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# School-Based Recommendations for Addressing Nonsuicidal Self-Injury: Application to Rural Settings

Nonsuicidal self-injury (NSSI) has emerged as a common and serious concern in school settings. Up to one in five students report having self-injured and continued NSSI engagement is associated with a multitude of mental health difficulties. Moreover, NSSI uniquely and significantly exacerbates the risk of death by suicide. Despite this, many schools report having limited resources to address NSSI among students, with staff often feeling underequipped when working with students who self-injure. Unfortunately, this may be particularly true for schools in rural regions, which often face other unique challenges (e.g., increased stigma in these communities around the acceptability of help-seeking). This article presents a brief overview of current NSSI knowledge and offers practical recommendations for schools in rural areas to effectively respond to students who self-injure. We hope that by using these guidelines, schools in rural areas will be better positioned to address the needs of students who self-injure, reduce the burden on school staff, and foster greater student well-being.

*Keywords:* nonsuicidal self-injury, self-harm, school, rural

## Public Health Significance Statement

Intended for rural school professionals, the current article offers a brief overview of the current literature regarding self-injury among students. Next, practical guidance is offered about how to effectively respond to students who engage in self-injury. By drawing on the information presented in this article, rural schools should be better positioned to respond to and support students who engage in self-injury.

Nonsuicidal self-injury (NSSI), the deliberate damage (e.g., cutting) of one's body tissue without suicidal intent (International Society for the Study of Self-Injury [ISSS], 2018), is a prevalent behavior among school-aged youth. Although there are numerous reports that school personnel and school mental health professionals frequently encounter youth who engage in NSSI (Berger et al., 2014), many schools report feeling ill-equipped to effectively respond to students who self-injure (Heath et al., 2011). To this end, numerous efforts have been spearheaded to assist schools when working with and supporting students who self-injure (e.g., Hasking et al., 2016). Nevertheless, schools remain limited in the resources that can be offered to support students who self-injure (Berger et al., 2014; Glennon et al., 2020). Ostensibly, this is especially the case for rural schools, which because of geographic location, may have fewer resources available.

The existing literature on NSSI in rural settings is limited to a few studies investigating the prevalence of NSSI in such settings (reviewed below), and the provision of services to students who self-injure in the rural context is virtually unexplored. Rural areas may have unique strengths, such as a strong sense of community (e.g., Hornberger & Cobb, 1998). At the same time, they are often disproportionately affected by resource barriers (e.g., mental health provider shortages; Brown et al., 2018; Hastings & Cohn, 2013). Beyond barriers to services, there are several reports of increased stigma related to mental health difficulties and associated helpseeking in rural contexts (Crumb et al., 2019; Stewart et al., 2015). Considering the unique and significant stigma associated with NSSI (e.g., Staniland et al., 2021), as well as the risks with which NSSI is associated, an effective response to NSSI in rural contexts is critical.

Mental health professionals working in rural settings often report few well-developed policies and protocols, particularly for supporting highrisk students (Brown et al., 2018). This is especially concerning given emerging evidence indicating that rural populations have comparable prevalence rates of psychological disorders for youth compared to urban peers (Siceloff et al., 2017) and potentially higher rates of suicide and substance use (Fontanella et al., 2015; Hirsch & Cukrowicz, 2014). As NSSI often co-occurs with mental health disorders and can heighten the risk for suicidal behavior (Kiekens et al., 2018), school professionals in rural settings need to be equipped with relevant NSSI knowledge and resources.

Hence, in this article, we, members of the International Consortium on Self-injury in Educational Settings (ICSES), draw upon the extant literature, our research and clinical expertise as international leaders in the field of NSSI, and our collective expertise and experience working with schools to provide guidelines for rural (or otherwise resource-limited) schools. First, we provide a brief overview of the existing literature regarding NSSI in schools (Part I). Second, we offer recommendations for staff working in rural-based settings about to effectively support students, considering both the unique needs and strengths of schools in rural settings (Part II).

