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ABSTRACT

EQUIPPING PARENTS TO SUPPORT YOUTH WHO SELF-INJURE: A MULTI-METHOD APPROACH TO UNDERSTANDING THE NEEDS OF PARENTS

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Non-suicidal self-injury (NSSI) is a common mental health concern among youth, and parents can be valuable supports for these youth through the recovery process. However, youth NSSI can have a significant impact on parents’ wellbeing, which may in turn alter parents’ ability to support the youth. This dissertation focuses on understanding the needs of parents of youth who self-injure. First, a systematic literature review synthesized the literature on parent factors implicated in youth NSSI risk, the role of parents in help-seeking and intervention for youth NSSI, and the impact of youth NSSI on parents. Next, a second study presented a model linking adolescent mental health challenges to parent wellbeing through parenting self-efficacy within a sample of parents (n = 112) of youth with a history of NSSI. Results indicated that parenting self-efficacy partially mediated the relation between young people’s mental health challenges and parent wellbeing (i.e., symptoms of depression, anxiety, perceived stress, and life satisfaction). Furthermore, parent emotion dysregulation mediated the relation between NSSI literacy and parenting self-efficacy, as well as the relation between social support and parenting self-efficacy. A second phase of this study then used thematic analyses to identify salient themes regarding the impact of youth’s self-injury on parents (i.e., elicitation of difficult emotions, exacerbation of mental health difficulties, uncertainty as a parent, recognition of growth).
parents’ needs as they support their youth (i.e., need for NSSI literacy, need for peer support, need for effective professional support, need for self-care), and the ways in which parents anticipate the Internet could meet their needs (i.e., information and self-help tools, connection with peers, readily-available mental health professionals). Sources from which parents seek help (i.e., both informal and professional supports, including the Internet), the barriers to seeking help (i.e., inability to access effective mental health resources, parent negative expectations, youth’s resistance to receiving help), and what makes these sources helpful (i.e., validation and connection, competent family-centered professional support, caring for the parent as separate from the youth) was also assessed. Clinical implications and implications for the role of the Internet in equipping parents to support youth who self-injure are discussed.
Dedication

For my parents.
Acknowledgements

This dissertation is a small part of a very long adventure. Looking back, I am amazed at the twists and turns that this journey has taken, and I am excited about the view from where I stand now. I wouldn’t change how I got here. There are quite a few people that need to be thanked for accompanying me at various points in this project.

First, this project was strengthened through the input and support from several key people. My utmost thanks go to my advisor Dr. Stephen P. Lewis, whose heart and passion for this line of research ensured that this project could be useful towards improving clinical interventions. His strong belief in work-life balance and self-care also ensured that I had the necessary support to overcome several obstacles during this project, which ultimately enhanced my devotion to my dissertation. I also wish to thank Dr. Nancy Heath and Dr. Margaret Lumley for their valuable ideas and alternate ways of looking at the research questions, results, and implications for clinical practice. Furthermore, support for this thesis was provided through funding from the Canadian Institutes for Health Research.

Next, I need to acknowledge the contributions of my own parents, who believed that I have the potential to change the world. While my sights are not set on changing the world, I am thrilled to walk alongside youth and their families as they change their lives. Although my mother was unable to see the project completed, I have no doubt that she would be beyond proud of me.

I am constantly thankful for the three little bundles of chaos in my life: Avery, Lachlan, and Leah. They encourage me to see the world through the lens of adventure, and remind me how important it is as a parent to have self-compassion. My steadfast partner, Shane, has been...
my rock throughout this journey. Thanks also to Alexa, who reminds me of the value of peer-
support.

Finally, my deepest thanks go to the parents who participated in this research project. I am honoured by their openness and courage in sharing with me experiences that were often extremely painful, and I am in awe of their resilience and determination to help their youth. This project could not have been completed without these parents, and it is my hope that the results from this project will be able to help other parents like them. Sometimes being a parent is the most overwhelming job in the world. To all parents of youth struggling with self-injury, I extend both encouragement that as parents they are valuable resources for these youth, and faith that both they and their youth can and will find their way through. Don’t give up.
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Chapter One

Introduction to the Project

Non-suicidal self-injury (NSSI) is the intentional damage of one’s own body tissue (e.g., cutting, burning) without conscious suicidal intention and for reasons that are not socially sanctioned (Nock & Favazza, 2009). NSSI commonly takes the form of cutting, scraping, carving or burning the skin, hitting oneself, or biting oneself (Lewis & Heath, 2015; Lloyd-Richardson, Perrine; Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013), though other methods are also reported (Gratz & Chapman, 2009). Approximately 18% of adolescents have a history of at least one episode of NSSI (Muehlenkamp, Claes, Havertape, & Plener, 2012), and over a quarter of these adolescents engage in NSSI repeatedly (Jacobson & Gould, 2007). Indeed, the average age at NSSI onset is in the early-to-mid teen years (Lewis & Heath, 2015; Rodham & Hawton, 2009; Whitlock, Eckenrode, & Silverman, 2006).

There are many reasons for engaging in NSSI, including both intrapersonal (e.g., to stop bad feelings, to generate feelings in the absence of feeling anything) and interpersonal (e.g., to communicate feelings) reasons (Lloyd-Richardson et al., 2007; Nock, Prinstein, & Sterba, 2009). Risk factors and concomitants for NSSI in youth include a host of cognitive factors (e.g., rumination, negative thinking) (e.g., Bjärehed & Lundh, 2008), emotional factors (e.g., decreased distress tolerance, negative affectivity) (e.g., Buckholdt, Parra, & Jobe-Shields, 2009; Nock & Mendes, 2008), and relationship factors (e.g., negative feelings towards parents or peers; social-problem solving deficits) (e.g., Bjärehed & Lundh, 2008; Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Nock & Mendes, 2008). Youth who engage in NSSI are more likely than those who do not self-injure to have at least one diagnosed mental illness (e.g., mood disorders, eating disorders) (Janis & Nock, 2009; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006),
and it is common for youth who engage in NSSI to also engage in other maladaptive behaviours such as substance abuse and disordered eating (Bjärehed & Lundh, 2008; Hilt et al., 2008; Laukkanen et al., 2009; Nock et al., 2006; Ross, Heath, & Toste, 2009). Not only are youth who engage in NSSI more likely to have a history of suicide ideation and suicide attempts (Andover, Morris, Wren, & Bruzzese, 2012; Janis & Nock, 2009; Lloyd-Richardson et al., 2007; Nock et al., 2006), NSSI may also confer a specific risk for future suicidal behaviour (Hamza, Stewart, & Willoughby, 2012; Whitlock et al., 2013).

Parents may have a key supportive role to play during the youth’s recovery from NSSI (Glenn, Franklin, & Nock, 2015; Hollander, 2008; Rissanen, Kylma, & Laukkanen, 2009b). However, NSSI can have a significant impact on parents’ wellbeing (Byrne et al., 2008; Ferrey, 2016; McDonald, O’Brien, & Jackson, 2007; Oldershaw, Richards, Simic, & Schmidt, 2008). Indeed, parents report an abundance of negative emotions (Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008), difficulties understanding NSSI (Oldershaw et al., 2008; Rissanen, Kylma, & Laukkanen, 2008), increased parenting challenges (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008), and difficulties prioritizing their own needs (Oldershaw et al., 2008; Rissanen et al., 2008). These challenges may make it more difficult for parents to effectively support their youth through recovery from NSSI.

Knowledge dissemination to parents is thus far inadequate; NSSI is laden with stigma and misconceptions (e.g., Gratz & Chapman, 2009; Rissanen et al., 2008), and parents have difficulties accessing accurate and helpful information regarding this behaviour. Online approaches may be effective in disseminating knowledge to caregivers (e.g., Dietz, Cook, Billings, & Hendrickson, 2009). Not only is the Internet widely accessible, it is also a means by which caregivers seek resources and support for a variety of issues experienced by their children.
—perhaps especially for more stigmatized concerns such as mental health difficulties. Thus, the Internet may have potential as a promising medium for supporting parents as they support their youth.

**Proposed Project**

The overarching purpose of this research program is to explore ways in which parents of youth who self-injure may be equipped to support their youth more effectively, and to assess the potential role that the Internet could have in this endeavor. To this end, this project begins in Chapter Two with a systematic literature review to synthesize the current knowledge in the field about the role of parents in youth NSSI (i.e., risks for NSSI associated with parents, the role of parents in help-seeking and treatment for youth NSSI, the impact of youth NSSI on parents). This review details the ways in which parents are central to the prevention and treatment of youth NSSI, as well as indicating ways in which parents could be better supported for these tasks.

Next, Chapter Three presents a novel model linking adolescent mental health challenges to parent wellbeing through parenting self-efficacy within a sample of parents of youth with a history of NSSI. Greater mental health challenges may reduce parents’ capacity to support their youth; understanding ways to bolster parents’ mental health and wellbeing (e.g., through enhanced parenting self-efficacy) may enable them to support their youth more effectively.

Finally, Chapter Four outlines a mixed-methods approach to assessing the perceived needs of parents of youth who self-injure, the means by which these parents attempt to have these needs met through help-seeking activities (including barriers to help-seeking and what they find helpful or unhelpful), and the viability of the Internet as a means to meet parents’ needs. Parents themselves, as experts in their own experiences, may be in the best position to explain
what they need in order to support their youth; thus, meeting parents’ perceived needs may be central towards equipping them to support their youth.

Theoretical and clinical implications, as well as limitations and future directions, are presented within each chapter. Chapters Two through Four are written as stand-alone manuscripts and thus contain some degree of repetition, though efforts have made to minimize unnecessary redundancy. A concluding discussion in Chapter Five integrates the key findings from this project.
Chapter Two

Parents of youth who self-injure: A review of the literature and implications for mental health professionals

To date, no single paper has consolidated the literature on parents of youth who self-injure. A review paper which provides a thorough understanding of the role of parents in youth NSSI may better equip clinicians to treat youth NSSI by involving parents as valuable resources of the youth’s circle of care. Indeed, when parents are appropriately supported, they can be instrumental throughout a young person’s NSSI recovery process (Glenn, Franklin, & Nock, 2015; Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015; Rissanen, Kylma, & Laukkanen, 2009b). Such a review may also help to identify where research is needed to further understand how parent factors play a role in the context of NSSI onset and treatment among youth, and how to support parents such that they are better able to support their youth. This review begins with a synthesis of the literature examining parents of youth who engage in NSSI, including the risks for NSSI associated with parents, the role of parents during help-seeking and treatment for NSSI, and the impact of youth NSSI on parents. Next, clinical implications for supporting parents are explored. Finally, gaps in the literature are identified and avenues for further research are suggested.

Review

Papers for this review were identified through the Psych-Info and PubMed databases in April 2015 using the search query (parent* OR family OR interpersonal OR caregiver) AND (self-harm* OR self-injur* OR self-mutilat*) AND (child* OR youth OR adolescen* OR teen OR student OR young). References of resultant papers were also reviewed. Figure 2.1 outlines the

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1 This chapter is adapted with permission from Arbuthnott and Lewis (2015).
study acquisition and inclusion process. The following inclusion criteria were used: studies had to be peer-reviewed, written in English, and examined NSSI or non-suicidal self-harm among children and/or adolescents (≤ 19 years). Included studies also had to examine the role of parents in relation to NSSI in at least one of four categories: youth NSSI risk factors; youth help-seeking for NSSI; intervention for youth NSSI; and parent experiences of youth NSSI. Articles were excluded for the following reasons: NSSI or self-harm was examined in young adults or college student populations; samples were drawn from populations with developmental disabilities, psychosis, or youth who were not living at home (e.g., incarcerated youth, street youth); the harm to self was accidental or socially sanctioned (e.g., salt and ice challenges).

Although the initial intent of this review was to examine parents in relation to youth NSSI specifically, the review was expanded to include deliberate self-harm (DSH) in combination with NSSI. DSH encompasses NSSI behaviours as well as behaviours with indirect harm (e.g., self-poisoning, overdoses), and DSH may or may not include behaviours with suicidal intent. Thus, NSSI is subsumed under DSH. The focus was broadened for two reasons. First, there is a paucity of research examining the role of parents during help-seeking and treatment for NSSI specifically, and there were no published studies examining the impact of exclusive NSSI on parent wellbeing. Second, NSSI and DSH are often examined on a continuum of self-harming behaviours rather than as distinct categories (Hooley, 2008; Latimer, Covic, & Tennant, 2012). To this end, and for many studies, it was impossible to determine which behaviour (i.e., NSSI versus DSH) was measured based on the methodology provided in the text. Thus, expanding the scope of the review to include DSH as well as NSSI may provide a more comprehensive picture of the role of parents in youth NSSI. The term NSSI is used throughout this review when the study included NSSI behaviours; the reader should note that at times these
studies may also have included behaviours that extended beyond the definition of NSSI. To best approximate the goals of the initial review, studies of DSH that clearly did not include NSSI (i.e., self-poisoning was the only method examined; only behaviours with suicidal intent were included; or suicide ideation confounded the measure of self-harm), were excluded. Furthermore, as there may be key differences between adolescents who engage in DSH with suicidal intent versus nonsuicidal intent (Brausch & Gutierrez, 2010; Hamza, Stewart, & Willoughby, 2012; Ougrin et al., 2012), only studies measuring exclusively nonsuicidal DSH were included in the review of risks for NSSI associated with parents. A total of 82 articles were included in this review (Table 2.1). A visual summary of the role of parents in youth NSSI is provided in Figure 2.2.

