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Helping schools support caregivers of youth who self-injure: Considerations and recommendations

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Short title: NSSI and supporting caregivers

Abbreviations used: NSSI (non-suicidal self-injury)

Abstract

Non-suicidal self-injury is a significant international mental health concern, with consequences for not only youth who self-injure, but for their entire family system. Helping caregivers respond productively to their child's self-injury is a vital part of effectively addressing NSSI. This paper will assist school-based mental health practitioners and other personnel support caregivers of youth who self-injure by reviewing current literature, highlighting common challenges faced by school-based professionals, and providing evidenced-informed recommendations for supporting caregivers of youth who self-injure. We posit that schools can best support caregivers by having clear and well-articulated self-injury protocols and by engaging caregivers early. Once engaged, helping caregivers to navigate first conversations, keep doors open, know what to expect, seek support for themselves and understand and address safety concerns will ultimately benefit youth who self-injure and the school systems that support them. We also review recommendations for working with youth whose caretakers are unwilling or unable to be engaged.

Keywords: school mental health; non-suicidal self-injury; family; caregivers; supporting caregivers

Introduction

Nonsuicidal self-injury (NSSI), the direct and intentional destruction or alteration of bodily tissue in the absence of lethal intent (American Psychiatric Association, 2013), is a common behavior among school-aged youth in all countries studied (Swannell, Martin, Page, Hasking, & St John, 2014). NSSI can include behaviors such as self-cutting, burning, and severe scratching (Heath, Toste, Nedecheva, & Charlebois, 2008), but does not include behaviors that are socially sanctioned (e.g., tattooing, piercings) or habitual behaviors that occur as a result of a developmental disability (American Psychiatric Association, 2013).

NSSI is a significant mental health concern, which negatively impacts both youth and the entire family system (Arbuthnott & Lewis, 2015; Baetens, Andrews, Claes & Martin (2015); Kelada, Whitlock, Hasking & Melvin, 2016; Whitlock, Lloyd-Richardson, Fisseha, & Bates, 2017). Once NSSI is discovered, it is common for families to experience acute stress and a sense of crisis. The cascade of negative feelings and self-appraisals, along with confusion about how to best respond, can lead to hypervigilance and increased caregiver control (Kelada, Whitlock, et al., 2016; McDonald, O'Brien, & Jackson, 2007) which may be perceived as intrusive by the youth, leading to worse family functioning and increased risk of NSSI (Baetens, Andrews, et al., 2015).

For schools and other youth-serving settings, helping caregivers respond to their youth's self-injury is a vital part of effectively addressing NSSI (Arbuthnott & Lewis, 2015). The purpose of this paper is to help school-based mental health practitioners (e.g., school psychologists, guidance counsellors, nurses, school social workers) support caregivers of youth who self-injure. We first provide an overview of current literature on the role of caregivers and family in the onset, maintenance, and recovery of NSSI, and on the impact of NSSI on caregivers and the larger family system. Next, we review common challenges faced by school-based professionals working with caregivers of youth who self-injure, such as knowing how and when to contact caregivers. Finally, we provide evidence-informed recommendations for supporting caregivers of youth who self-injure. Since school mental health teams, roles and structures vary across the world, we acknowledge that not all of what we recommend will be suitable for all environments. We urge readers to acquaint themselves with policies and laws that govern institutional responses to mental health challenges, such as NSSI, and to incorporate recommendations as they make sense in the readers contexts.

Overview of NSSI in adolescence

NSSI is a behavior which occurs internationally, with comparable rates of prevalence across North America (Muehlenkamp, Claes, Havertape & Plener, 2012), Europe (Plener, Libal, Keller, Fergert & Muehlenkamp, 2009), Asia (You, Deng, Lin, Leung, 2016), Australia (Andrews, Martin, Hasking & Page, 2014), and New Zealand (Garisch & Wilson, 2015). Estimates suggest that as many as 8-10% of elementary school students (Barrocas, Hankin, Young, & Abela, 2012; Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008) and from 12% - 25% of secondary school students have engaged in NSSI, with an international pooled prevalence rate of 17% (Muehlenkamp et al., 2012; Swannell et. al., 2014). Although the age of onset can vary considerably, the average age is often between 13-15 years of age (Heath et al., 2008; Gandhi et al., 2018), making school environments critical for addressing the behavior. NSSI is most often enacted by youth with cognitive, emotional, and self-efficacy related vulnerabilities to avoid or regulate unwanted emotions (see Hasking, Whitlock, Voon & Rose, 2016 for review). NSSI is also sometimes used to regulate stressful interpersonal situations and/or to elicit help from others (Klonsky & Glenn, 2009).