## Part I: Understanding NSSI

### Rates, Method, and Demographics

NSSI is a significant concern among youth, with about 17% of young people reporting a lifetime history of NSSI (Swannell et al., 2014). Due to a lack of research focused on NSSI in rural settings, it is somewhat difficult to determine if NSSI prevalence rates differ for rural versus urban youth. However, a review of existing studies suggests that rates of NSSI may be higher among rural youth (Brausch & Woods, 2019; Liang et al., 2014). NSSI engagement is highly variable, with most youth reporting infrequent NSSI, whereas others reported more chronic NSSI (Whitlock et al., 2011). There is often a mistaken belief that self-injury is largely
or exclusively limited to self-cutting; however, NSSI also includes self-hitting, burning, and
common methods such as inserting sharp objects into the skin (Garisch & Wilson, 2015; Whitlock et al., 2011). Youth often report using more than one method of NSSI, and methods can change over time (Baetens et al., 2012). Thus, it should never be assumed that a young person “is a cutter” as NSSI method may vary, and such labels are stigmatizing (Lewis, 2017).

Although NSSI often has its onset in middle school (ages 12–14) and high school (ages 14–18) and peaks around 15–16 years of age, emerging research also suggests that NSSI occurs among elementary school students (under 12 years; e.g., Borschmann et al., 2020; DeVille et al.,
2020). Across international studies, females are slightly more likely to report a history of NSSI than young males, although this difference is small (Bresin & Schoenleber, 2015; Steinhoff et al., 2021). However,

males are less likely than females to use methods more often associated with NSSI (e.g., cutting, scratching) and instead are more likely to use burning and hitting (Bresin & Schoenleber, 2015; Sornberger et al., 2012).

Emerging evidence suggests that NSSI rates may be higher among transgender youth, particularly from rural contexts (Leon et al., 2021). Other marginalized youth, including lesbian, gay, bisexual, or queer youth or ethnic minorities, may also engage in higher rates of NSSI than cisgendered heterosexual youth (Fraser et al., 2018; Rojas-Velasquez et al., 2021), which may stem from a lack of community support and distress. Notably, greater levels of school and family belonging are associated with lower levels of distress among minority adolescents (Cohn & Leake, 2012; RojasVelasquez et al., 2021), emphasizing the importance of the role of schools for social connection in rural settings. Although studies investigating the link between socioeconomic status and NSSI are limited, greater distress stemming among low income may elevate NSSI risk (Robinson et al., 2017). To ensure greater equity, diversity, and inclusion in NSSI research, efforts to better understand the unique and intersecting factors (e.g., systemic racism, socioeconomic inequities) involved in NSSI among marginalized populations are needed.

**NSSI Recovery**

Evidence suggests that not all individuals who first engage in NSSI continue to do so (e.g., Klonsky & Olino, 2008). However, when NSSI is repeated and becomes more clinically germane, it is essential to recognize that NSSI and NSSI recovery do not follow predictable or linear paths (e.g., Lewis & Hasking, 2021). Research indicates that NSSI recovery is a process that varies across individuals and that this process may involve recurrences of NSSI (Kelada et al., 2018). In line with this, people with lived experience of NSSI report that recovery involves an array of factors (e.g., scarring, learning new coping methods, self-acceptance) that go beyond cessation of NSSI; further, they often report that NSSI thoughts never fully disappear (Lewis et al., 2019). When working with youth who self-injure, awareness of the complex nature of NSSI recovery is critical for two reasons. First, it allows for a realistic set of expectations for school professional(s) working with

the youth. For example, it is important to recognize that recurrences of NSSI are a normal part of recovery. Second, understanding the complexity of recovery helps ensure realistic expectations for youth. Many youth believe NSSI recovery occurs when the behavior is no longer enacted and when NSSI-related thoughts and urges are absent (e.g., Kelada et al., 2018; Lewis et al., 2019). Yet, these views may set them up for disappointment, as they do not reflect the actual set of experiences many people may have (e.g., Lewis & Hasking, 2021).