**Risks for NSSI Associated with Parents**

Fifty-three studies (see Table 2.1) met the inclusion criteria for this section of the review. Table 2.2 outlines all potential NSSI risk factors associated with parents that have been measured across the included studies. A variety of background factors associated with parents (i.e., socioeconomic status, family structure, parent health and mental health history), parent-child relationship factors (i.e., parenting methods, relationship quality, parent support, affect towards parents, adverse childhood experiences associated with parents specifically), and family system factors (i.e., family environment, adverse childhood experiences associated with the family system, family mental health history) have been associated with elevated risk for NSSI. Many background parent factors (e.g., parental level of education, family socioeconomic status, parent marital status, maternal depression) are widely used as covariates in youth NSSI research; as such, it is not unlikely that some studies that should have been included in this review were missed despite the intensive search and screening process.
Research examining youth NSSI risk beyond the use of correlations and group differences is still in its infancy. Cross-sectional research methods make it difficult to determine the direction of the effect (i.e., whether the parent factor influences youth NSSI, whether youth NSSI changes parent behaviour, or some combination) or the influence of a third unmeasured variable. Although an increasing number of longitudinal studies have used factors associated with parents to predict NSSI risk (see Table 2.1), only three studies (Baetens et al., 2014b; Hilt et al., 2008; Tatnell, Kelada, Hasking, & Martin, 2014) have examined the associations between NSSI and future parent variables, regardless of parents’ awareness of the youth’s NSSI.

Similarly, more research is needed to examine the full course of youth NSSI—including NSSI cessation—in relation to factors associated with parents; despite the role that parents and families have in treatment for youth NSSI, only one study in this review examined family factors in NSSI cessation (Tatnell et al., 2014). Understanding the role of parents over the course of NSSI may allow clinicians to better equip parents to support their youth. Although there is no standard model for how parents and adolescents should interact to reduce risk for NSSI, some parental responses towards adolescent emotions (e.g., comfort, validation, support) may protect against NSSI (Claes, Luyckx, Baetens, Van de Ven, & Witteman, 2015) or may encourage NSSI cessation (Tatnell et al., 2014). Thus, equipping parents with the skills necessary to model adaptive emotional acceptance, regulation and expression may be helpful in enhancing parents’ ability to support their youth.

Help-Seeking and Parents

Many youth who engage in NSSI tell no one about it ( Fortune, Sinclair, & Hawton, 2008b; Rossow & Wichstrøm, 2010), and parent reported rates of youth NSSI are considerably lower than actual youth NSSI rates (Baetens et al., 2014b; Mojtabai & Olfson, 2008). Those
adolescents who seek help most frequently do so from peers and less frequently from family members, including parents (De Leo & Heller, 2004; Evans, Hawton, & Rodham, 2005; Fortune et al., 2008b; Rossow & Wichstrøm, 2010; Watanabe et al., 2012). One study found that youth with a history of NSSI were less likely to know how parents could help, more likely to suggest that nothing could be done by parents, and less likely to suggest that parents talk to youth who self-injure or that parents refer these youth to professional help (Berger, Hasking, & Martin, 2013).

Help from family may more frequently be sought after, rather than before, an episode of NSSI (Evans et al., 2005; Fortune et al., 2008b), and has been associated with subsequent help-seeking from health services (Fadum et al., 2013). Youth may be more likely to seek help from parents when they feel as though their parents authentically care for them, and they are able to openly discuss self-injury with their parents (Fortune, Sinclair, & Hawton, 2008a; Rissanen, Kylma, & Laukkanen, 2009a). This highlights the need for clinicians who work with families in which a youth self-injures to foster open communication about emotions in family contexts early in the treatment process. Disclosure of NSSI is sometimes made to parents on behalf of the youth by school personnel or a physician (Oldershaw et al., 2008), and parents who receive poor initial support from schools and health professionals may be unlikely to continue to seek help (Oldershaw et al., 2008). The period of initial NSSI discovery may represent a key opportunity for parents to gain knowledge about NSSI, and to encourage professional help-seeking for their youth when warranted.

**Interventions Involving Parents**

Parents may have an essential role in initiating and supporting treatments for youth NSSI (Clarke et al., 2004; Fadum et al., 2013; Rissanen et al., 2009b). Youth may be more likely to
accept professional help for NSSI when parents are supportive of treatment (Rissanen et al., 2009b). For example, parents’ expectations about the helpfulness of counseling may influence the youth’s decision to attend—or not attend—counseling sessions following presentation at an emergency department following NSSI (Clarke et al., 2004). A caring environment and open discussion about NSSI may contribute not only to help seeking (Rissanen et al., 2009a), but also toward supporting the youth to understand, work through, and stop NSSI (Rissanen et al., 2009b).

Only a handful of studies have examined interventions involving parents for NSSI behaviours specifically (i.e., measured as an outcome either in the absence of, or in combination with, DSH with suicidal intent). The interventions listed below have been found to have some degree of support for DSH (see Glenn et al., 2015; Ougrin et al., 2015 for reviews). Studies of family-based therapies included multi-systemic therapy (Huey et al., 2004) and single-family therapeutic assessments (Ougrin, Boege, Stahl, Banarsee, & Taylor, 2013). Although attachment-based family therapy and family-based problem solving have some evidence of being efficacious for suicidal behaviours, outcomes related to NSSI have not yet been investigated (Glenn et al., 2015; Ougrin et al., 2015). Mentalization-based treatment, which consists of both individual and family psychodynamic psychotherapy, has been examined in relation to NSSI in one study (Rossouw & Fonagy, 2012). Studies assessing cognitive behaviour therapies (CBT) for youth NSSI have involved parents through family CBT in addition to individual CBT for the youth (Brent et al., 2009), or through a parent psycho-education component (Taylor et al., 2011); the inclusion of family problem solving sessions or parent training in CBT has not yet been assessed in relation to NSSI (Glenn et al., 2015). Finally, dialectical behaviour therapy for adolescents (Rathus & Miller, 2002) has gained recent empirical interest for youth NSSI (Fleischhaker et al.,
Reviews (Glenn et al., 2015; Ougrin et al., 2015) of interventions for youth DSH, including NSSI, have found that the inclusion of strong parent components in some interventions may result in significant reductions in youth DSH. While no interventions to date have been found to be well-established treatments for DSH in youth, common core elements across treatments that are probably or possibly efficacious include family skills training, parent education and training, and individual skills training (Glenn et al., 2015). Currently, the most efficacious treatments appear to come from a range of theoretical orientations, including cognitive-behavioural, family, interpersonal, and psychodynamic theories (Glenn et al., 2015). In comparison, in a meta-analysis of treatments for DSH, the treatments with the largest effect sizes included dialectical behavior therapy, cognitive-behaviour therapy, and mentalization-based therapy (Ougrin et al., 2015). Although few studies have assessed the benefits of these interventions on parents’ wellbeing and ability to support their youth, preliminary evidence suggests that parent (Woodberry & Popenoe, 2008) and family (Pineda & Dadds, 2013) functioning may significantly improve through participation even when youth NSSI behaviours may not (Woodberry & Popenoe, 2008).

Beyond interventions for youth specifically, parent education programs may have merit in assisting parents to cope with their youth’s NSSI and better support their youth. For example, a school-based program for parents (Tambourou & Gregg, 2002) was found to reduce youth NSSI among students of parents who participated; this program consisted of parent education groups that empowered parents to assist each other to improve communication and relationships
with youth. Similarly, two support programs (i.e., Resourceful Adolescent Parent Program: RAP-P, Pineda & Dadds, 2013; Supporting Parents and Carers: SPACE, Power et al., 2009) have been reported for parents of youth who have engaged in, or expressed thoughts of, suicidal behaviour or DSH (including NSSI); RAP-P used a single-family format (Pineda & Dadds, 2013), whereas SPACE had a group format (Power et al., 2009). Both programs provided parents with information pertaining to DSH and NSSI in youth, parenting adolescents, and family communication and conflict. SPACE also provided explicit information about parental self-care. When combined with routine care, RAP-P resulted in significant improvements in family functioning. Similarly, parents in the SPACE pilot study reported subsequent decreased psychological distress and greater parental satisfaction. Parents and youths also reported that youth experienced fewer difficulties following parent participation (Pineda & Dadds, 2013; Power et al., 2009). Taken together, parent participation in interventions pertaining to youth NSSI may have positive outcomes both for the youth and parent.

Impact on Parent Wellbeing

The process of supporting a youth who self-injures can be traumatic and emotionally taxing on parents (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2009b). Parents report an abundance of negative emotions (e.g., sadness, shame, embarrassment, shock, disappointment, self-blame, anger, frustration) in relation to their youth’s DSH (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). Many parents have expressed feeling overwhelmingly alone, isolated and helpless (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). These feelings can be exacerbated by the stigma surrounding NSSI and the perceived absence of services and supports for NSSI (Byrne et al., 2008). Parents have reported being unable to talk to anyone about the youth’s NSSI or being extremely selective
in choosing to whom they disclose (e.g., disclosing to a close friend, but not to family members) (Byrne et al., 2008). Many parents have reported a desire for peer support from other parents of youth who self-injure (Byrne et al., 2008; Rissanen et al., 2009b), with the anticipated benefits involving the sharing of similar circumstances, learning from each other, and relief from knowing that they are not alone (Byrne et al., 2008).

Although parents may recognize that NSSI serves a function for the youth (e.g., to provide relief from distress), many parents have reported being unable to understand NSSI as chosen behaviour (Oldershaw et al., 2008; Rissanen, Kylma, & Laukkanen, 2008). Indeed, many parents believe common misconceptions about this behaviour (Byrne et al., 2008; Oldershaw et al., 2008; Rissanen et al., 2008). For example, one study assessing parent conceptions about NSSI found that many parents believed that cutting oneself—one of the more common methods of NSSI among youth who self-injure (Lloyd-Richardson et al., 2007; Zetterqvist et al., 2013)—is a typical phase of adolescence, occurs only in females, is synonymous with a suicide attempt, or is an indicator of a psychological disorder (Rissanen et al., 2008). The availability of accurate information about NSSI has been identified as a priority by parents of youth who self-injure (Byrne et al., 2008).

Youth NSSI may increase parenting burden and stress (Oldershaw et al., 2008), and parents often report a loss of parenting confidence (Byrne et al., 2008; McDonald et al., 2007). Indeed, in families in which a youth self-harms, poor parental wellbeing has been predicted by poor family communication, low parenting satisfaction, and more difficulties for the youth (Morgan et al., 2013). Although a key developmental process during adolescence is to individuate from parents, many parents report believing their youth was more mature and capable than they really were (Rissanen et al., 2008), and many struggled to find and allow the
youth an appropriate level of independence (McDonald et al., 2007). Nervousness about triggering NSSI (i.e., causing an episode of NSSI) can affect parents’ ability to set limits and maintain boundaries (Oldershaw et al., 2008). Parents have also reported that typical difficulties associated with parenting adolescents (e.g., bullying, peer pressure, monitoring Internet use) may be intensified when their youth self-injures, as the adolescent’s experiences in these domains may precipitate or maintain NSSI behaviours (Byrne et al., 2008). Indeed, parents of youth with NSSI have expressed a need for more effective parenting skills (Byrne et al., 2008). Despite the difficulties associated with NSSI, many parents hope to rebuild a positive relationship with the youth, recognize the importance of parent-child communication in the youth’s wellbeing, and want to help the youth develop emotion regulation and coping strategies (Byrne et al., 2008).

Finally, parents may also experience difficulties balancing and meeting the varying needs of individual family members (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). Disruptions in family dynamics may occur, and the youth with NSSI may be perceived to hold the central position of power within the family (Byrne et al., 2008). Some parents have reported that caring for the youth who self-harms led to changes in employment (e.g., reducing hours, leaving paid employment), which may have increased financial strain on families (McDonald et al., 2007). Finally, parents may deny their own needs, and change or limit their lifestyle to increase support for the youth who self-harms (Oldershaw et al., 2008). Taken together, NSSI can have a significant impact on parent wellbeing and parenting, which may in turn affect parents’ ability to support their youth; accordingly, parents of youth who self-injure may benefit from additional support for themselves as they support their youth.
Clinical Implications for Supporting Parents

Parents may be valuable members of the youth’s circle of care. One study found that among youth who presented to an emergency department for self-harm, ongoing parental concern was a better predictor of future DSH than clinical risk assessments (Cassidy et al., 2009); thus, under some circumstances, parents may be in a position to gauge their youth’s ongoing wellbeing and alert health professionals about concerns when warranted (Cassidy et al., 2009; Rissanen et al., 2008). Indeed, another study found that many parents consider themselves to be the youth’s principal helper and advocate (Rissanen et al., 2009b), which may have both positive and negative implications for both parent and youth wellbeing. For many parents, taking care of themselves while their youth struggles with NSSI is challenging (Power et al., 2009; Rissanen et al., 2009b). Thus, parents may need to be encouraged to practice self-care (Power et al., 2009). As parents may also benefit from receiving accurate information about NSSI, parenting skills, and social support (Byrne et al., 2008), the inclusion of parents in empirically-informed treatments—such as those listed above—may be an optimal way to provide parents with education, skills training, and peer support that they can draw upon when supporting their youth at home. Parent education programs for parents of youth who self-injure may also have merit and should be investigated in future research.