A number of individual and interpersonal factors heighten the risk of engaging in NSSI, including a number of emotional and cognitive factors (Hasking, Whitlock, et al., 2016), low self-esteem and low levels of peer support (Andrews, Martin, Hasking & Page, 2013; Andrews et al., 2014; Plener, Schumacher, Munz & Groschwitz, 2015; Tatnell, Hasking, Newman, Taffe & Martin, 2017). In contrast to students who do not engage in NSSI, those who do report lower perceived levels of caregiver relationship quality (Baetens, Andrews, et al., 2015), and higher caregiver criticism and psychological control (Baetens, Claes, Hasking, Smits, Grietens, Onghena, & Martin 2014; Yates, Tracy & Luthar, 2008), underscoring the importance of family factors.

In addition to the potential to cause severe or unintended bodily harm, NSSI may increase later risk for suicidal ideation (i.e., thoughts about ending one's own life), as well as risk for making a suicide attempt (Hamza, Stewart & Willoughby, 2012; Whitlock et al., 2013). As such, addressing NSSI should be a priority among school mental health practitioners. Effectively addressing NSSI in school settings requires collaborative and multi-pronged approaches that link school mental health teams, other members of the school community (e.g., teachers), and family and caregivers (Arbuthnott & Lewis, 2015; Hasking, Heath, et al., 2016). Clear protocols and procedures that guide response to NSSI in schools are imperative to an effective response (Berger, Hasking & Reupert, 2015; Bubrick, Goodman, & Whitlock, 2010; De Riggi, Moumne , Lewis& Heath, 2017; Hasking, Heath, et al., 2016; Walsh & Muehlenkamp, 2013). The majority of protocols that have been developed delineate the roles and responsibilities of all school staff, outline when a risk assessment is needed, emphasize the need for established referral networks, describe how to safely talk about NSSI, and explain the importance of communicating with caregivers and families (Hasking, Heath, et al., 2016). In an evaluation of such a protocol, Berger et al., (2013) noted particular concern among school staff about exactly when, and how, to involve caregivers in a discussion about their child's self-injury.

Families and non-suicidal self-injury

Research underscores the powerful connection between family relationships and NSSI onset, maintenance, and recovery. Young people who self-injure report poorer quality family relationships than do their non-injuring peers (Di Pierro, Sarno, Perego, Gallucci & Madeddu, 2012; Hilt et al., 2008) including experiencing greater caregiver criticism and control (Baetens, Claes, Martin, et al., 2014; Wedig & Nock, 2007), less support (Muehlenkamp, Brausch, Quigley, & Whitlock, 2013) and greater family-related loneliness (Giletta, Scholte, Engels, Ciairano, & Prinstein, 2012). In laboratory-based conflict discussions, caregivers of children who self-injure displayed greater negative affect, less positive affect, and less cohesiveness (Crowell, et al., 2008), as well as greater emotional reactivity (Crowell et al., 2017) than dyads with a youth who had not self-injured. Adolescents who had self-injured over the past year reported less support from family than did their peers who do not engage in NSSI (Hankin & Abela, 2011; Tatnell, Kelada, Hasking & Martin, 2014). Similarly, greater family invalidation predicts subsequent NSSI engagement (You & Leung, 2011).

Complex dynamics within the family can set the stage for many of the risk factors that lead to NSSI. For example, problems in family relations are related to greater emotion dysregulation which, in turn, is associated with an increase in NSSI (Adrian, Zeman, Erdley, Lisa & Sim, 2011). Similarly, perceived lack of caregiver emotional support is associated with depression (Baetens, Andrews, et al., 2015) Moreover, Tatnell and colleagues (2014) report that over the course of a year, caregiver attachment anxiety directly predicted poorer self-esteem, which was related to onset of NSSI**.** In short, family environments and caregiver-child relationships can have both direct and indirect effects on risk of NSSI, making interventions with caregivers and families a necessary component of effective NSSI intervention.