**Why Do Youth Self-Injure**

It is likely that a significant contributor to NSSI stigma stems from misconceptions around the underlying reason(s) for the self-injury. Although often perceived as attention-seeking and manipulative (Heath et al., 2011), NSSI is seldom used to elicit attention or to manipulate others (Taylor et al., 2018). Instead, NSSI is most often used to regulate internal distress, which may include the need to manage overwhelming emotions, express anger toward oneself, and reduce feelings of dissociation or numbness. Less commonly, NSSI may also be used to mitigate interpersonal distress by communicating pain or a need for help or creating boundaries between the self and others (Klonsky, 2007). Although it is helpful to acknowledge that NSSI is an attempt to cope with negative and unwanted emotions (Taylor et al., 2018), a central goal for practitioners is to help youth learn alternative coping strategies.

**Iatrogenic Effects**

Although school personnel may fear that talking about NSSI with students in schools or in school-based research may provoke the onset of NSSI, research has shown that talking about NSSI in schools (e.g., via psychoeducation on how to respond to friends who self-injure) or asking youth whether they self-injure in research contexts does not evoke new instances of NSSI (Baetens et al., 2020; Muehlenkamp et al., 2015). Moreover, when NSSI discussions are silenced, stigmatization is likely to increase. At the same time, when discussing NSSI in schools, it is critical to avoid detailed conversations about NSSI (e.g., methods, descriptions of specific NSSI episodes), and the use of NSSI imagery should be avoided (Hasking et al., 2016). Doing so can mitigate concerns about triggering students who already self-injure (e.g., provoking distress or NSSI urges). We advise that NSSI be situated within the broader context of

coping and well-being. When schools provide this kind of psychoeducation about NSSI (e.g., where to seek support, how to support a friend who is self-injuring), a supportive climate where NSSI is not stigmatized can be developed (see Table 1 and Figure 1).

## NSSI and Online Communication

Given the pervasiveness and relevance of the internet and social media for today's youth, coupled with the stigma associated with NSSI, it is of little surprise that many young people go online to obtain resources about NSSI and to connect with other youth who also self-injure (see Lewis et al., 2019, for review). Researchers have found that the internet offers youth a means to obtain the social support they need, provide support to other youth who also self-injure, and obtain coping and recovery-focused resources (e.g., Lewis & Seko, 2016; Rodham et al., 2013).