The Internet may be a unique medium to support parents of youth who self-injure. Researchers have found that parents use the Internet to access both information related to their children’s medical conditions (Oh, Jorm, & Wright, 2009; Plantin & Daneback, 2009; Tuffrey & Finlay, 2002; Wainstein, Sterling-Levis, Baker, Taitz, & Brydon, 2006), and social support that is not being accessed offline (Plantin & Daneback, 2009; Scharer, 2005). The Internet has the potential to be a particularly effective method to educate parents about more stigmatized mental
health issues such as NSSI, and to equip parents to support their youth with these difficulties. Unfortunately, there is an abundance of non-credible and low-quality information about NSSI on the Internet (Lewis, Mahdy, Michal, & Arbuthnott, 2014). Thus, clinicians need to be mindful of parents’ use of the Internet to access support for youth NSSI, and be prepared to recommend credible websites containing accurate NSSI information. Mental health professionals may find that the Self-Injury Outreach and Support (www.sioutreach.org) and Cornell Research Program on Self-Injury and Recovery (www.selfinjury.bctr.cornell.edu/resources.html) websites are particularly useful online resource for parents, as they provide credible and accurate information for parents seeking to understand their youth’s NSSI and how to support their youth (e.g., how to talk to their youth about NSSI, treatments for youth NSSI), as well as providing suggestions for additional online and offline resources specific to parents.

**Implications for Further Research**

There are several limitations in the cited studies that suggest avenues for future research. First, there is a paucity of research pertaining to parents of youth who engage in NSSI specifically; much of what is known about these parents is inferred from studies assessing parents of youth who engage in similar behaviours such as self-harm, which may or may not include a suicidal intent. Thus, more research is needed to determine to what extent parents of youth with NSSI differ from parents of youth who self-harm. This information may assist mental health professionals to develop empirically-informed programs for parents of youth who self-injure that may be modeled on programs already existing for parents of youth who self-harm (Pineda & Dadds, 2013; Power et al., 2009).

Next, studies linking parenting factors to NSSI risk are predominantly correlational, and thus causation cannot be inferred. Researchers should consider complex ways in which factors
associated with parents might interact to increase risk for, or protect against, NSSI. Similarly, factors that may mediate or moderate the relation between youth NSSI and the effects of this NSSI on parents are not yet known. To date, studies examining the impact of youth NSSI on parent wellbeing and parenting have been almost exclusively qualitative. Empirical studies are needed in this area to better understand the effects of youth NSSI on parenting and parents’ subsequent ability to support the youth.

Finally, the effects of parent and youth gender on NSSI risks and NSSI impact on parents are unclear. The impact of NSSI on parent wellbeing has almost exclusively been examined through mothers due to an inability to recruit adequate numbers of fathers; thus, these findings should be generalized cautiously to fathers and other caregivers. Similarly, there may be gender differences in NSSI risk and protective factors. For example, connectedness with parents may be particularly important in protecting adolescent females against NSSI (e.g., Taliaferro, Muehlenkamp, Borowsky, McMorris, & Kugler, 2012), and parent-child relationship quality may confer different risks for NSSI when associated with mothers versus fathers (e.g., Di Pierro, Sarno, Perego, Gallucci, & Madeddu, 2012). Further research is needed to identify whether fathers have similar experiences to mothers in supporting youth who self-injure, and how factors associated with mothers and fathers may confer different risks or protection for youth NSSI.

**Conclusions**

Parents can play a key role in supporting youth who self-injure. However, youth NSSI affects parents’ wellbeing, which may, in turn, affect how parents can support their youth. Providing parents with accurate information about NSSI, parenting skills, and social support may help parents to better support their youth. Professionals should consider family dynamics and related contextual factors when selecting appropriate interventions for youth who self-injure;
parents may be valuable members of the circle of care. More research is needed to identify salient parent factors affecting youth NSSI risk and parent wellbeing, and to determine the most effective ways to support parents of youth who self-injure. Efforts in this regard may bolster the quality of clinical care provided to youth who self-injure.
Table 2.1. Studies included in the review of parents’ role in youth NSSI.

<table>
<thead>
<tr>
<th>Risk Factors Associated with Parents*</th>
<th>Help-Seeking from Parents</th>
<th>Interventions Involving Parents</th>
<th>Impact on Parent Wellbeing</th>
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<tbody>
<tr>
<td>Cross-Sectional</td>
<td>Longitudinal</td>
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<tr>
<td>Clinical Sample*</td>
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<td>Adrian et al., 2011</td>
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<td>Boxer, 2010</td>
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<td>Esposito-Smythers et al., 2010</td>
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<td>Guertin et al., 2001</td>
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<td>Kaess et al., 2013</td>
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<td>Tan et al., 2014</td>
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<td>Tuisku et al., 2009</td>
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<td>Venta &amp; Sharp, 2014</td>
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<td>Warzocha et al., 2010</td>
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<td>Wolff et al., 2014</td>
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<td>Cohort Sample</td>
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<td>Baetens et al., 2014</td>
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<td>Community Sample</td>
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<td>Deliberto &amp; Nock, 2008</td>
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<td>Wedig &amp; Nock, 2007</td>
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<td>School Sample</td>
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<td>Baetens et al., 2015</td>
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<td>Bjärehed &amp; Lundh, 2008</td>
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<td>Brausch &amp; Gutierrez, 2010</td>
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<td>Brunner et al., 2007</td>
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<td>Cerutti et al., 2011</td>
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<td>Claes et al., 2015</td>
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<td>Di Pierro et al., 2012</td>
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<td>Duke et al., 2010</td>
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<td>Giletta et al., 2012</td>
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<td>Hargus et al., 2009</td>
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<td>Hay &amp; Meldrum, 2010</td>
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<td>Kaminski et al., 2010</td>
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<td>Laye-Gindhu &amp; Schonert-Reichl, 2005</td>
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<td>Liang et al., 2014</td>
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<td>Lloyd-Richardson et al., 2007</td>
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<td>Mossige et al., 2014</td>
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<td>Swahn et al., 2012</td>
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<td>Taliaferro et al., 2012</td>
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<td>Tang et al., 2010</td>
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<td>Yates et al., 2008</td>
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<td>Zetterqvist et al., 2013</td>
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<td>Qualitative</td>
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<td>Cognitive Behaviour Therapy</td>
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<td>Berger et al., 2013</td>
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<td>Brent et al., 2009</td>
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<td>Jantzer et al., 2013</td>
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<td>Taylor et al., 2011</td>
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<td>Tuisku et al., 2014^4</td>
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<td>Cohort Sample</td>
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<td>Dialectical Behaviour Therapy</td>
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<td>Baetens et al., 2014b</td>
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<td>Fleischhaker et al., 2011</td>
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<td>Geulayov et al., 2014</td>
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<td>Geddes et al., 2013</td>
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<td>Lereya et al., 2013</td>
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<td>Mehlum et al., 2014</td>
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<td>Page et al., 2014</td>
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<td>Tormoen et al., 2014</td>
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<td>Community Sample</td>
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<td>Woodberry &amp; Poponec, 2008</td>
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<td>Hankin &amp; Abela, 2011</td>
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<td>Keenan et al., 2014</td>
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<td>Family Based Therapy</td>
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<td>School Sample</td>
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<td>Huey et al., 2004</td>
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<td>Andrews et al., 2014</td>
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<td>Ougrim et al., 2013</td>
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<td>Hilt et al., 2008</td>
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<td>Psychodynamic Therapy</td>
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<td>Jutengren et al., 2011</td>
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<td>Rossouw &amp; Fonagy, 2012</td>
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<td>Law &amp; Shek, 2013</td>
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<td>Lundh et al., 2011</td>
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<td>Parent Education Program</td>
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<td>Shek &amp; Yu, 2012</td>
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<td>Pineda &amp; Dadds, 2013</td>
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<td>Tattrell et al., 2014</td>
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<td>Power et al., 2009</td>
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<td>Yates et al., 2008</td>
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<td>Tambourou et al., 2002</td>
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<td>You &amp; Leung, 2012</td>
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Note: Table reproduced with permission from Arbuthnott and Lewis (2015).

a Studies in which nonsuicidal DSH cannot be distinguished from DSH with suicidal intent, (e.g., sample consists of DSH regardless of intent or intent is not specified) are excluded.

b Includes inpatient [Adrian et al., 2011; Boxer, 2010; Giletta et al., 2012; Kaess et al., 2013; Venta & Sharp, 2009; Warzocha et al., 2010; Wolff et al., 2014] and outpatient (Tan et al., 2014; Tuisku et al., 2009; Tuisku et al., 2014) youth samples as well as samples of youth with specific
diagnoses (i.e., bipolar disorder, Esposito-Smythers et al., 2010; ADHD, Hurtig et al., 2012), and youth of parents with specific diagnoses (i.e., cancer, Jantzer et al., 2013; mood disorders, Cox et al., 2012).

Although a test-retest design was used, relevant results were presented for Time 1 and Time 2 cross-sectionally.

Only the first follow-up (1 year after baseline) is included in this review, as the mean age at the second follow-up (8 years after baseline) was beyond the age for inclusion.
Table 2.2. Risk factors for youth NSSI associated with parents.

