board and Hospital-based mental health services
- Allows for the formation of a network of professionals who can assess the level of urgency, liaise with families and provide appropriate level of intervention

Triage Guidelines for Urgent Care

- Urgent Outpatient Appointment (within 7 days)
  - Suicidal ideation but not active plan or intent
  - Able to contract for safety
    - Willing to tell someone if feeling increasingly suicidal (formulating a plan for example)
    - Doesn't mean won't be suicidal

Triage Guidelines for Urgent Care

- Send to Emergency Department
  - Active suicidal planning with intent
    - Multiple psychosocial risk factors such as lack of adult support/supervision and acute and severe ongoing stressors
    - History of previous suicidal behaviour/attempts

Mary

- In the Emergency Department, Mary is assessed first by an Emergency Physician
  - who sutures her cuts
  - then refers her to the Crisis Intervention Worker for a full risk assessment and mental health brief assessment

Role of Emergency Physician

- Address medical concerns
  - Suturing, bandaging
  - Medically stabilizing (overdose, ingestion of objects etc)
- Referral to on site mental health depending on needs
  - Crisis Intervention Worker
  - Psychiatry on call
  - Social worker

Role of Crisis Intervention Worker

- Risk Assessment
  - Triggers and stressors precipitating suicidal behaviour
  - Review with patient degree of suicidal ideation, planning and intent
  - Assess degree of hopelessness
  - Ask about previous attempts, family history of suicide
  - Assess the degree of social support available

Role of the Crisis Intervention Worker

- Assessment of NSSI
  - Onset, frequency, triggers, most recent episode of NSSI
  - Role of NSSI for the patient
    - Release tension, distract from disturbing thoughts
    - To feel physical pain, to feel something
    - To express anger towards others

Mary

- Mary meets with the CIW who creates an atmosphere of acceptance and support
- Mary feels at ease with the CIW and talks freely about her feelings and her thoughts
- Through talking with the CIW, Mary felt relieved that she no longer has to cope with all her issues alone

Mary

- After spending time with Mary alone, the CIW spoke with Mary and her mother together
- She is surprised at how supportive and caring her mother is as she had feared her mother was too overwhelmed with her own issues to offer her support, so Mary had kept her struggles to herself

Mary

- Mary expresses relief that her mother now knows more about what is going on in her life including her NSSI
- Mary recognizes that she needs help to manage her emotions related to the major issues happening in her life and to develop better coping skills
- She is feeling more hopeful about things and agrees to a referral to see a psychiatrist in follow up next week

Mary

- The CIW speaks with the psychiatrist on call who agrees with the plan to discharge Mary home in the care of her mother and referral to the Crisis Intervention psychiatrist for follow up the following week as there are concerns regarding symptoms of depression that require further evaluation

Some points to consider

- Parental involvement or non involvement and issues of confidentiality
- Modified school program when necessary
- Communication and skill building
- Build on strengths, what is working
  - eg sports, peer contact, “favorite course”
- Behavioural Interventions
  - Breathing, meditation, exercise, resource room access
- Cognitive restructuring
  - Youth with NSSI have many negative automatic thoughts
- Lack of efficacy of no-harm contracts

Contagion in the school environment

- The social environment is a key aspect of adolescence
- Need for identification/acceptance as a part of human nature
- Effects of influence of peers during the adolescent period in those most vulnerable
- Hearing, talking or seeing NSSI can be a trigger to NSSI in some youth but mostly those who already self injure
- Multiple students who know or have found each other and NSSI can cluster in terms of "outbreaks"
- NSSI has powerful communication/reinforcement indirectly
  - *"My friend must really be upset to cut herself so many times…."*
  - *"Finally my parents/friends believe I'm in a lot of pain"*

Suggestions for Reducing Contagion in Schools

Leiberman et al. 2009

- Refrain from discussion in detail in school publications or other public school venues re NSSI
- Discourage revleation of scars by discussing with youth the risk associated with this re triggers and potential concern/distress in other students
- Discourage open sharing by the youth of an NSSI event with other peers in the school setting
- Target more individualized interventions for key youth with serious and repetitive NSSI to minimize contagion risk
- School based groups should focus on coping, skills, tension relief not NSSI specifically as group based inteventions for NSSI require significant training and expertise as well as clear rules re any discussion of NSSI