The role of caregivers in NSSI desistance and recovery

Research into the role of family in NSSI recovery and cessation is in its infancy. Compared to young people who have recently engaged in NSSI, those who no longer self-injure report greater family support (Kelada, Hasking & Melvin, 2017; Rotolone & Martin, 2012). However, an in-depth understanding of the way families thwart or facilitate recovery is nascent. Healthy family functioning is associated with greater likelihood of NSSI recovery, even for more vulnerable young people (Kelada et al., 2017). Furthermore, greater perceived family support predicts future NSSI cessation (Tatnell et al., 2014) and young people who no longer self-injure consistently indicate that changes in relationships with important others, such as caregivers, were key contributors to their discontinuing self-injury (Whitlock, Prussien & Pietrusza, 2015). This reinforces Berger, Hasking and Martin's (2013) finding that young people generally believe that strong family relationships protect against NSSI.

The effects of NSSI on caregivers

About a third of caregivers of children who self-injure are aware of their child's NSSI, and only about 50% of adolescents who self-injure disclose this behavior to others (Baetens, Claes, Willem, Muehlenkamp, & Bijttibier, 2011; Baetens, Claes, Onghena, et al., 2014; Kelada et al., 2017). Even in retrospective studies of youth aged 18-24 years, about a quarter say no one knew or knows about their self-injury and fewer than half report that their caregivers know and have discussed it (Pietrusza, Rothenberg, & Whitlock, 2011). This means that school mental health professionals may be alerting caregivers about their child's self-injury for the first time. Thus, sensitivity to caregiver discomfort and, possibly, shock, is paramount. Even for caregivers aware of their child's NSSI, repeated encounters with the behavior are disconcerting and can challenge a caregiver's sense of efficacy and direction.

Not surprisingly, studies of caregiver responses to children's disclosure of self-injury suggest they often feel guilt, shame, embarrassment, helplessness, and confusion (Kelada, Whitlock, et al., 2016; McDonald et al., 2007; Whitlock et. al., 2017). Physical symptoms such as insomnia, fatigue, loss of appetite, nausea and weight loss, and heart palpitations are common among caregivers (Kelada, Whitlock, et al., 2016). Caregivers are also likely to become hypervigilant regarding future episodes of NSSI because of the increased risk for potentially lethal suicidal attempts (McDonald et al., 2007). This can lead to "secondary stress" in which caregiver wellbeing is compromised, overwhelmed or underprepared to manage their child's needs (McDonald et al., 2007; Whitlock, et. al., 2017), feelings that may lead to empathy burnout, and a gradual diminishment of compassion over time (Thomas, 2013). Such shifts in caregiver approaches may be more than temporal and may inadvertently exacerbate or lengthen the duration of self-injury, which can, in turn, reinforce an unhelpful caregiving style. This circle of influence can be positive, when caregivers become more supportive in the wake of finding out about self-injury, or it can be negative, when caregivers become more controlling upon NSSI discovery (Baetens, Claes, Onghena, et al., 2015).

In addition to emotional strain, caregivers often report social isolation, perhaps because perceived stigma reduces likelihood of reaching out for support (Ferrey et al., 2016; Whitlock et al., 2017). Chronic emotional and social strain may, in turn, interfere with caregiver ability to meet core life responsibilities related to work, family care, or civic engagement (McDonald et al., 2007). Moreover, responsibilities of managing care for children who self-injure can be financially costly (Ferry et al., 2016).

Working with caregivers

Since family support is a significant predictor of whether a young person ceases self-injury, efforts to actively involve families are likely to increase positive student outcomes (Tatnell et al., 2014; Whitlock et al., 2015). Assisting caregivers may feel burdensome for school personnel, particularly in settings where it is not normative for school mental health professionals to view communicating with caregivers in circumstances like this as part of their position. Nevertheless, helping caregivers respond productively can increase student competence and decrease student need for intensive school support. Moreover, caregivers of youth who engage in NSSI often express a desire for resources and support (Byrne et al., 2008; Kelada, Whitlock, et. al., 2016; Whitlock et. al., 2017), needs that school professionals can provide.