<table>
<thead>
<tr>
<th>Parent Factor</th>
<th>Summary of Findings</th>
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</thead>
<tbody>
<tr>
<td><strong>Parent Background Factors</strong></td>
<td></td>
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<tr>
<td>Parent Socio-Economic Status</td>
<td>No differences in NSSI risk (Cox et al., 2012; Giletta et al., 2012; Laye-Gindhu et al., 2005; Mossige et al., 2014). Elevated risk for NSSI associated with lower parent education level (Baetens et al., 2014a). Lower maternal education during pregnancy weakly protected against NSSI risk in adolescence (Page et al., 2014).</td>
</tr>
<tr>
<td>Education</td>
<td>No differences in NSSI risk (Mossige et al., 2014). Elevated risk for NSSI associated with parent unemployment (Baetens et al., 2014a; Brunner et al., 2014; Zetterqvist et al., 2013).</td>
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<tr>
<td>Unemployment</td>
<td>No difference in NSSI risk (Mossige et al., 2014). Elevated risk for NSSI associated with parent unemployment (Baetens et al., 2014a; Brunner et al., 2014; Zetterqvist et al., 2013).</td>
</tr>
<tr>
<td>Lower income</td>
<td>No differences in NSSI risk (Cox et al., 2012; Liang et al., 2014). Elevated risk for NSSI (Baetens et al., 2014a; Page et al., 2014).</td>
</tr>
<tr>
<td>Financial problems</td>
<td>Elevated risk for NSSI (Hurtig et al., 2012; Mossige et al., 2014; Zetterqvist et al., 2013). Parents receiving social welfare benefits elevated risk for NSSI (Mossige et al., 2014). Parental ownership of the house they live in was not associated with NSSI risk (Mossige et al., 2014).</td>
</tr>
<tr>
<td>Family social status</td>
<td>No differences in NSSI risk (Hurtig et al., 2012; Page et al., 2014; Shek &amp; Yu, 2012).</td>
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<tr>
<td><strong>Family Structure</strong></td>
<td></td>
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<tr>
<td>Non-intact family</td>
<td>No differences in NSSI risk (Baetens et al., 2014b; Hargus et al., 2009; Hay &amp; Meldrum, 2010; Kaess et al., 2013; Lloyd-Richardson, 2007). Elevated risk for NSSI (Brunner et al., 2007; Hurtig et al., 2012; Laye-Gindhu &amp; Schonert-Reichl, 2005; Mossige et al., 2014; Zetterqvist et al., 2013). Elevated risk for NSSI associated with not living with biological parent (Brunner et al., 2007). Elevated risk for NSSI associated with youth living with mother or father and a stepparent, or living with neither mother nor father (Kaminsinski et al., 2010). Elevated risk with single-parent family (Liang et al., 2014).</td>
</tr>
<tr>
<td>Parents divorced</td>
<td>No differences in NSSI risk (Hargus et al., 2009; Tuisku et al., 2009). Elevated risk for NSSI (Warzocha et al., 2010). Elevated NSSI risk associated with youth whose parents were divorced and remarried to other people (Shek &amp; Yu, 2012). Not meeting with a divorced parent associated with NSSI risk among youth with ADHD (Hurtig et al., 2012).</td>
</tr>
<tr>
<td><strong>Parent Health &amp; Mental Health History</strong></td>
<td>No differences in NSSI risk associated with the number of miscarriages a mother has had (Deliberto &amp; Nock, 2008). Trend toward significant NSSI risk associated with parent history of cancer (Jantzer et al., 2013). Elevated risk for NSSI associated with parent history of a serious illness or disability (Laye-Ginghu &amp; Schonert-Reichl, 2005).</td>
</tr>
<tr>
<td>Illness or disability</td>
<td>No differences in NSSI risk associated with parental history of mood disorders (Esposito-Smythers et al., 2010), depression, bipolar disorders, anxiety disorder, posttraumatic stress disorder, or cluster B personality disorder (Cox et al., 2012). Elevated risk for NSSI associated with lower depressive symptoms among youth of parents with a history of depression (Cox et al., 2012). Elevated risk for NSSI associated with maternal depression (Hankin &amp; Abela, 2011).</td>
</tr>
<tr>
<td>Mental illness</td>
<td>No differences in NSSI risk associated with parental history of suicide attempts [Cox et al., 2012; Geulayov et al., 2014], suicide ideation, or NSSI/DSH (Cox et al., 2012).</td>
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<tr>
<td>Self-harm</td>
<td>No differences in NSSI risk associated with parental history of alcohol or substance abuse (Cox et al., 2012).</td>
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<tr>
<td>Substance use</td>
<td>No differences in NSSI risk associated with parental history of alcohol or substance abuse (Cox et al., 2012).</td>
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<tr>
<td>Parental stress</td>
<td>No difference in NSSI risk (Baetens et al., 2014a).</td>
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<tr>
<td>Parent Factor</td>
<td>Summary of Findings</td>
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<tr>
<td><strong>Parent Abuse History</strong></td>
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<tr>
<td>Abuse</td>
<td>No differences in NSSI risk for parent history of physical or sexual abuse (Cox et al., 2012).</td>
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<tr>
<td><strong>Parent-Child Relationship Factors</strong></td>
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<tr>
<td>Quality of Relationship</td>
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<tr>
<td>Relationship quality</td>
<td>No differences in NSSI risk associated with relationship quality with fathers (Di Pierro et al., 2012). Elevated risk for NSSI associated with lower overall relationship quality (Hilt et al., 2008), and lower quality relationships with mothers (Di Pierro et al., 2012). Higher NSSI frequency is associated with lower relationship quality with both mothers and fathers (Di Pierro et al., 2012). NSSI predicts an increase in positive relationship quality both overall and with fathers (Hilt et al., 2008).</td>
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<tr>
<td>Connectedness with parents</td>
<td>Elevated risk for NSSI associated with less connectedness with parents (Taliaferro et al., 2012).</td>
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<tr>
<td>Attachment &amp; alienation</td>
<td>Elevated risk for NSSI onset and maintenance associated with attachment anxiety (Tatnell et al., 2014). Individuals who had ceased NSSI continued to have greater attachment anxiety compared to controls, but less than those who maintained NSSI (Tatnell et al., 2014). Attachment classification (secure, dismissing, preoccupied, disorganized) did not predict NSSI (Venta &amp; Sharp, 2014). The indirect path between parental criticism and NSSI risk through parental alienation accounted for much of the direct relation between parental criticism and NSSI youth from high-income families (Yate et al., 2008).</td>
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<tr>
<td><strong>Support from Parents</strong></td>
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<tr>
<td>General support</td>
<td>No differences in NSSI risk (Baetens et al., 2014b). Elevated risk for NSSI associated with lower support from parents (Baetens et al., 2015; Brausch &amp; Gutierrez, 2010; Claes et al., 2015; Swahn et al., 2012). Interaction between support and parent behavioural control, such that high control and low support increased the change for NSSI (Baetens et al., 2014a). Lack of parental emotional support had a direct effect on NSSI frequency and an indirect effect through depressive symptoms (Baetens et al., 2015). Parent support moderated the relation between bullying/victimization and NSSI, such that bullying/victimization and NSSI are only significantly related at low levels of parental support (Claes et al., 2015). Parent support moderated the relation between depressed mood and NSSI, such that among participants who engaged in bullying there is a stronger association between depressed mood and NSSI at low levels of parental support (Claes et al., 2015).</td>
</tr>
<tr>
<td>Rule-setting</td>
<td>NSSI predicted less future perceived parental rule-setting among adolescents with high psychological distress (Baetens et al., 2014b). Increased rule-setting associated with parent-reported awareness of youth’s NSSI (Baetens et al., 2014b).</td>
</tr>
<tr>
<td>Positive parenting</td>
<td>No differences in NSSI risk (Baetens et al., 2014b).</td>
</tr>
<tr>
<td>Criticism</td>
<td>Greater parental criticism associated with an elevated risk for NSSI presence in both boys and girls (Wedig &amp; Nock, 2007; Yates et al., 2008), and with repeated NSSI in boys from high-income families (Yates et al., 2008). Adolescent self-criticism moderated the relation between parental criticism and NSSI such that adolescent self-criticism was associated with NSSI at borderline and high levels of parental criticism, but not at low levels of parental criticism (Wedig &amp; Nock, 2007). Parental criticism had only an indirect effect on NSSI frequency through self-criticism (Baetens et al., 2015). An indirect path between parental criticism and NSSI risk through parental alienation accounted for much of the direct relation between parental criticism and NSSI risk among youth from high-income families (Yates et al., 2008).</td>
</tr>
<tr>
<td>Invalidation</td>
<td>Elevated risk for NSSI associated with greater parental invalidation (Tan et al., 2014).</td>
</tr>
<tr>
<td>Parent Factor</td>
<td>Summary of Findings</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Interest, understanding attention</strong></td>
<td>No differences in NSSI risk associated with parental interest for youth with ADHD (Hurtig et al., 2012). Elevated risk for NSSI associated with perception that parents do not pay attention to youth (Brunner et al., 2007), and that parents do not understand the youth’s problems (Brunner et al., 2007). NSSI risk higher for females, related to males, when reporting that parents do not understand youth’s problems (Brunner et al., 2007).</td>
</tr>
<tr>
<td><strong>Parental hostility</strong></td>
<td>No differences in NSSI risk (Lereya et al., 2013).</td>
</tr>
</tbody>
</table>

**Discipline and Control**

| Authoritative | Authoritative parenting diminishes the negative effects of bullying victimization on NSSI (Hay & Meldrum, 2010). |
| Behavioural control | No differences in NSSI risk when reported by parents (Baetens et al., 2014a). Elevated risk for NSSI associated with greater behavioural control when reported by youth (Baetens et al., 2014a). No unique risk in NSSI beyond other parenting variables (Baetens et al., 2014b). Interaction between behavioural control and support from parents, such that high control and low support increased the change for NSSI (Baetens et al., 2014a). |
| Harsh parenting | Elevated risk for NSSI associated with harsher parenting (Jutengren et al., 2011). Trend towards elevated risk for NSSI associated with harsher parenting (Keenen et al., 2014). No unique variance in NSSI predicted by harsh parenting when the model included peer victimization, though this was moderated by adolescent’s gender (Jutengren et al., 2011). |
| Psychological control | No differences in NSSI risk when reported by parents (Baetens et al., 2014a). Elevated risk for NSSI associated with greater psychological control when reported by youth (Baetens et al., 2014a). No unique risk for NSSI beyond other parenting variables (Baetens et al., 2014b). |
| Monitoring | Elevated risk for NSSI associated with lower parental monitoring (Swahn et al., 2012). |
| Emotion socialization | Elevated risk for NSSI associate with punishing emotion socialization when combined with other family relational problems, though this risk may be mediated by emotion regulation (Adrian et al., 2011). |

**Youth Affect Towards Parents**

| Idealization | Elevated risk for NSSI associated with idealization of mothers but not of father (Di Pierro et al., 2012). |
| Feelings | Elevated risk for NSSI associated with absence of positive feelings, more negative feelings, and overall feelings (more negative and less positive feelings, combined) towards parents (Bjärehed & Lundh, 2008). No unique variance in NSSI predicted beyond that which was predicted by youth’s rumination/negative thinking (Bjärehed & Lundh, 2008; Time 1). Unique variance in NSSI predicted beyond that which was predicted by youth’s rumination/negative thinking (Bjärehed & Lundh, 2008; Time 2) |
| Dysphoric relations | With fatigue, dysphoric relations to parents predicted NSSI (Lundh et al., 2011). |
| Academic expectations | Elevated risk for NSSI associated with greater stress from parental academic expectations (Tan et al., 2014). |

**Adverse Childhood Experiences**

| Antipathy | Elevated risk for NSSI associated with antipathy from both mothers and fathers (Kaess et al., 2013). Paternal antipathy associated with interpersonal influence functions of NSSI (Kaess et al., 2013). |
| Maladaptive parenting | Parental hitting or shouting in preschool years predicted NSSI in adolescence (Lereya et al., 2013). |
| Abuse by parent | Elevated risk for NSSI associated with verbal abuse by a parent (Mossige et al., 2014). Elevated risk for NSSI associated with physical abuse by a parent (Mossige et al., 2014; Tang et al., 2010), and by fathers specifically (Kaess et al., 2013). Maternal physical abuse predicted peer identification functions of NSSI (Kaess et al., 2013). |
### Parent Factor

<table>
<thead>
<tr>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical neglect</td>
</tr>
<tr>
<td>No difference in NSSI risk associate with physical neglect (Cerutti et al., 2011).</td>
</tr>
<tr>
<td>Elevated NSSI risk associated with physical neglect from mothers (Kaes et al., 2013).</td>
</tr>
<tr>
<td>Greater NSSI frequency, but not presence, was associated with physical neglect from a parent (Di Pierro et al., 2012).</td>
</tr>
<tr>
<td>Paternal neglect predicted peer identification functions of NSSI (Kaes et al., 2013).</td>
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</table>

### Family Systems Factors

#### Family Environment

<table>
<thead>
<tr>
<th>Factor</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family functioning</td>
<td>No differences in NSSI risk when reported by youth (Guertin et al., 2001), or parents (Baetens et al., 2014a).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI associated with lower family functioning (Law &amp; Shek, 2013).</td>
</tr>
<tr>
<td>Support</td>
<td>No differences in NSSI risk (Tuisku et al., 2014; Warzocha et al., 2010).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI presence (Andrews et al., 2014; Tuisku et al., 2009; Wolff et al., 2014), onset and maintenance associated with lower support from parents (Tatnell et al., 2014).</td>
</tr>
<tr>
<td></td>
<td>NSSI onset associated with a decrease in family support (Tatnell et al., 2014).</td>
</tr>
<tr>
<td></td>
<td>NSSI cessation associated with an increase in family support over time, though individuals who had ceased NSSI continued to perceive lower levels of support from family relative to individuals with no NSSI history (Tatnell et al., 2014).</td>
</tr>
<tr>
<td>Adaptability and cohesion</td>
<td>No differences in NSSI risk associated with family adaptability (Cox et al., 2012).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI associated with greater family rigidity (Liang et al., 2014).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI associated with lower family cohesion (Adrian et al., 2011; Kaminiski et al., 2010; Liang et al., 2014), though this risk may be mediated by emotion regulation (Adrian et al., 2011).</td>
</tr>
<tr>
<td></td>
<td>Elevated NSSI risk associated with lower family adaptability and cohesion among youth of parents with a history of depression (Cox et al., 2012).</td>
</tr>
<tr>
<td>Conflict</td>
<td>Elevated risk for NSSI associated with greater family conflict, though this risk may be mediated by emotion regulation (Adrian et al., 2011).</td>
</tr>
<tr>
<td>Invalidation</td>
<td>Elevated risk for NSSI (You &amp; Leung, 2012).</td>
</tr>
<tr>
<td>Arguments between parents</td>
<td>No difference in NSSI risk (Hargus et al., 2009).</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Elevated risk for NSSI associated with family-related loneliness among Dutch and US adolescents, but not among Italian adolescent (Giletta et al., 2012).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for repeated NSSI associated with family-related loneliness (Giletta et al., 2012).</td>
</tr>
<tr>
<td>Socializing with family</td>
<td>Elevated risk for NSSI associated with youth with ADHD who socialize less with the family (Hurtig et al., 2012).</td>
</tr>
</tbody>
</table>

#### Adverse Childhood Experiences

<table>
<thead>
<tr>
<th>Factor</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>No difference in NSSI risk associated with witnessing family violence (Duke et al., 2010; Taliaferro et al., 2012).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI associated with witnessing family violence (Cerutti et al., 2011).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI associated with domestic violence in preschool years (Lereya et al., 2013), and with witnessing parents being verbally or physically abused (Mossige et al., 2014).</td>
</tr>
<tr>
<td>Abuse</td>
<td>No differences in NSSI risk associated with sexual abuse in the family (Warzocha et al., 2010).</td>
</tr>
<tr>
<td></td>
<td>Elevated risk for NSSI associated with both physical and sexual abuse by a household adult (Duke et al., 2010).</td>
</tr>
<tr>
<td>Negative life events in the family</td>
<td>No differences in NSSI risk when reported by parents (Baetens et al., 2014a).</td>
</tr>
<tr>
<td>Death of a family member</td>
<td>No difference in NSSI risk (Hargus et al., 2009; Warzocha et al., 2010).</td>
</tr>
</tbody>
</table>
### Parent Factor

<table>
<thead>
<tr>
<th></th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Health and Mental Health History</strong></td>
<td></td>
</tr>
<tr>
<td>Health problems</td>
<td>Elevated risk for occasional, but not repetitive, NSSI associated with some (but not many) health problems in the family (Brunner et al., 2007).</td>
</tr>
<tr>
<td>Mental illness</td>
<td>No differences in NSSI risk associated with a family history of mental illness (Boxer, 2010; Warzocha et al., 2010), emotional or behavioural problems, depression, bipolar disorder, anxiety, eating disorder, schizophrenia, or Tourette’s (Deliberto &amp; Nock, 2008).</td>
</tr>
<tr>
<td>Substance use</td>
<td>No differences in NSSI risk associated with a family history of alcohol (Warzocha et al., 2010) or substance (Taliaferro et al., 2012) abuse. Elevated risk for NSSI associated with a family history of alcohol or substance abuse (Deliberto &amp; Nock, 2008). Elevated risk for NSSI when alcohol or substance use caused problem (Duke et al., 2010).</td>
</tr>
<tr>
<td>Criminality or Violence</td>
<td>Elevated risk for NSSI associated with both criminality (Boxer, 2010) and violence (Boxer, 2010; Deliberto &amp; Nock, 2008).</td>
</tr>
</tbody>
</table>

Note: Table adapted with permission from Arbuthnott and Lewis (2015).
2,008 studies were identified through PubMed and PsycINFO. Abstracts were screened for clear evidence of inclusion/exclusion criteria.

Full text was obtained for 304 articles.

181 articles were excluded.