Summary

- Adolescents spend a large amount of time at school and in the school environment with peers, teachers and other school staff
- These professionals indicate that levels of knowledge and training on NSSI in youth vary markedly
  - ongoing education about risk factors and functions of NSSI can promote both increased awareness and improved understanding of what to do when such a student is identified

Summary

- Schools could benefit in having a protocol in place regarding the management and interventions for students with NSSI
- There are means to deal with “outbreaks” of clustered NSSI
- Linkages need to be built between school boards and local hospital psychiatry/mental health services to ensure those at risk are assessed promptly

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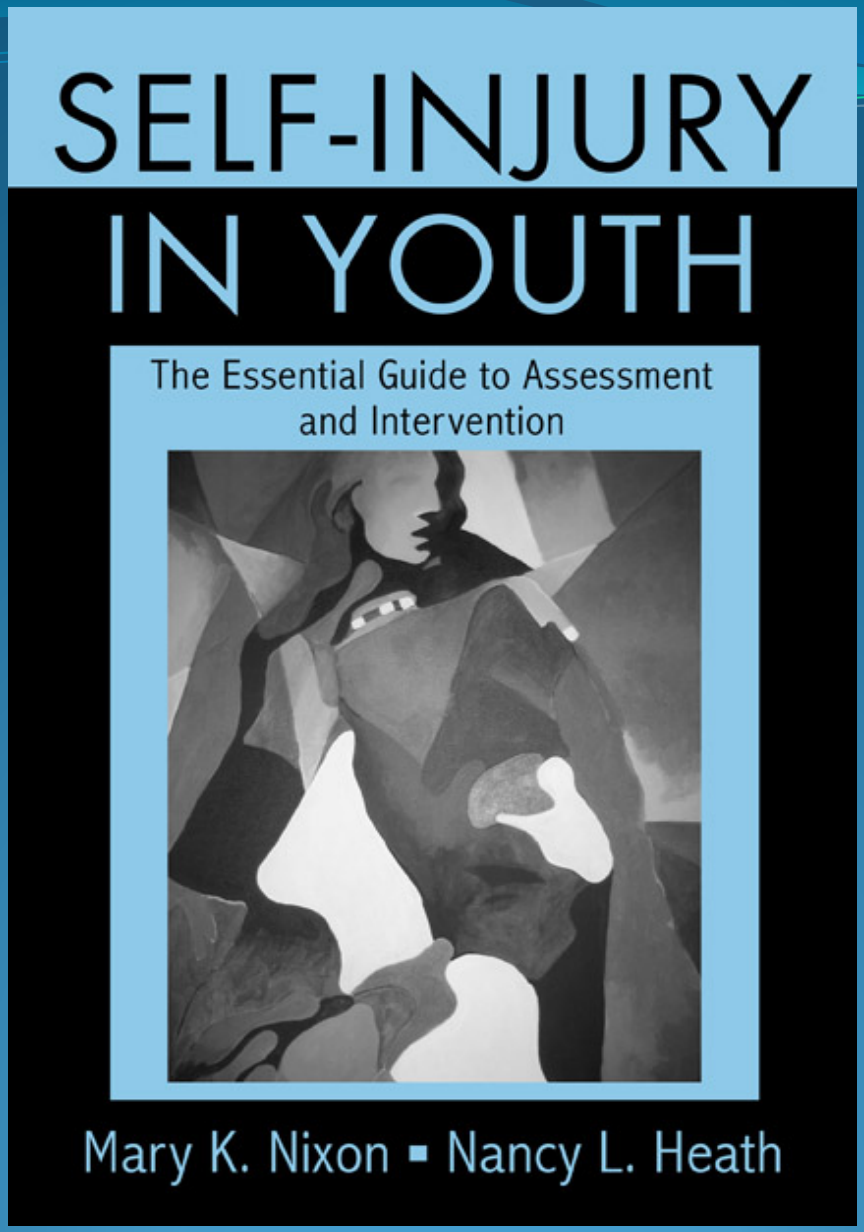
INSYNC website

www.insync-group.ca



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