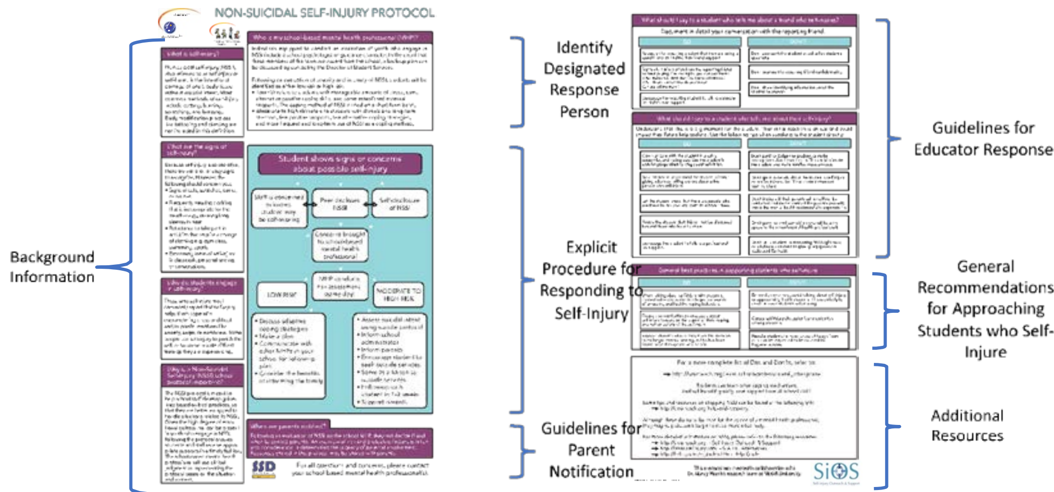
**Table 1**

*Key Elements in School Protocol*

| Elements and related steps for a self-injury protocol |
| --- |
| 1. Roles and responsibilities |
| • Outline roles/responsibilities of school staff for identifying/responding to nonsuicidal self-injury (NSSI). |
| • Establish a point person and/or team self-injury team with NSSI training to coordinate all aspects of the case management for students who disclose NSSI, including schoolwide staff education about NSSI. |
| • The self-injury team communicates to all staff the need to refer to them when a staff member has reason to believe a student is engaging in NSSI. The importance of referring directly to the team and maintaining confidentiality is emphasized. |
| • The self-injury team is responsible for providing follow-up, within the constraints of confidentiality, to the first responder staff member following a referral to the self-injury team, informing them the student was provided appropriate follow-up. |
| • The self-injury team should be available to staff following an interaction that resulted in the staff having intense feelings or reactions. Referral for the staff as needed should be available. |
| 2. Risk assessment |
| • The appropriate self-injury team member conducts an initial risk assessment to identify possible suicide risk. |
| • From here, the self-injury team determines next steps. At one end of the continuum, for students at high risk and imminent risk to themselves, an immediate referral to hospital may be needed. On the other end, students at low risk (e.g., less frequent NSSI) could be provided with follow-up in the school to explore alternative coping strategies and monitor changes in their behavior. |
| 3. Referral |
| • The self-injury team should make the appropriate referral as needed based on the risk assessment and with the involvement of the parent/guardian where appropriate. |
| • The self-injury team should develop and maintain a list of potential referral options for different common risk profiles and socioeconomic levels. |
| 4. Parent/guardian notification/involvement |
| • Legal regulations regarding student confidentiality/parent notification vary regionally; it is imperative that the school protocol recommendations around parent notification be developed with explicit reference to local regulations. |
| • However, when possible, it is beneficial if the self-injury team can work with the student to involve parent/guardians, as they can be invaluable supports. |
| • When parent/guardians are involved, the self-injury team should be sure to share information and resources about NSSI with them and provide early support. |
| 5. Managing iatrogenic effects |
| • School communication about NSSI should be handled with care and focus on the larger context of coping, with emphasis on enhancing healthy coping. Discussions involving detailed descriptions or imagery about self-injury should be avoided. |
| • Peer communication about self-injury should be guided but not banned, being very clear that it is out of concern for others who may be triggered by explicit detail. |
| • Students should be asked to cover wounds wherever possible, again with the explicit emphasis on the need to support others who may be struggling with recovery and the potential for triggering them. |

**Figure 1**

*Sample Self-Injury Protocol for Schools*




*Note*. The Non-suicidal Self-injury Protocol. Copyright by the Lester B. Pearson School Board, Dorval, Quebec, Canada. Reprinted with permission. See the online article for the color version of this figure.

At the same time, concerns have been expressed about the adverse impact of particular forms of online material, including graphic NSSI imagery, which may trigger NSSI urges and behavior (e.g., Baker & Lewis, 2013), and hopeless messages about recovery, which may contribute to continued NSSI and thwarted recovery efforts (e.g., Lewis et al., 2012). As students in rural areas may have fewer resources and lower access to mental health resources and services (Brown et al., 2018; Hastings & Cohn, 2013), the internet may have particular salience for rural youth. Thus, it is essential that school professionals are cognizant of the double-edged nature of online NSSI activity. Further, banning online activity should not be a solution, as it will likely encourage secrecy and reluctance for students to come forward; doing so may also take away a critical means of obtaining NSSI resources. Instead, in line with published guidelines (Lewis et al., 2019), familiarity with the nature of online NSSI activities related is recommended. From here, encouraging the use of supportive networks as well as online resources for NSSI (e.g.,

strategies to cope with urges) is advised. The resources outlined in Figure 2 may be useful in this regard.