Reasons:
38 Articles were review papers, critical analyses, or clinical guidelines (relevant papers from references were obtained and included).
3 Articles were case studies.
42 Studies used excluded population (i.e., adults, college students, developmental disabilities, youth not living at home, parents of adult children who self-harm).
15 Studies did not include a measure of DSH or included DSH as a component of a broader risk-taking variable.
18 Studies examined DSH with exclusively suicidal intentions.
10 Studies examined self-poisoning/overdoses as the exclusive method of DSH.
14 Studies measured suicide ideation rather than DSH, or confounded DSH with suicidal ideation in creating DSH groups.
20 Studies did not include a parent factors.
22 Studies did not assess the relation between the parent factor and NSSI risk.

9 Articles were obtained through references in relevant articles.

50 Studies were excluded from the review of NSSI risk factors because DSH included, or did not specify, suicidal intent.

82 articles included (Table 2.1)

Figure 2.1. Flow diagram of identified studies (reproduced with permission from Arbuthnott & Lewis, 2015).
**Risk Factors for Youth NSSI**

- Parent Factors
  - Socio-economic status
  - Family Structure
  - Parent Health/Mental Health
- Parent-Child Relationship Factors
  - Relationship Quality
  - Parental Support
  - Discipline and Control
  - Adverse Childhood Experiences
- Family Factors
  - Family Environment
  - Adverse Childhood Experiences
  - Family Mental Health History

More research is needed to understand:
- Parents’ role in NSSI cessation.
- How NSSI alters parenting and the resulting effects on youth NSSI.

**Interventions Involving Parents**

- Parents may be valuable members of the youth’s circle of care.
- Several interventions have included parent components to successfully treat youth NSSI.
- Parent education programs may help parents to better cope and to support their youth more effectively.

**Parent Experience of Youth NSSI**

- Youth NSSI may negatively affect parent mental health and wellbeing.
- Parents report misconceptions about NSSI.
- Developmentally appropriate parenting challenges may be exacerbated by the youth’s NSSI.
- Youth NSSI may affect family dynamics and increase financial burdens.
- Parents may have difficulties prioritizing their own needs.

To best support their youth, parents need:
- Accurate information about NSSI
- Peer support
- Parenting resources
- Self-Care

*Figure 2.2.* Visual summary of the role of parents in youth NSSI (reproduced with permission from Arbuthnott & Lewis, 2015).
Chapter Three

A model of parenting self-efficacy and parent wellbeing among parents of youth who self-injure

While NSSI affects the wellbeing of youth, it can also have a significant impact on parents/caregivers who can play a vital supportive role through a young person’s recovery process (e.g., Byrne et al., 2008; Ferrey et al., 2016; Hollander, 2008; McDonald, O’Brien, & Jackson, 2007; Oldershaw, Richards, Simic, & Schmidt, 2008). This paper presents a model linking adolescent mental health challenges to parent wellbeing through parenting self-efficacy within a sample of parents of youth with a history of NSSI. Understanding the relation between adolescent NSSI and parental wellbeing is key to providing supports for parents to effectively support their youth while also taking care of themselves.

Parent Wellbeing

As outlined in Chapter Two, supporting a youth who self-injures is stressful and can have a significant impact on the parents’ wellbeing. Parents describe an abundance of difficult emotions including anxiety, sadness, shame, self-blame and helplessness, among others (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). Parents may also experience social isolation (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008) and a reduction in quality of life due to stress and changes (e.g., in employment or financial circumstances, disruptions in family dynamics, altered social support) resulting from supporting the youth who self-injures (Bryne et al., 2008; McDonald et al., 2007). Together, these impacts may place parents at risk for the development or exacerbation of their own mental health challenges such as depression and anxiety (Ferry et al., 2016). Factors that may affect the relation between youth NSSI and parent wellbeing are not yet understood.
Self-Efficacy

One factor that may affect the relation between youth NSSI and parent wellbeing may be perceived self-efficacy, or the belief that one has the ability to successfully perform a specific behaviour (Bandura, 1977, 1986)—in this case parenting a youth who self-injures. Bandura’s concept of self-efficacy is a core component of his social cognitive theory, which explains human functioning through the reciprocal interactions between the individual’s behaviour, cognitive factors, and environment (Bandura, 1986). In this theory, self-referent thoughts (e.g., self-efficacy beliefs) mediate the relation between knowledge (i.e., knowing what to do, having the necessary skills) and behaviour (i.e., chosen action) within a particular environmental context (e.g., youth self-injury). Given the interrelation between cognitions and behaviours, perceptions of inefficacy may lead to psychological difficulties characterized by maladaptive cognitions and behaviours (Bandura, 1986). Self-efficacy has been shown to affect parent functioning, both in terms of parenting competence (see reviews in Coleman & Karraker, 1997; Jones & Prinz, 2005) and parent psychological wellbeing in the form of depression and anxiety (e.g., Gross, Conrad, Fogg, & Wothke, 1994; Hasting & Brown, 2002; Streisand et al., 2008). While NSSI is known to affect parent psychological wellbeing and makes parenting more complicated (e.g., Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2009b), the role of parenting self-efficacy has not been investigated in this population.

Bandura (1977) identified four factors that influence self-efficacy: a) performance or mastery (i.e., experiencing success in performing a behaviour); b) modeling or vicarious experience (i.e., seeing someone else successfully perform a behaviour); c) verbal persuasion (i.e., direct encouragement); and d) emotional arousal (i.e., physiological reactivity). For this study, three variables (i.e., NSSI literacy, emotion regulation skills, social support) are proposed
to tap into these factors and influence the self-efficacy of parenting youth who self-injure. These three variables are discussed in more detail below.

**NSSI Literacy.** Mental health literacy refers to knowledge and beliefs that influence the prevention, recognition and management of mental disorders (Jorm, 2000, 2012). Components of mental health literacy generally include knowledge of how to prevent mental illness, understanding and recognition of a developing mental illness, knowledge of effective self-help and professional treatments for the mental illness, and first-aid skills to support others who are developing or living with a mental illness, or who may be in a mental health crisis (Jorm, 2012). NSSI literacy specifically has not been examined in the literature; however, the above components of mental health literacy (e.g., Jorm, 2012) may be adapted to understand NSSI literacy. For parents of youth who self-injure, NSSI literacy may represent the knowledge and beliefs that influence the parents’ abilities to recognize and manage NSSI and its associated difficulties among these youth. More specifically, this may include knowledge and skills related to NSSI causes and prognosis, characteristics and functions, help-seeking and treatment options, self-care, first aid, and general parenting of adolescents that may be complicated by the presence of NSSI. Many of these components reflect key information commonly provided in books (e.g., Gratz & Chapman, 2009; Hollander, 2008) and websites (e.g., Self-Injury Outreach and Support: www.sioutreach.org; Cornell Research Program on Self-Injury and Recovery: www.selfinjury.bctr.cornell.edu/resources.html) for non-professional audiences such as parents, and also address common NSSI myths, which are discussed in the next paragraph.

Although NSSI literacy among parents has not yet been systematically examined, some research suggests that many parents hold inaccurate beliefs about the behaviour (e.g., Byrne et al., 2008; Oldershaw et al., 2008; Rissanen et al., 2008). For example, one study found that
parents believed self-cutting was a typical phase of adolescence, occurred only in females, was synonymous with a suicide attempt, and was an indicator of a psychological disorder (Rissanen et al., 2008); each of these beliefs reflects a common misconception about NSSI (Klonsky, Victor, & Saffer, 2014). For this reason, perceived NSSI literacy may differ from actual NSSI literacy. However, given that self-efficacy is the belief that one has the ability to perform a specific behaviour (Bandura, 1977, 1986), it is the self-perception of possessing these skills and knowledge that is expected to impact self-efficacy. Perceived NSSI literacy reflects perceived performance or mastery of knowledge and skills specifically related to parenting a youth who self-injures. Experiencing success with challenging situations is likely to increase expectations of success in future situations, thereby increasing self-efficacy (Bandura, 1977).

**Emotion Regulation Skills.** Parenting self-efficacy needs to be considered within the context of parents’ ability to regulate their emotions (Barros, Goes, & Pereira, 2015). Emotion regulation refers to the parent’s ability to experience, control, alter and express their emotional states in adaptive ways (Gratz & Roemer, 2004; Gross, 1998). This includes both the modulation of emotional arousal (Gross, 1998), as well as an ability to observe, understand and accept internal emotional experiences, and to act in ways that are consistent with goals and values regardless of emotional states (Gratz & Roemer, 2004). Parent emotion regulation may be central to parenting competence; emotions orient parents to their children’s needs and motivate them to respond (e.g., Dix, 1991). Parent emotion dysregulation has been linked to inappropriate emotion expression during parenting, and may contribute to harsh or punitive parenting styles (Barros et al., 2015; Dix, 1991). In contrast, parents with more adaptive emotion regulation strategies may be better able to use effective responses to youth negative affect (Barros et al., 2015; Dix, 1991; Remmes & Ehrenreich-May, 2014; Rutherford et al., 2015). For example, one study found that
parents who used reappraisal as an emotion regulation strategy also provided more emotion coaching responses towards their adolescents with anxiety or depression (Remmes & Ehrenreich-May, 2014).

Stressful parenting situations may also elicit emotional arousal that influences the parent’s perceived parenting competency (Bandura, 1977; Barros et al., 2015; Rutherford, Wallace, Laurent, & Mayes, 2015). High arousal usually has a detrimental effect on performance (Bandura, 1977; Barros et al., 2015; Rutherford et al., 2015). For example, physiological hyperarousal has been linked to caregiver aggression towards children (McCanne & Hagstrom, 1997) Furthermore, parents with low self-efficacy may demonstrate increased physiological reactivity when anticipating interactions with difficult children, relative to parents with high self-efficacy (Bugental & Cortez, 1988). When parents are better able to regulate their arousal they may be more likely to expect successful parenting performances (Bandura, 1977; Barros et al., 2015; Rutherford et al., 2015). To this end, a small pilot study examining a mindfulness-based parenting intervention found that when parents were more aware of their own emotions, their parenting was less reactive and more thoughtful (Duncan, Coatsworth, & Greenberg, 2009). Thus, parenting self-efficacy may be influenced by the parent’s emotion regulation skills (Barros et al., 2015).

Social Support. Social support is the perception that one is part of a social network where they are cared for and may receive assistance. Receiving social support is believed to enhance coping by altering cognitions, and may lead to potential threatening situations being perceived as less stressful (see Lakey & Cohen, 2000). Perceived social support around parenting challenges is expected to increase the parent’s belief that they can successfully cope with these challenges. When parents believe they can cope with parenting challenges, parenting self-
efficacy increases. Researchers have suggested that parents with greater social support may indeed feel more efficacious as parents (e.g., Gao, Sun, & Chan, 2014; Izzo, Weiss, Shanahan, & Rodriguez-Brown, 2000).

Proposed Model

The theoretical model (Figure 3.1) underlying this study was informed by Bandura’s theory of self-efficacy (Bandura, 1977, 1986), outlined above. Within the proposed model, parents of youth who self-injure experience increased parenting stressors in the form of their youth’s mental health challenges. This parenting stress leads to a decrease in both parenting self-efficacy (i.e., perceived ability to parent and support the youth who self-injures) and psychological wellbeing (i.e., increased depression and anxiety, increased stress, decreased quality of life)—these psychological wellbeing variables are believed to tap into the known impacts of youth NSSI on parents; Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). The relation between youth mental health challenges and parental psychological wellbeing is expected to be at least partially mediated by parenting self-efficacy. Finally, when a youth self-injures, parenting self-efficacy is expected to be influenced by the parent’s perceived NSSI literacy, emotion regulation skills, and social support.

Hypotheses

This study tested the model linking youth NSSI with parent wellbeing through parenting self-efficacy (Figure 3.1). First (Question 1), it was hypothesized that parent perceptions of greater youth mental health challenges would be correlated with lower scores in parenting self-efficacy, and both parent perceptions of greater youth mental health challenges and lower parenting self-efficacy would be correlated with parent psychological wellbeing (i.e., higher levels of depression and anxiety, more perceived stress, lower quality of life). Second (Question
2), the relation between youth mental health challenges and parental psychological wellbeing was hypothesized to be at least partially mediated by parenting self-efficacy; that is, the relation between youth mental health challenges and parent wellbeing was expected to be explained through the relation with parenting self-efficacy. Finally (Question 3), among parents of youth who self-injure, low parenting self-efficacy was hypothesized to be correlated with lower NSSI literacy, greater emotion dysregulation and fewer social supports; given the novelty of linking these variables and the relatively small amount of research supporting this hypothesis, this analysis was exploratory and relations between the variables were further explored through subsequent mediation analyses.

**Methods**

**Participants**

This study received clearance by our Institutional Review Board prior to commencement. Parents and guardians of youth aged 11 to 18 with a history of NSSI were recruited via an advertisement on Facebook. Parents and guardians \((N = 112; n_{female} = 109, n_{male} = 2, n_{undisclosed} = 1)\) ranged in age from 31 to 55 years \((M_{age} = 41.90, SD_{age} = 5.995)\). Biological parents \((n = 103)\) comprised most of the sample, although adoptive parents \((n = 5)\), stepparents \((n = 2)\), and grandparents \((n = 2)\) were also represented. The majority of participants were married or common law \((n = 83)\), while the remaining parents were single and never married \((n = 11)\), divorced \((n = 10)\), separated \((n = 5)\), or widowed \((n = 3)\). Parents typically cared for multiple children \((M = 2.71\) children; median = 2.00 children, including the youth who self-injures). Most participants resided in Canada \((n = 60)\) or the United States \((n = 49)\); the remaining participants resided in Croatia, England and Serbia. Participants’ ethnicities included White \((n = 101)\),
Aboriginal \( (n = 8) \), Latin, Central or South American \( (n = 3) \), African \( (n = 1) \), and Multiracial \( (n = 4) \).