The first step in meeting caregivers' needs is to be sure that the school has clear and well-articulated self-injury protocols that stipulate when, and how, to involve caregivers in the care of students who self-injure (for guidance in developing a school-based self-injury protocol, see (Berger, Hasking & Reupert, 2015; Bubrick et al., 2010; De Riggi et al., 2017; Hasking, Heath, et al., 2016; Walsh & Muehlenkamp, 2013). It is also helpful to know about the student and their home environment. Alerting a caregiver to a child's self-injury, however, is often only the beginning. Caregivers are likely to feel overwhelmed at first (McDonald et al., 2007) and need support in responding effectively over time. Self-injury is often intertwined with both natural developmental processes (e.g., developing autonomy) and, in some cases, other comorbid conditions (such as disordered eating, anxiety, or depression) that can complicate the recovery process (Whitlock, Prussien & Pietrusza, 2015). Beyond this, schools can help caregivers understand what NSSI is and direct them to additional resources, by helping them understand what to expect and productively communicate with their child, encouraging them to use their support systems, and maintaining some level of connection for the family as a whole (Whitlock & Lloyd-Richardson, in press). If the school mental health team has concerns about risk of imminent suicidal behavior, psychosis, physical, emotional or sexual abuse, or risk to another person, they have a duty to break confidentiality and seek support for the student and any others involved (Lloyd-Richardson, Lewis, Whitlock, Rodham, & Schatten, (2015).

When and how to reach out to caregivers

Decisions about when and how to reach out to caregivers should take into account what is known about the student, the family, and how they are likely to react to self-injury disclosures (Hasking, Heath, et al., 2016). When caregivers are contacted, school psychologists should be mindful that first finding out could provoke a range of caregiver reactions (e.g., shock, fear, guilt) (McDonald et al., 2007; Byrne, et al, 2008). Because of this, it is important to provide accurate information about NSSI, to clearly explain the limits of confidentiality to the student and their caregivers, and to offer referrals as needed. We strongly recommend that the student is actively involved in decision-making. When viable, we recommend obtaining verbal or even written consent from the student to contact caregivers, allowing the student to be present when caregivers are informed of the NSSI, and being an active agent in decisions regarding treatment (Hasking, Heath, et al., 2016). We recognize of course that different situations may warrant different approaches; those stated above based on the cited literature as well as our collective experience working with students who self-injure in school contexts.

Helping caregivers navigate first conversations (the "acute" phase)

Figuring out how to have conversations about self-injury, especially how to keep them going, is a primary challenge for caregivers (Raphael, Clarke & Kumar, 2006; Walsh, 2012; Whitlock & Lloyd-Richardson, in press). School professionals can help by offering caregivers strategies to navigate these tricky conversations. Acknowledging the inherent challenges, providing written or web-based resources, and answering whatever questions they might have can be invaluable, since many caregivers are uncertain of the most appropriate caregiver response.

Not surprisingly, first conversations can go many ways. Advising caregivers to seek private and calm environments for hard conversations with their child is a first simple step. When initiating dialogue about NSSI, school professionals can suggest that caregivers start by expressing their concern (e.g., worry for their child's wellbeing), their love, and their commitment to staying present with their child for the whole process. Youth who self-injure often feel at high risk of being abandoned or unloved because of their behavior, so caregiver reassurance of love and support can make an enormous difference (Kaleda, Hasking, Melvin, Whitlock, & Baetens, 2016). However, it is equally important that caregivers understand the value of asking respectful questions that invite their child to share whatever they are comfortable sharing about *why* they self-injure; young people often want to share this information with a caregiver but may need time to feel safe enough to be honest (Walsh, 2012). Caregivers who focus only on the effects NSSI has on their lives risk closing important doors to conversation; the child may feel responsible for their caregiver's suffering and, in turn, retreat (Kaleda, Whitlock, Hasking, & Melvin, 2016). That said, caregivers sharing authentic feelings, (e.g. "*you self-injuring makes me feel afraid that I'm going to lose you. That can cause me to feel really scared, and sometimes angry, because I feel so powerless*"), can be very powerful and can model how to share difficult feelings (Whitlock & Lloyd-Richardson, in press).

Similarly, if caregivers try to "jump in and fix" the problem, youth may feel unheard. To facilitate dialogue, adults should use a calm, and validating tone by first acknowledging the concerns and challenges for the youth, and using open-ended questions to understand NSSI from their child's vantage point. They can be guided to adopt a stance referred to as "respectful curiosity" – asking questions in a way that conveys genuine interest and openness (Lewis & Heath, 2015; Walsh, 2012). It also helps to ask questions that a youth is likely to be able to answer (e.g., how it helps them feel better, what they recognize are their triggers) and to avoid potentially invasive questions or ones they are unlikely to know (e.g. what happened that "made them do this" or which of their friends they picked this up from). It can be exceptionally helpful for caregivers to start a sentence "*Can you help me understand*…." Addressing the youth in this way can help lower emotional intensity and create a platform for effective communication (Rathus & Miller, 2014). Here is an example of wording for caregivers:

> *"I can imagine that it is difficult for you to talk about this with me. I want you to know that I care about you and really want to understand what is happening for you. I'm here to support you and listen to you. From what I've learned, teens have a number of reasons for self-injury. I'm wondering if you can help me understand what it means for you and why you do it?"*

School professionals can also help caregivers understand that approaches that involve lecturing, ultimatums, punishment, or accusations are typically not very helpful (Hasking, Heath, et al., 2016). Because some youth may not be ready to stop NSSI, they may resist talking about its meaning and why they do it. If this occurs, caregivers can work on communicating both acceptance of their child as well as a need to continue the conversation later (Whitlock & Lloyd-Richardson, in press).