### NSSI, Mental Health, and Suicidal Behavior

NSSI is associated with myriad mental health difficulties (e.g., symptoms of depression, anxiety), and while the behavior may co-occur within particular mental disorders (e.g., eating disorders, borderline personality disorder), it also occurs in the absence of formally diagnosed disorders (see Lewis & Heath, 2015, for a review). NSSI has also been shown to be associated with suicide risk (Kiekens et al., 2018; Muehlenkamp, 2014). However, it is important to keep in mind that NSSI is distinct from suicidal behavior. People who self-injure are often trying to manage their distress, have future-focused aspirations, and most importantly, do not expect their injuries to result in death (Hamza et al., 2012). Given that suicide rates are higher in rural than in urban areas, and youth may have greater access to lethal means (e.g., firearms) in rural communities (Brown et al., 2018; Fontanella et al., 2015), staying vigilant and monitoring possible suicide risk among rural populations is critical. When a student is identified as having engaged in NSSI, a suicide risk assessment is necessary. However, many rural practitioners report minimal training in risk assessment and are often limited by few referral options (Hastings & Cohn, 2013). These findings highlight the need of providing specialized training in risk management to all practitioners in rural settings.

## Part II: Rural School Response to NSSI

The importance of having a whole-school response to, and training about, NSSI cannot be overstated. School mental health professionals, teachers, and school administrators often feel ill-equipped when responding to students who self-injure (Berger et al., 2014), but poor responses

**Figure 2**

*Recommended Resources*

| Websites |
| --- |
| **Self-injury Outreach & Support (SiOS):** www.sioutreach.org<br>SiOS offers current research-informed resources about NSSI for various stakeholders. For individuals who self-injure, SiOS provides general information, coping guides, and recovery stories. SiOS also provides general information as well as guides for families, friends, romantic partners, schools, as well as different health and mental health professionals. |
| **Shedding Light on Self-injury:** www.self-injury.org.au<br>This website provides resources for young people, schools, and health professionals. Also, on this website is general information for people wanting to learn more about self-injury. |
| **Self-injury and Recovery Research and Resources:** http://www.selfinjury.bctr.cornell.edu<br>Based at Cornell University, this website offers a breadth of information concerning self-injury. This includes content for individuals who self-injure as well as the different supports in their lives, such as parents and families, schools, and health professionals. |
| **Open-Access Infographics** |
| **Infographics for Schools & Families:** http://sioutreach.org/resources-self-injury/for-schools<br>Presents an infographic for school stakeholders for appropriate responding to students who self-injure (e.g., teacher, school mental health professional) and for parents/caregivers of youth who self-injure (e.g., navigating discussions, offering support). |
| **Online Training** |
| **Non-suicidal self-injury Training 101:** http://www.selfinjury.bctr.cornell.edu/training.html<br>Offers research-informed training for professionals who work with students who self-injure. |
| **Books** |
| Gratz, K. L., & Chapman, A. L. (2009). *Freedom from self-harm: Overcoming self-injury with skills from DBT and other treatments.* Oakland, CA: New Harbinger Publications.<br><br>Klonsky, E.D., Muehlenkamp, J.J., Lewis, S. P. & Walsh, B. (2011). Non-suicidal self-injury. Hogrefe & Huber, Cambridge, MA.<br><br>Walsh, B. W. (2012). Treating self-injury: A practical guide. New York: Guilford Press.<br><br>Washburn, J. J. (Ed.). (2019). *Nonsuicidal Self-injury: Advances in Research and Practice*. Routledge. |