Youth, as reported by parents, ranged in age from 11 to 18 years (Mean age = 15.21, SD = 1.87). Female youth \( (n = 93) \) were overrepresented in this sample; in contrast, 16 youth were male, and 3 were identified as gender fluid. All youth had a history of NSSI, with the number of NSSI episodes believed by parents to be between 2 and 100,503 (Median number of episodes = 96). Self-cutting \( (n = 105) \) was the most common method of NSSI reported, followed by interfering with wound healing \( (n = 47) \), scratching \( (n = 41) \), banging or hitting \( (n = 25) \), pinching \( (n = 22) \), carving \( (n = 21) \), burning \( (n = 14) \), biting \( (n = 12) \), rubbing skin against rough surfaces \( (n = 8) \), and swallowing dangerous substances (i.e., pins; \( n = 1 \)). In addition to engaging in NSSI, 15 (13.4%) of the youth also had a history of self-poisoning, including overdosing on medications, with non-suicidal intention. Mental illness was common, with 71 (63.4%) of the youth having been diagnosed with some combination of mood disorders, anxiety disorders, eating disorders, adjustment disorders, personality disorders, and/or attention deficit hyperactivity disorder. Most of the youth lived with their parent or guardian full time \( (n = 92) \), though some lived there part time (e.g., shared custody, \( n = 11 \)), some visited \( (n = 6) \), and some resided in alternate care (e.g., hospitalization or residential treatment, \( n = 2 \)); only one youth did not visit with the parents.

**Measures**

*Inventory of Statements about Self-Injury (ISAS; Klonsky & Glenn, 2009; Klonsky & Olino, 2008).* The ISAS is a self-report questionnaire assessing key characteristics of NSSI behaviours (e.g., method, frequency, recency, age of onset, contextual factors). The ISAS has good internal consistency (Klonsky & Glenn, 2009; Klonsky & Onlino, 2008), test-retest
reliability (Glenn & Klonsky, 2011; Klonsky & Glenn, 2009; Klonsky & Onlin, 2008), and
good construct validity (Klonsky & Glenn, 2009; Klonsky & Onlin, 2008). The ISAS was used
to assess the youth’s NSSI behaviours from the perspective of the parent. Thus, the wording of
the ISAS was modified to assess the parent’s perception of the youth’s NSSI. Although the ISAS
has not been modified to obtain parent perspectives on NSSI, one published study (Batejan,
Swenson, Jarvi, & Muehlenkamp, 2015) has modified the ISAS to examine perception of NSSI
from the perspective of non-self-injuring college students; adequate internal consistencies were
found in that study (Batejan et al., 2015).

**Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997).** The SDQ is a
parent-report measure of a youth’s general mental health and wellbeing. This measure consists of
25-items across five scales (i.e., emotional problems, conduct problems, hyperactivity, peer
problems, and prosocial behaviours). A total difficulties score is calculated by summing the
scores from all scales except the prosocial behaviours scale; higher scores indicate more
difficulties. The SDQ has adequate validity and reliability (Cronbach’s $\alpha = .74$ for the total
difficulties score in this study) and has been widely used in research (e.g., Goodman, 2001;
Mellor, 2004).

**Parenting Sense of Competence scale (PSC; Johnston & Mash, 1989).** The PSC is a
17-item scale assessing satisfaction with the parenting role, parenting self-efficacy, and interest
in parenting (Gilmore & Cuskelly, 2008). Higher scores indicate a greater sense of competence.
This scale has been validated using samples including parents of adolescents (Gilmore &
Cuskelly, 2009). Though this measure has had adequate internal consistency in previous studies
(Johnston & Mash, 1989; Ohan et al., 2000; Gilmore & Cuskelly) questionable internal
consistency was obtained in the current study (Cronbach’s $\alpha = .64$).
Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke, Williams, & Patient Health Questionnaire Primary Care Study Group, 1999). The PHQ-9 consists of eight items assessing symptoms of depression (a ninth question, which assesses current suicide risk, was removed as per the Institutional Review Board’s regulations). Higher scores indicate a greater number of depressive symptoms. The PHQ-9 has adequate convergent and discriminant validity (e.g., Kroenke, Spitzer, & Williams, 2001), and excellent internal consistency (Cronbach’s $\alpha = .92$ in this study).

Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). The GAD-7 assesses symptoms of anxiety using seven items, and higher scores indicate the presence of more anxiety symptoms. This scale was chosen for its brevity in screening for common symptoms of anxiety that may be experienced by parents of youth who self-injure. The GAD-7 has had good convergent and discriminant validity (e.g., Spitzer et al., 2006), and excellent internal consistency (Cronbach’s $\alpha = .92$ in this study).

Perceived Stress Scale (PSS; Cohen, Kamarch, & Mermelstein, 1983). The PSS uses ten items to measure the amount of stress that parents perceive themselves to have experienced over the past month. Higher scores reflect higher levels of perceive stress. The PSS has good convergent and discriminant validity (Cohen et al., 1983), and excellent internal consistency (Cronbach’s $\alpha = .92$ in this study).

Satisfaction with Life Scale (SLS; Diener, Emmon, Larson, & Griffin, 1985). The SLS is a 5-item self-report scale measuring global satisfaction with life, and higher scores indicate greater life satisfaction. This scale has been shown to have excellent reliability (Cronbach’s $\alpha = .90$ in this study) and adequate validity (Pavot, Diener, Colving & Sandvik, 1991; Pavot & Diener, 1993).
Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). The DERS is a 36-item self-report scale that measures difficulties in emotion regulation on six dimensions (i.e., non-acceptance of emotional responses, difficulties engaging in goal directed behaviour, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, lack of emotional clarity). Scores are tallied for each of the six dimensions as well as overall. Higher scores indicate greater emotion dysregulation. The DERS has excellent reliability (Cronbach’s $\alpha = .95$ for the overall score in this study) and adequate validity (Gratz & Roemer, 2004), and has been used extensively in NSSI research.

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS consists of 12-items measuring perceived social support from three sources: family, friends, and a significant other, which are summed to generate a composite social support score. Higher scores indicate greater perceived social support. This measure is self-report and uses a Likert scale. The MSPSS has excellent internal consistency (Cronbach’s $\alpha = .96$ overall in this study), and convergent and discriminant validity (Zimet et al., 1988).

Perceived NSSI Literacy. As there is currently no questionnaire assessing parent knowledge of NSSI, this domain was assessed using a questionnaire developed specifically for this study. This measure, which examines the parent’s perceived competence in NSSI literacy, includes 13-items developed by combining the mental health literacy literature (e.g., Jorm 2000; 2012) and the literature suggesting that parents struggle with understanding NSSI as a chosen behaviour and are unsure of how to support their youth (see Arbuthnott & Lewis, 2015). Several experts in the field previewed the items to ensure face validity. This questionnaire was piloted
during this study and achieved good internal consistency (Cronbach’s $\alpha = .88$). Higher scores indicate greater perceived NSSI literacy.

**Procedure**

All participation took place online. Potential participants were directed to the study website via advertisements on Facebook; the study website provided an overview of the study and a link to the online survey. Although participants chose when and where to complete the survey, the initial survey had to be completed in a single session. Upon accessing the online survey, participants provided informed consent for participation and complete two eligibility questions (i.e., one question verifying that the participant was a parent of a youth who has self-injured, and another question verifying that the participant was at least 18 years old). Participants then completed the study measures in the following order: parent demographics questionnaire, parenting self-efficacy measure (i.e., PSC), parent wellbeing measures (i.e., PHQ-9, GAD-7, PSS, SLS), parent emotion regulation measure (i.e., DERS), parent social support measure (i.e., MSPSS), parent-reported youth demographics questionnaire, parent-reported youth NSSI questionnaire (i.e., modified ISAS), NSSI literacy questionnaire, parent-reported youth mental health and wellbeing measure (i.e., SDQ).

Following these measures, although not part of this phase of the project, a help-seeking questionnaire was also administered and will be further discussed in Chapter Four. Participants then took part in a mood restoration task in which they watched funny cat videos, and were debriefed (including the provision of NSSI resources). Participants were provided with opportunities to enter a draw for a $50CAD Amazon e-gift certificate for participation, and to enter their email address if they wished to take part in the next phase of the study (see Chapter
Four); all email addresses were kept separate from study data, such that emails could never be linked to individual participant responses.

**Results**

**Analytic Plan**

Several analyses were undertaken to explore the relations between study variables. First (to assess Question 1), study variables were correlated to understand the associations between them. Next (to assess Question 2), the mediating role of parenting self-efficacy (i.e., PSC) on the relations between parent-reported youth mental health challenges (i.e., SDQ) and each of the parent wellbeing variables (i.e., PHQ-9, GAD-7, PSS, SLS) was assessed using four mediation analyses (i.e., one for each of the four parent wellbeing variables). Results were based on 10,000 bootstrapped samples and 95% bias corrected and accelerated confidence intervals (Hayes, 2009), and were obtained using the Process macro for SPSS (Hayes, 2013).

Finally (to assess Question 3), stepwise regression was used to determine the extent to which perceived NSSI literacy, emotion regulation skills (DERS), and social support (MSPSS) would predict parenting self-efficacy while controlling for youth mental health challenges. Youth mental health challenges was entered in Step 1; emotion regulation, social support and NSSI literacy were entered in Step 2. The unique variance in parenting self-efficacy accounted for by each of the predictors was examined.

To further explore the relations between NSSI literacy, emotion regulation skills, social support, and parenting self-efficacy, the potential mediating role of emotion dysregulation was explored through mediation analyses. Two mediation analyses using two separate independent variables (i.e., social support, NSSI literacy) were conducted. Results were again based on
Correlation analyses (Table 3.1) revealed small to medium relations between youth mental health challenges and parent wellbeing, small relations between youth mental health challenges and parenting self-efficacy, and medium relations between parenting self-efficacy and parent wellbeing (i.e., PHQ-9, GAD-7, PSS, SLS).

Question 2: Self-Efficacy as a Mediator Variable

Formal tests of statistical mediation (Figure 3.2) revealed that parenting self-efficacy partially mediated the relation between youth mental health challenges and each parent wellbeing variable. Confidence intervals for all indirect pathways did not include zero (Bootstrapping BCa 95% CI: PHQ-9 = .04 to .20; GAD-7 = .03 to .14; PSS = .04 to .24; SLS = -.21 to -.03). The direct effects of youth mental health challenges were no longer significant at the \( p < .05 \) level on parent depression (PHQ-9), parent stress (PSS) and parent life satisfaction (SLS); there remained a statistically significant—though reduced—direct effect of youth mental health challenges on parent anxiety (GAD-7).

Question 3: Predictors of Self-Efficacy

Youth mental health challenges predicted 7% of the variance in parenting self-efficacy, \( F(3, 95) = 7.25, p = .008 \). Together, emotion regulation, social support and NSSI literacy predicted an additional 13% of the variance in parenting self-efficacy beyond that which was predicted by youth mental health challenges, \( \Delta F(4, 92) = 5.74, p = .001 \). When all four variables were included in the regression, only emotion regulation predicted unique variance in parenting self-efficacy \( (sr^2 = .11, t(92) = -3.61, p = .001) \), while the unique variance predicted by youth
mental health challenges trended towards significance, $\text{sr}^2 = .03$, $t(92) = -1.92$, $p = .06$. Neither perceived NSSI literacy nor social support predicted unique variance in parenting self-efficacy (perceived NSSI literacy: $\text{sr}^2 = .00$, $t(92) = .12$, $p = .91$; social support: $\text{sr}^2 = .01$, $t(92) = -.93$, $p = .35$).

As shown in Figure 3.3, emotion dysregulation mediated the relation both between NSSI literacy and parenting self-efficacy, as well as between social support and parenting self-efficacy. Correlation analyses (Table 3.2) revealed small effect sizes both between perceived NSSI literacy and parenting self-efficacy, and between social support and parenting self-efficacy. The relation between emotion dysregulation and parenting self-efficacy was medium. Confidence intervals for all indirect pathways fell above zero (Bootstrapping BCa 95% CI: Perceived NSSI Literacy = .07 to .40; Social Support = .72 to 2.80). The direct effects of perceived NSSI literacy and social support on parenting self-efficacy were no longer significant.

**Discussion**

This study used mediation analyses to test the sufficiency of the proposed model describing the relation between youth mental health challenges, parent wellbeing, and parenting self-efficacy among parents of youth who self-injure. Factors affecting parenting self-efficacy (i.e., perceived social support, NSSI literacy, parent emotion regulation) were also explored. This model provides a preliminary understanding of how these variables may work together to affect parents’ wellbeing and thus the parents’ ability to support their youth. It extends the current literature by examining possible processes, rather than focusing on isolated parent variables that may affect parents and youth throughout the youth’s recovery process. Thus, this study provides a springboard for further research into understanding the mechanisms through which parents
support their youth, and avenues for potential interventions that may further equip parents for this task.