One of the most important things caregivers can do is to keep the door open for future conversation and connection. School professionals can assist by encouraging caregivers:

- To not press a child too hard, especially in early conversations;
- To avoid the impulse to try to fix everything all at once; and
- To be aware of the understandable tendency to control and manage; communicating care and connection is more important than getting their way.

Most caregivers report not knowing where to turn for information, or where to seek support for themselves (Byrne et al., 2008; Oldershaw, Richards, Simic, & Schmidt, 2008; Raphael et al., 2006). Many websites are available that contain multiple resources for caregivers (See Appendix, Online Supplemental Materials))

Working with difficult family situations

Although involving caregivers is often instrumental in the recovery process, the fact that families can contribute to NSSI can complicate the school's mission to provide support. Poor family functioning, a history of abuse, and a lack of family connectedness are associated with NSSI (Baetens, Andrews, et al., 2015; Baetens, Claes, Martin, et al., 2014) so interacting with less than functional family systems is a common NSSI-related challenge for schools. Indeed, some families may be resistant to efforts to support their child because of reduced caregiver capacity (e.g., competing demands on caregiver time such as family conflict, caregiver mental health issues) (Whitlock et al., 2017). In some cases, family-related risk or resistance may be mitigated by concurrent family systems therapy (although in these cases the family must be functional enough to see value in family therapy). It can be helpful to reach beyond the immediate family to engage others (e.g., grandparents, relatives, parents of friends; Selekman, 2006), although caregiver and student consent will be needed.

In cases in which it is clear that the family poses a clear danger to the child, local child protective service providers may need to be consulted. Since breaking confidentiality risks damaging trust established with the student, and might signal that the student's needs are not being heard or met, conditions for breaching confidentiality should be clearly articulated to the student in advance. Ideally, such cases will be considered by multiple members of the school mental health team and administration, according to the agreed upon protocol but this may not be possible in all cases. When a breach is warranted, the student has the right to understand why and what s/he can expect to happen next. This is particularly important for adolescents who may already be struggling with a sense of low autonomy and power. If involving caregivers is contraindicated because of concern for the child (or caregiver's) wellbeing (e.g., when disclosing to a caregiver may increase risk of suicide), then direct contact with the child's therapist, general practitioner, or other local clinic or clinical support may be warranted (see Hasking, Heath, et. al, 2016 for a review of managing NSSI in schools).

Helping caregivers to anticipate and manage safety concerns

Caregivers are often instinctually driven to do whatever they can to protect their child from harm. This can involve jumping to extremes, such as taking doors off hinges to reduce privacy, removing all knives, scissors, and razor blades from the house, or never leaving their child alone (Whitlock et al., 2017). Although understandable, school personnel should encourage a thoughtful approach that considers whether these reactive steps are helpful for the child. School staff can be encouraged to educate caregivers on the common reasons youth self-injure. Language such as the following may be useful:

> *"For many, self-injury is about control. It is a way of regaining a sense of emotional control and of bringing a sense of normalcy to moments that may otherwise feel*

completely out of control. People who self-injure tend to turn to it as a way of regaining control of their emotions or other events around them. They often see it as the quickest and easiest route to self-soothing in moments of emotional distress or turmoil. Taking away all privacy or access to normal household items may actually increase this out-of-control feeling rather than make it better.

Further, a major part of recovering from self-injury is being able to live and function in normal environments. Most normal household environments include scissors, knives, etc. Even if you are able to temporarily remove all potential threats, your child will eventually need to learn to be and live in environments that include these things. People desperate to self-injure do not need specific tools or places to engage in the behavior – a variety of things you would not think to remove (e.g. staples from magazines) and things you cannot remove (e.g., fingernails) can be used to self-injure."