*Note*. NSSI = nonsuicidal self-injury. See the online article for the color version of this figure.

can thwart future support and help-seeking among students (Hasking et al., 2016). This concern is particularly relevant in rural areas, where access to mental health care and support for students may be limited, creating situations where teachers or untrained paraprofessionals may be tasked with responding to students who self-injure (Brown et al., 2018). Additionally, access to specialized referral services and training for mental health professionals working in rural schools is scarce, adding further constraints on the system (Hastings & Cohn, 2013). Rural systems also tend to operate in silos where they lack meaningful opportunities for referral options or integrated care, interagency cooperation, and collaboration (Gamm et al., 2010). Finally, schools in rural areas may have higher degrees of stigma due to their denser social networks, and stigma may be more pronounced in the case of NSSI (Staniland et al., 2021), reducing help-seeking. The current section offers concrete, research-informed guidelines for professional development concerning NSSI for rural school personnel, recommendations for a schoolwide approach to NSSI, and prevention and school-based interventions for NSSI, as well as outlines guidelines for providing appropriate parental support.

## Professional Development Concerning NSSI for Rural School Personnel

A lack of understanding and/or knowledge about NSSI may result in several negative outcomes for both the student (e.g., invalidation, impeded support-seeking, continued NSSI engagement) and the school (e.g., parental backlash about mishandling NSSI, less inclusive school climate, unwanted media attention). Hence, an essential first step is to provide foundational knowledge about self-injury to all school staff (i.e., what NSSI is, why students engage in NSSI). This professional development should address issues of NSSI within the context of overall wellness and healthy versus unhealthy coping strategies (i.e., not as a single focus on NSSI). As noted earlier, this should also include knowledge about online NSSI

communication among youth, including its potential impact (i.e., benefits as well as risks). Also important is providing research-informed online resources to youth and others who play key supportive roles (e.g., parents, coaches, religious leaders). Online resources that may prove helpful for developing this content can be found at http://sioutreach.org.

**Recommendations for a Schoolwide Protocol for NSSI**

Following the provision of professional development for all staff, the next step in addressing NSSI in rural settings is to create and implement a schoolwide protocol (Hasking et al., 2016; Walsh & Muehlenkamp, 2013). Given that rural mental health practitioners note a lack of consistent policy and protocols in schools, particularly in responding to at-risk youth (Brown et al., 2018), providing guidelines for rural practitioners to inform protocols is a key aim of this article. School protocols for NSSI should clearly indicate the roles and responsibilities for all stakeholders and indicate who is in the best position to respond to students who self-injure, based on their training, comfort, and role in the school. A protocol should also include how school staff should and should not respond to a student who discloses NSSI. Consideration of whether (and when) to inform parents/caregivers should be indicated. Finally, proper follow-up from a school team and possible referral to specialized services (if available) should be indicated. Ongoing training and review of the protocol and updating it with current research and best practices is key (see Table 1, for an overview of what a protocol comprises, and Figure 1, for a sample protocol).

In a rural school context, creating a clear and consistently used protocol for staff to follow may be difficult with limited resources and scarce referral sources. As such, school staff in this context need to be well trained and feel comfortable in supporting and talking to students

who self-injure. This can partially be accomplished through online and web-based training (i.e., response to and intervention with NSSI). The use of technology to supplement and enhance information sharing and the best practice approaches can augment knowledge in rural contexts. In some cases, rural schools may have parents undertake more active roles within the school context (e.g., sports team coach). In these cases, it would be important to ensure they too know how to effectively respond to student NSSI and refer students appropriately thereafter. If there are no local mental health resources or clinicians, or there are concerns about taking on dual roles, drawing on telehealth to offer support may be needed. Often, schools can obtain a list of providers and contacts via state/provincial organizations and licensing boards.