First, as hypothesized in Question 1, parents’ perceptions of greater youth mental health challenges were associated with poorer parent wellbeing (i.e., increased depression, anxiety and perceived stress, and decreased life satisfaction). Thus, when youth are emotionally unwell, parents may be more likely to experience symptoms of depression, anxiety, stress, and lower life satisfaction. This is consistent with the impact of youth NSSI on parent wellbeing previously reported qualitatively in the literature (see Arbuthnott & Lewis, 2015; Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2009b). Although these symptoms may not specifically be caused by the challenges youth experience, these challenges may be contributing factors to parent wellbeing (e.g., Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2009b).

Next, also as hypothesized in Question 1, parenting self-efficacy was found to account for greater parent wellbeing. This extends Bandura’s theory of self-efficacy (Bandura, 1986) to parents of youth who self-injure. These results are also consistent with previous research suggesting that parenting self-efficacy influences parent wellbeing both among parents in general (e.g., Gross, Conrad, Fogg, & Wothke, 1994; Hasting & Brown, 2002; Streisand et al., 2008) and among parents of children with special needs (Kuhn & Carter, 2006; Streisand, Swift, Wickmark, Chen, & Holmes, 2005). Among parents of youth who self-injure, specifically, greater parenting self-efficacy is associated with greater parent wellbeing in the form of lower levels of depression, anxiety and stress, as well as greater life satisfaction.

Among this sample of parents of youth who self-injure, parenting self-efficacy was found to statistically mediate the relation between parents’ perceptions of youth mental health
challenges and parent wellbeing variables; this result is consistent with the hypothesis for Question 2. Although few studies to date have explored this specific relation, two studies have found a meditational role of parenting self-efficacy on the relation between parenting stress or child behaviour problems and anxiety and depression among mothers of children with autism spectrum disorder (Hastings & Brown, 2002; Rezendes & Scarpa, 2011). In one study, parenting self-efficacy partially accounted for the relation between parenting stress and mother’s anxiety and depression, such that decreases in parenting self-efficacy were associated with increases in anxiety and depression (Rezendes & Scarpa, 2011); in the presence of high parenting stress (in the form of the child’s greater level of difficulties), high self-efficacy may have served as a protective factor in mothers’ mental health. Parenting self-efficacy may have a similar protective role for parents of youth who self-injure.

Finally, the influence of perceived parent NSSI literacy, emotion regulation, and perceived social support on parenting self-efficacy was also explored in this study through Question 3. Although perceived NSSI knowledge and skills, emotion regulation, and perceived social support each predicted greater parenting self-efficacy individually, only emotion regulation accounted for unique variance in parenting self-efficacy. Emotion regulation mediated the relation between parenting self-efficacy and both perceived NSSI literacy and perceived social support. These results support the literature suggesting that parents’ ability to regulate their own emotions may be a key factor in determining how they feel about their parenting abilities (Barros et al., 2015; Rutherford et al., 2015). These results may also extend this literature by suggesting a pathway in which parent emotion regulation is central in allowing the parent to gain self-confidence in the integration of support, knowledge and skills into parenting situations. Together, parent emotion regulation and parenting self-efficacy may influence the
parent’s ability to self-regulate during challenging parenting situations (Barros et al., 2015; Rutherford et al., 2015), which may in turn affect parents’ ability to effectively support their youth. Further research is needed to confirm the exploratory results from this study.

**Clinical Implications**

The results from this study may have several implications for clinical practice with youth who self-injure and their families. First, they provide evidence for the inclusion of a parent component in interventions targeting youth NSSI, regardless of whether the youth themselves is in treatment. To this end, several treatment modalities for youth NSSI already include parent components (for reviews see Interventions Involving Parents in Chapter Two; Arbuthnott & Lewis, 2015; Glenn, Franklin, & Nock, 2015). Working with parents may benefit parents directly by improving parents’ wellbeing and mental health (Woodberry & Popenoe, 2008). However, given the link between parenting self-efficacy and parenting competence, it may also benefit the youth through more effective parenting (e.g., Coleman & Karraker, 1997; Jones & Prinz, 2005) and improved family functioning (Pineda & Dadds, 2013; Woodberry & Popenoe, 2008) as the parents may be better equipped to support the youth. Future research should examine the relation between changes in parenting self-efficacy and parents’ ability to support youth.

Although providing information about NSSI and ensuring that parents have adequate social supports and self-care practices may be useful to reduce parent stress, it may also be beneficial to provide parents with support around emotion regulation. This may help parents to better regulate their own affect, which may, in turn, foster more effective responses towards their youth (Barros et al., 2015; Rutherford et al., 2015). One study examining the use of parent emotion regulation strategies and parent responses to youth with diagnoses of anxiety or depression found a positive relationship between parent-reported use of adaptive emotion
regulation strategies (e.g., reappraisal) and emotion-coaching responses to youth negative affect (Remmes & Ehrenreich-May, 2014). Thus, the ability to regulate their own affect may allow parents to both model adaptive emotion regulation and to coach their youth through difficult emotions (Rutherford et al., 2015). Further research is needed to assess the mechanisms by which parent components of interventions for youth NSSI may enhance the parents’ ability to support their youth.

**Limitations and Future Directions**

There are several limitations related to this study’s methodology that should be considered when interpreting the present findings. First, participants were predominantly mothers, biological parents of the youth who self-injure, married or common law, and White. These demographic factors may limit the generalizability of the results. Self-efficacy may have a different effect among fathers in particular. Research with parents of children with other mental health difficulties supports the need to examine mothers and fathers separately. In one study of parents of children with autism spectrum disorder, a mediating role between child behaviour problems and parent anxiety and depression applied only to mothers and no mediating effect was observed among fathers (Hastings & Brown, 2002). Thus, further research should focus on recruiting fathers for studies on parenting self-efficacy among parents of youth who self-injure, as this may provide valuable information about the roles that fathers may play in supporting these youth. Similarly, more research is needed with caregivers who are not biological parents (e.g., stepparents, grandparents, foster parents), who are single parents (e.g., never married, separated, divorced, widowed), and with more ethnically diverse parents.

Next, this study used a correlational design and assumptions regarding causality cannot be made. Thus, there is insufficient evidence to conclude that youth mental health challenges
cause decreases in parents’ wellbeing, or that parenting self-efficacy causes improved parents’ wellbeing. Similarly, the relation between parents’ emotion regulation and parenting self-efficacy is correlational; while it is logical to assume that increasing parents’ emotion regulation skills would improve self-efficacy, it is also possible that a third variable influences both parents’ emotion regulation and parenting self-efficacy. As emotion regulation, perceived NSSI knowledge and skills, and perceived social support together accounted for only 17% of the variance in parenting self-efficacy, further research is needed to elucidate other factors (e.g., parents’ attachment style, parent-child interaction; Coleman & Karraker, 1997) that may influence parenting self-efficacy. Research examining parent and parent-child variables throughout interventions that include parent components may be particularly valuable in determining the mechanisms of change for parenting self-efficacy and parents’ wellbeing.

This study used parenting self-efficacy as a proxy for actual parenting competence, and parents’ perceived NSSI literacy was used in lieu of measured NSSI knowledge and skills. Thus, this study assessed parents’ cognitions in these areas rather than their performance. Research suggests that parenting self-efficacy is strongly associated with parenting competence (Coleman & Karraker, 1997; Jones & Prinz, 2005). Indeed, parenting self-efficacy may actually exert a greater influence on parenting competence under stressful circumstances as these situations rely more heavily on cognitive resources including self-efficacy (see Coleman & Karraker, 1997). Nonetheless, further research is necessary to determine the extent to which cognitions about abilities (i.e., parenting self-efficacy, perceived NSSI literacy) predict competence (i.e., parenting competence, actual NSSI knowledge and skills) within this specific population.

Similarly, the parent’s perception of their youth’s mental health challenges was the only means of assessing the youth’s mental health challenges in this study. However, parent’s
perception of their youth’s challenges may have been influenced by the parent’s own sense of wellbeing. The inclusion of youth reports of parenting variables alongside parents’ reports may allow youth and parent reports to be compared and contrasted, such that it may elucidate key information about the youth’s perspective of how parents may be best equipped to support their youth.

A final limitation of this study is that only perceived NSSI literacy was measured, and other aspects of perceived mental health literacy (e.g., knowledge and skills related to comorbid diagnoses) were not included. Parents in this study reported that a high proportion of the youth were experiencing a mental illness in addition to the NSSI. Thus, the measure of perceived NSSI literacy may have been insufficient to capture the perceived knowledge and skills that parents require to manage their youth’s mental health challenges beyond NSSI. A measure of overall mental health literacy that includes a wider range of mental health challenges may more accurately capture the influence of perceived mental health literacy on parenting self-efficacy. Future research should explore the effect of mental health literacy on parent variables.

This model was developed to examine parenting self-efficacy and parent wellbeing among parents of youth who self-injure, specifically. However, it may also be applicable to parents of youth experiencing other mental health challenges. Further research extending this model to other mental health challenges may elucidate trans-diagnostic mechanisms that enable parents to support their youth, regardless of the youth’s specific mental health difficulties. This knowledge may, in turn, allow clinicians to better support parents as they support their youth.

Conclusion

Parents may have a critical supportive role in a young person’s recovery from NSSI (e.g., Arbuthnott & Lewis, 2015; Hollander, 2008). However, youth NSSI may have a considerable
impact on parent wellbeing and mental health (e.g., Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). This study assessed a model in which parenting self-efficacy partially mediated the relation between parents’ perceptions of youth mental health challenges and parent wellbeing (i.e., anxiety, depression, stress, decrease life satisfaction). Furthermore, parenting self-efficacy was predicted by parent emotion dysregulation, which also mediated the relation between parent self-efficacy and both parent NSSI literacy and social support. These results have a variety of theoretical implications for the proposed model, and clinical implications for working with parent of youth who self-injure.
Table 3.1. Zero-order correlations between model variables.

<table>
<thead>
<tr>
<th>Measure</th>
<th>SDQ</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>PSS</th>
<th>SLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSC</td>
<td>.29**</td>
<td>-.43***</td>
<td>-.37***</td>
<td>-.40***</td>
<td>.34***</td>
</tr>
<tr>
<td>SDQ</td>
<td>.27**</td>
<td>.35***</td>
<td>.33***</td>
<td>-.18*</td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td></td>
<td>.76***</td>
<td>.76***</td>
<td>-.43***</td>
<td></td>
</tr>
<tr>
<td>GAD-7</td>
<td></td>
<td></td>
<td>.72***</td>
<td>-.62***</td>
<td></td>
</tr>
<tr>
<td>PSS</td>
<td></td>
<td></td>
<td></td>
<td>-.62***</td>
<td></td>
</tr>
</tbody>
</table>

Note: PSC = Parenting Sense of Competence Scale (parenting self-efficacy); SDQ = Strengths and Difficulties Questionnaire (youth wellbeing); PHQ-9 = Patient Health Questionnaire (depression screen); GAD-7 = Generalized Anxiety Disorder scale (anxiety screen); PSS = Perceived Stress Scale; SLS = Satisfaction with Life Scale.

*** p < .001  
** p < .05  
* p < .10
Table 3.2. Zero-order correlations between variables predicting parenting self-efficacy.

<table>
<thead>
<tr>
<th>Measure</th>
<th>NSSI Lit</th>
<th>DERS</th>
<th>MSPSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSC</td>
<td>.18*</td>
<td>-.43***</td>
<td>.23**</td>
</tr>
<tr>
<td>NSSI Lit</td>
<td></td>
<td>-.34**</td>
<td>.22**</td>
</tr>
<tr>
<td>DERS</td>
<td></td>
<td></td>
<td>-.47***</td>
</tr>
</tbody>
</table>

Note: PSC = Parenting Sense of Competence Scale (parenting self-efficacy); NSSI Lit = Perceived NSSI Literacy; DERS = Difficulties with Emotion Regulation Scale (emotion regulation skills); MSPSS = Multidimensional Scale of Perceived Social Support (social support)

*** $p < .001$
** $p < .05$
* $p < .10$
Figure 3.1. Proposed model of parenting self-efficacy as a mediator of the relation between youth mental health challenges and parent wellbeing. Parenting self-efficacy is hypothesized to be affected by parent knowledge, skills, and social support.
**Figure 3.2.** Parenting self-efficacy mediates the relation between youth mental health challenges and parent wellbeing.
Figure 3.3. Emotion dysregulation mediates the relations between perceived NSSI literacy (above) and parenting self-efficacy, as well as between social support (below) and parenting self-efficacy.
Chapter Four

What do parents need and where are they getting help?:

The viability of the Internet as a means to equip parents to support youth who self-injure

Parents have a unique supportive role for youth recovering from NSSI (Arbuthnott & Lewis, 2015; Rissanen, Kylma, & Laukkanen, 2009b); however, parents themselves may not be receiving sufficient support for this position (see Arbuthnott & Lewis, 2015 for a review; Hollander, 2008; McDonald, O’Brien, & Jackson, 2007; Oldershaw, Richards, Simic, & Schmidt, 2008). Indeed, NSSI can have a considerable social and emotional impact on parents (see Arbuthnott & Lewis, 2015; Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). This study examined the impact of youth NSSI on parents, the needs of parents of youth who self-injure, the means by which parents attempt to have these needs met (e.g., through seeking help for their youth and themselves), and the viability of the Internet as a medium to support parents.

Impact on Parents and Parents’ Needs

Supporting a youth who self-injures can be extremely difficult for parents (see Chapter Two for a full review of the literature regarding the impact of youth NSSI on parents; Arbuthnott & Lewis, 2015). Parents report a variety of negative emotions (e.g., sadness, shame, disappointment, anger; Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). They may struggle to understand NSSI as a chosen behaviour (Oldershaw et al., 2008; Rissanen et al., 2008), and to know how to support the youth (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008). Parenting burden may increase (Oldershaw et al., 2008), while parenting confidence decreases (Byrne et al., 2008; McDonald et al., 2007). Parents may also have difficulties balancing the needs of various family
members (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008), and may neglect their own needs (Oldershaw et al., 2008).