Caregivers can use their desire to limit their child's access to tools or places to self-injure as the starting point for conversation. Caregivers can be encouraged to honestly share their feelings (e.g., fear, sadness, frustration) and youth can be encouraged to share their perceptions on safety. Some youth on the road to recovery find that some limitations are useful For instance, some may appreciate having a go-to person to whom they will reach out when having an urge to self-injure; or like not having access to self-injuring implements. Others may balk at the idea of major restrictions, like having all knives removed from the kitchen, because it limits autonomy and reduces their sense of control and self-efficacy. Caregivers can use this topic as a means of negotiating mutual agreements, giving everyone an opportunity to have their voice heard and reflected. Building collaboration instead of coercion is a powerful route to reconnection (Selekman, 2006; Whitlock & Lloyd-Richardson, in press). Helping caregivers understand this may assist in the recovery process. Caregivers may find it useful to discuss this with their child's therapist or their own.

Helping caregivers understand what to expect

Caregivers are likely to have an array of concerns (e.g., about safety, how to talk about NSSI) and expectations about their youth's recovery trajectory (e.g., believing recovery is linear) (Whitlock et al., 2017). School personnel can help caregivers understand the recovery process. For many youth, NSSI is a behavior that is not easy to stop (Kelada, Hasking, Melvin, Whitlock & Baetens, 2016; Whitlock et al., 2015) and is often non-linear, so setbacks are common and caregivers need to know that recovery may take some time. School personnel can say something like:

> *"It may be helpful for you to know that, because self-injury can work so well for some people, it can take time and practice to stop. If it's your child's primary way of managing difficult emotion, then they are going to have to learn new skills. They are also going to have to learn how to be more comfortable with uncomfortable emotions. Even once they have really started to work on this, it is likely that they will have some setbacks along the way. I am hoping that understanding this will help you be patient with the process."*

It can also be helpful for caregivers to understand that learning to live without using self-injury takes more than just learning new behavioral habits and coping mechanisms. Because the origins of self-injury are often deeply buried, it can be difficult to find other ways to cope and to articulate why it initially started. Learning how not to self-injure is dependent on learning how to deal with strong, unwanted feelings and thoughts in other ways. Because subtle signs of recovery often occur before bigger shifts in behavior, it may help caregivers to understand that:

- Changes in capacity to cope, cognitive style (less negativity and more positivity), healthy sociability, and self-care may occur before any changes in self-injury; behavior and that these are important signs of progress;
- Finding support for themselves is a core part of supporting their child;
- Clear expectations are helpful for everyone; and
- Using healthy, effective communication will assist in challenging conversations.

In addition to caregiver support, a strong relationship with a therapist may be instrumental in successful treatment (Selekman, 2006; Walsh, 2012). Caregivers are often anxious and stressed about the prospect of their child attending therapy. Before broaching therapy with a child, it can be helpful to encourage caregivers to think about expectations and comfort with being involved in therapy (Sweet & Whitlock, 2010).

Encouraging caregivers to practice self-care

While the primary concern for school staff will be the welfare of the student who is self-injuring, caregivers may also need support or encouragement to seek outside services for their wellbeing. Despite the overwhelming nature of the experience for many caregivers, most urgently want to address their child's concern and often devote considerable time, energy, and money to connect their child with needed resources. Consequently, caregivers commonly overlook their own needs (Oldershaw et al., 2008; Whitlock, et al., 2017). It is absolutely vital that caregivers understand that they will be best positioned to assist their child when they themselves are well cared for and tended to. Encouraging families to engage in family therapy, or approaches that actively involve caregivers in treatment, may benefit everyone (Arbuthnott & Lewis, 2015). Caregivers will benefit immensely from supports that allow them to share feelings and worries that may not be appropriate to share with the child or at home.

Summary

Family support is a powerful predictor of whether a young person ceases self-injury, so actively involving families in supporting students who self-injure is critical to the recovery process. Schools can best support caregivers by a) having a clear and well-articulated self-injury protocol; b) engaging caregivers early; and c) helping caregivers navigate first conversations by keeping doors open, knowing what to expect, and understanding and addressing safety concerns. It is very common for caregivers to focus on securing support for their child but not for themselves. Encouraging caregivers to seek informal or formal support for themselves is important. In all cases, school staff must work within the legislative requirements of their own setting, particularly in deciding when to disclose NSSI to caregivers. Yet, having a clear plan for how to involve caregivers, and some concrete strategies for how to help caregivers address their child's NSSI, will benefit all involved.

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