Within a school protocol, the importance of the first response should be emphasized. Specifically, the importance of first response by educators, administrators, the designated person, or mental health professional(s) is critical, as a negative reaction to a student can lead to them foregoing help-seeking and further engaging in NSSI. Additionally, if students feel judged or shamed by school staff, they are likely to feel more stigmatized and isolated. As outlined in Figure 1, when first speaking with a student about their NSSI, it is important to communicate in a calm, respectful, and caring way. Using the student's own language when talking about self-injury (e.g., if they refer to NSSI as "self-harm" or "my cutting," then use this phrasing) is also advised. Listening attentively to understand the student without giving advice or telling stories about other people who self-injure can also help in fostering rapport and enabling students to feel heard and understood. Finally, encouraging professional support-seeking is paramount.

**Designated Person**

A school protocol for addressing NSSI requires that one or more school staff agree to be the "designated person/people" to mobilize and serve as the contact person/people. This is a

uniquely challenging role; frequently, and perhaps especially in rural settings, the designated person will be working largely in isolation, without similarly trained colleagues for support (Hastings & Cohn, 2013). Furthermore, they will be undertaking additional work in seeking out and updating their knowledge and training in this area, which may be especially challenging given that rural mental health practitioners already report having too many obligations. For example, school mental health practitioners in rural settings work in more schools than practitioners in urban settings, spend more time traveling between schools, and support a greater diversity of students' needs (Brown et al., 2018; Goforth et al., 2017). Finally, mental health professionals frequently report that supporting students who self-injure is particularly difficult for their own well-being (De Stefano et al., 2012), and rural mental health practitioners already report high levels of stress and burnout with limited collegial support (Hastings & Cohn, 2013).

Accordingly, when seeking out training, we strongly recommend that the designated person connect with others who similarly work with students who self-injure in rural schools. For instance, this could occur by fostering connections at training sessions or conferences; developing a community of practice; identifying/developing online networks (e.g., Facebook groups), holding online debriefings (e.g., via Zoom) with colleagues, or contacting relevant organizations and groups comprising school professionals who work in the area of rural mental health. We encourage the designated person to ensure that they have their administration's acknowledgment and support in this regard, as well as recognition of the demands involved.

**Prevention and School-Based Interventions**

In responding to NSSI within school settings, school professionals are often concerned about their ability to appropriately provide intervention with limited resources and training

(Berger et al., 2014). Furthermore, the desire to proactively prevent NSSI is frequently expressed by school professionals. Although there is no definitive research documenting a best practice for preventing or intervening with NSSI within schools, there are research-informed and clinically recommended components for use within schools (e.g., Baetens et al., 2020; Mazza et al., 2016). These focus on common underlying contributors to youth's engagement in NSSI, such as the need to cope with intense painful emotions (emotion regulatory difficulties), self-criticism, and difficulties in communicating needs and feelings. Recommendations for prevention and support/intervention focus on enhancing emotion regulation and addressing self-criticism through the use of mindfulness, thought challenging/testing, emotion management skills, and distress tolerance. Recently, an approach that incorporates all of these elements that is specifically for use in schools has emerged. Mazza et al. (2016) developed a unique social–emotional learning curriculum that focuses on helping adolescents develop and practice emotion management and decision-making skills, critical dialectical behavior therapy (DBT) skills that have been shown to be effective for reducing self-injury and when working with high-risk youth (Kothgassner et al., 2020). This universal program can be used in schools by educators as well as practitioners and nonpractitioners to help reduce the likelihood of emotion dysregulatory behaviors. Furthermore, this can be undertaken using the DBT Skills in Schools manual (Mazza et al., 2016) purchased (e.g., via Amazon) at a minimal cost.

The standardized lesson plans and concrete strategies can be integrated by teachers or mental health professionals universally within classrooms, in small groups, or used individually with students. The structured lessons allow for peer-to-peer support as well as teacher instruction and modeling based on the four standard modules of DBT: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The lessons are laid out and taught in such a

way that they can be easily integrated within the curriculum. In sum, specialized training in this area alongside focusing on supporting student emotion regulation and interpersonal effectiveness within the school curriculum could be one example of how to effectively address this constraint. However, we recommend this program as a resource to inform and guide both prevention and ongoing support for students who self-injure. It is important to emphasize that this program is not focused specifically on NSSI but on enhancing effective coping for all youth. Further, this program is not intended to be used in place of formal intervention (e.g., psychotherapy). However, as rural areas tend to have fewer formal resources available, this program may have utility to foster skills that can lead to healthier coping.

**Parent Communication and Support**

In most cases, it is recommended that parents and caregivers become involved in the student's support circle. Youth tend to fare better with supportive parent involvement (Whitlock & Lloyd-Richardson, 2019), but this is often easier said than done. Accordingly, we recommend that a first step in the involvement of parents is to discuss with the youth what their expectations are regarding their parents' response to the disclosure of their NSSI. When a student has serious reservations or fear about involving the parent, this should be acknowledged and not dismissed as it may reflect a reality of which the school professional is unaware, but that may be pertinent to the circumstances of the youth. Unlike other concerning behaviors, parents frequently have intense responses to learning of their child's self-injury (e.g., horror, anger, shame; Whitlock et al., 2018). Alternatively, some parents may be prone to minimizing the behavior as a "passing fad" or "attention getting ploy." In rural settings, in particular, there may be greater resistance to acknowledging mental health concerns due to stigma (Crumb et al., 2019), and worry about the stigmatization of family members of youth with mental health concerns (e.g., "guilty by

association”; Heflinger et al., 2014). Research has shown that individuals with mental health challenges in rural settings are more likely to delay treatment until the difficulty becomes severe (Stewart et al., 2015). In all cases, parents need to be provided with information to help them understand NSSI and why their child self-injures, guidelines about how to respond and support their child, identify additional resources, and information to support themselves (e.g., engagement in self-care). Figure 2 provides resources that schools can share with parents; recommendations for school professionals when working with parents of youth who self-injure are also available (Whitlock et al., 2018).

### Strengths of Rural Settings

Mental health professionals living and working in rural settings are likely aware of the unique strengths and resiliencies of their communities. Research indicates that adolescents in rural settings often report strong connections with the broader community. Indeed, a strong rural community has been described as supportive and caring, particularly for youth (Hornberger & Cobb, 1998). Thus, the often close-knit nature of rural communities may offer unique opportunities for supporting youth who self-injure. Mental health professionals and school staff embedded in rural communities may have unique insight into the experiences of the youth they serve, and may be well-positioned to identify local resources to support youth who self-injure.

## Conclusion

Rural schools face many unique challenges, including the prevalence of NSSI in schools in general, the challenges educators and staff face in supporting students who self-injure, and the likelihood that these difficulties pose an even greater challenge in the rural context, where resources may be limited. The current article advocates for rural school professionals to use the provided information and resources to create a more informed response to NSSI in their schools.

The three steps of (a) educating staff about NSSI, (b) creating a school protocol to ensure appropriate and prompt response, and (c) providing necessary supports and/or resources to families, are well within the capacity of all schools. Even in the absence of direct mental health resources, rural schools have the potential to significantly change the trajectory of students' help-seeking and coping. Furthermore, incorporating skill-based social–emotional curricula (e.g., Mazza et al., 2016) wherever feasible can enhance coping for all students, regardless of whether they self-injure. In conclusion, the decision to avoid responding to NSSI due to the perception that the needed mental health expertise is absent is in itself a response—and one that is harmful and potentially risky. NSSI still occurs within schools that choose to avoid responding to NSSI, and this avoidance may result in negative outcomes for students who are not provided with the support they need. Finally, in our clinical practice, we have observed how even simple changes in first response and parent support materials can positively influence the student's well-being.

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