The literature suggests that parents have four key unmet needs in regards to supporting their youth who engage in NSSI. First, parents may need access to accurate information about NSSI (Byrne et al., 2008). Parents express wanting to make sense of their youth’s NSSI (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008); however, many parents believe misconceptions about NSSI that may hinder their ability to understand and support their youth (Byrne et al., 2008; Oldershaw et al., 2008; Rissanen et al., 2008). For example, some parents hold the misconceptions that NSSI only occurs in female adolescents and that it is a typical phase of development, or that NSSI is a suicide attempt or indicator of a psychological disorder (Rissanen et al., 2008).

Next, parents may need more effective parenting skills (Byrne et al., 2008). Indeed, typical difficulties associated with parenting adolescents (e.g., setting limits, allowing independence, peer pressure, bullying, Internet use) may be exacerbated in the presence of NSSI (Byrne et al., 2008; Oldershaw et al., 2008). Parenting burden and stress (Oldershaw et al., 2008), a loss in parenting confidence (Byrne et al., 2008; McDonald et al., 2007), challenges balancing the needs of all family members (Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008), and financial strains resulting from caring for the youth with NSSI (Ferrey et al., 2016; McDonald et al., 2007) may make supporting the youth with NSSI more difficult. Nonetheless, many parents recognize the importance of their support for the youth’s wellbeing and hope to both rebuild a positive relationship with the youth and assist the youth to develop healthy coping strategies (Byrne et al., 2008; Ferrey et al., 2016).
Third, parents may need to practice self-care to ensure that they themselves are emotionally healthy and thus are able to best support their youth (Ferrey et al., 2016; Oldershaw et al., 2008; Power et al., 2009). Indeed, supporting a youth who self-injures can be emotionally taxing for parents (Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2009b), and some parents report the onset or worsening of clinical depression in reaction to the youth’s NSSI (Ferrey et al., 2016). Some parents may alter their lives (e.g., limit lifestyle, change employment) in an attempt to increase support for the youth (Ferrey et al., 2016; Oldershaw et al., 2008). It is not uncommon for parents to deny their own needs in favour of meeting those of their youth (Oldershaw et al., 2008). Indeed, parents report becoming “worn down” as their youth’s NSSI continues (Ferrey et al., 2016).

Finally, parents report a need for peer support (Byrne et al., 2008; Rissanen et al., 2009b). Many parents have expressed feeling helpless and overwhelmingly alone due to the youth’s NSSI (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). Some parents hope that access to other parents of youth who self-injure would allow them to share their circumstances, learn from each other, and to feel less alone (Byrne et al., 2008). This isolation may be intensified by the stigma associated with NSSI (Byrne et al., 2008; Ferrey et al., 2016).

**Help-Seeking**

Parents may have a key role in initiating treatment for youth NSSI (Clarke et al., 2004; Fadum et al., 2013; Rissanen et al., 2009b). However, many parents report having difficulties finding and accessing services and professional supports for their youth in relation to the NSSI (Byrne et al., 2008). Some parents even report the need to keep the youth’s problems private (Ferrey et al., 2016). No study to date has formally examined from whom or where parents of youth who self-injure seek help, either for their youth or for themselves, and only one study
(Ferrey et al., 2016) has shed light on the types of help that parents may obtain for themselves. In this study, parents reported receiving help through various forms, including medications (e.g., antidepressants), counselling (e.g., cognitive-behavioural therapy) and mindfulness training (Ferrey et al., 2016). Although parents felt they could only help their youth if they were taking care of themselves, several parents in this study did not seek help for themselves when this was needed (Ferrey et al., 2016). More research is needed to understand help-seeking from the parent’s perspective.

**Internet Use**

Parents may use the Internet to access both information and social support (Plantin & Daneback, 2009). That parents frequently use the Internet to search for information related to their children’s medical conditions has been well documented in the literature (e.g., Tuffrey & Finlay, 2002; Plantin & Daneback, 2009; Wainstein, Sterling-Levis, Baker, Taitz, & Brydon, 2006). Due to increased stigma associated with mental health difficulties, parents of youth with these difficulties may be even more likely to turn to electronic resources to obtain information (e.g., Oh, Jorm, & Wrigth, 2009) and social support that is not being accessed offline (e.g., Scharer, 2005). Indeed, one study testing a web-based program for enhancing general mental health literacy among parents found that parents reported both greater knowledge of mental health concerns among youth, as well as greater self-efficacy to deal with these concerns following the intervention (Dietz et al., 2009). Thus, the Internet may have the potential to be a particularly effective medium to educate parents about more stigmatized mental health issues such as NSSI, and to equip parents to support their youth with these difficulties.
Proposed Study

This study examines the perceived impact of NSSI on parents, parents’ perceived needs for supporting their youth, help-seeking with respect to the youth NSSI (i.e., from where or whom parents seek help for their youth and for themselves, barriers to help-seeking, and what constitutes a helpful response), and parents’ reports on how the Internet could be used as a medium to support them as they support their youth. As this study is exploratory, no hypotheses are made.

Methods

Participants

This study received clearance by our Institutional Review Board prior to commencement. Parents and guardians of youth (aged 11 to 18) with a history of NSSI were recruited via an advertisement on Facebook. The initial survey was completed by 112 participants; demographic variables for these participants are described in Chapter Three. Of the participants who completed the initial survey, 39 completed a follow-up short answer survey. There were no statistically significant difference on any of the demographic variables between participants who took part in the follow-up survey and those who did not, either in terms of parent variables or parent-reported youth variables.

Measures

Inventory of Statements about Self-Injury (ISAS; Klonsky & Glenn, 2009; Klonsky & Olino, 2008). Data from the ISAS used in the initial survey were also used in this phase of the study; detailed information about the ISAS can be found in Chapter Three.

NSSI Help Seeking Questionnaire. Participants reported the help-seeking activities that they have engaged in with respect to the youth’s NSSI. This included help both for themselves,
as parents of a youth who has engaged in NSSI, and for their youth who has self-injured. Participants indicated whether they had sought help from a variety of different sources (i.e., Internet, friends, family, family doctor, school personnel, psychologist, social worker, other counselor), and rated the perceived helpfulness (i.e., very helpful, somewhat helpful, neither helpful nor unhelpful, somewhat unhelpful, not at all helpful) for each of these sources. Participants were also asked to reflect on what was helpful and unhelpful when they sought help, and what barriers might prevent them from seeking help. Finally, parents were asked to indicate what types of support they would like to use the Internet to obtain, and the extent to which they would expect different types of e-content (e.g., information about NSSI, quizzes to self-test NSSI knowledge, self-help resources, e-forums, videos, stories from other parents) to be useful towards helping them to support their youth who self-injures.

**Follow-Up Needs Questionnaire.** The follow-up needs questionnaire consisted of five open-ended questions: How has your youth’s self-injury affected your parenting (e.g., your ability to parent, your confidence as a parent)?; How has your youth’s self-injury affected your own mental health and wellbeing?; What role has the Internet had in your journey through your youth’s self-injury?; What do you think parents and guardians need to help them better support their youth who have self-injured?; How could the Internet meet these needs or be used as a more effective resource for parents of youth who have self-injured? What features of topics would be most useful in an online program to support parents of youth who have self-injured? Asking these questions in a follow-up survey allowed parents a greater opportunity to think about their responses prior to responding, and may also have reduced fatigue effects among participants who agreed to participate.
**Procedure**

Participation took place online through two surveys; participant recruitment and the procedure for the initial survey are outlined in detail in Chapter Three. This initial survey included the NSSI help-seeking questionnaire after the administration of the other study questionnaires described in Chapter Three. Following completion of this initial survey, participants were invited to complete the second survey, which consisted of the follow-up needs questionnaire. Those participants who wished to take part in the follow-up survey were emailed a unique link to the second survey. While the initial survey was completed in a single sitting; the second survey could be completed over a period of up to two weeks to allow participants to carefully consider their open-ended responses. Following each survey, participants took part in a mood restoration task that consisted of watching a funny cat video, were debriefed (including the provision of NSSI resources), and had the opportunity to be entered into a draw for a $50CAD Amazon e-gift certificate for participation. Data from the initial and follow-up surveys were linked through a unique participant code generated by the participant; five participants used different codes for each survey, which prevented the linking of their data between surveys.

**Results**

**Analytic Plan**

Four broad questions were explored through this study. Question 1: What is the impact of youth NSSI on parents? Question 2: What do parents believe they need in order to effectively support their youth? Question 3: (a) Where are parents seeking help with respect to their youth’s NSSI and how helpful do parents perceive these sources to be, (b) what are the barriers to help-seeking, and (c) what do parents find to be helpful when they seek help? Question 4: (a) How
can the Internet be used as a medium to more effectively support parents, and (b) what types of e-content do parents believe would be most helpful?

To answer these questions, analyses began with thematic analyses (Braun & Clarke, 2006; 2013) conducted to understand the impact of NSSI on parents (Question 1) and the perceived needs of parents of youth who self-injure (Question 2), as captured in the Follow-Up Questionnaire. Next, help-seeking reported on the NSSI Help-Seeking Questionnaire was examined both quantitatively and qualitatively. This includes frequencies of where participants have sought help for their youth and for themselves, with respect to the youth’s NSSI, and how helpful these sources were (Question 3a). Thematic analyses were then used to extract themes about the perceived barriers that prevent help-seeking (Question 3b), and what was helpful when help was sought (Question 3c). Finally, the ways in which the Internet could be used to support parents was explored through responses on both the Follow-Up Questionnaire and the NSSI Help-Seeking Questionnaire. Here, a thematic analysis was conducted on the text responses from the Follow-Up Questionnaire’s Internet usage questions (Question 4a), and frequencies were used to assess the perceived utility of specific types of NSSI e-content on the NSSI Help-Seeking Questionnaire (Question 4b).

A thematic analysis approach to analysing the data was chosen because it captures the experiences and perceptions of participants, allows for patterns in the participants’ responses to be collated into meaningful themes that answer the research questions, and is useful across phenomenological epistemologies (Braun & Clark, 2006; 2013). In contrast to an approach like grounded theory, thematic analysis allows for the consideration and integration of current literature when developing themes (Braun & Clark, 2006). Unlike a qualitative content analysis approach, there was no attempt to quantify the extracted themes or impart significance based on
frequency of themes (Braun & Clark, 2006; Vaismoradi, Turunen, & Bondas, 2013); quantifying themes may inadvertently minimize the experiences of some participants, whereas the goal of this analysis was to identify and describe the multitude of participants’ experiences. All thematic analyses were conducted following Braun and Clarke’s (2006; 2013) methods, using a theoretical (“top-down”) and semantic approach to answer the specific research questions (i.e., Questions 1, 2, 3b, 3c, and 4a, described above). This occurred through several phases, in accordance with the steps prescribed by Braun and Clarke (2006, 2013):

1. In phase one, the researcher became familiar with the data. Here, the data corpus was read repeatedly. It quickly became apparent that almost all of the participants’ responses related to each of the five research questions were contained within the specific questionnaire item(s) that directly asked about their experiences in relation to that research question. For example, all responses related to barriers to help-seeking were contained within responses to the NSSI Help-Seeking Questionnaire items that asked participants what would prevent them from seeking help for their youth or for themselves. Thus, the data corpus was divided by relevant questionnaire items into five data sets that each focused on one of the research questions. In the few instances where the participant’s response also contained information related to another research question, these responses were also included in the data set related to the other research question. For example, in a response to a single questionnaire item asking about the impact of youth NSSI on parents, one participant discussed both the impact of their youth’s NSSI on their mental health (data extract related to Question 1), as well as what they needed from mental health professionals to maintain their mental health while supporting their
youth (data extract related to Question 2); in this case, this response was included in both datasets.

Once data sets were finalized, five thematic analyses (one for each of the five research questions) were conducted independent of each other. This approach was chosen as a means to ensure that the research questions were answered through the analysis without simply using the research questions as themes in and of themselves. Each dataset was then read repeatedly and the researcher began identifying potential codes. The researcher made notes of both key words extracted from the responses and summarizing words that described the participant’s stated experience. When identifying potential codes, the researcher focused on participant responses that pertained to the specific research question.

2. Phase two consisted of generating initial codes. Codes reduce participant responses into units that capture the participant’s salient experiences. Codes were identified at the semantic level in relation to the research question; key words (e.g., when participants explicitly stated that they blamed themselves for their youth’s NSSI, this was coded as *self-blame*), synonyms of words used by participants (e.g., when parents indicated in some way that they felt scared, terrified, or afraid as a result of their youth’s NSSI, this was coded as *fear*), and summarizing words describing the experiences reported by the participant (e.g., when parents described how they altered their parenting behaviours in some way as a result of the NSSI, this was coded as *parenting behaviour change*) were extracted and used as codes. There were times when the participants’ responses appeared to contradict the research question; these were also coded. For example, when asked about barriers to help-seeking, a *no barrier* code was generated to reflect that some
participants stated that nothing would prevent them from seeking help for their youth.

Once codes were identified, data extracts demonstrating each code were copied from the individual responses and collated together.

3. Phase three involved searching for themes. While codes were used to capture participant experiences at the individual level, themes represent patterns in participants’ experiences across the data set. Themes were identified through the meaningful cohesions of related codes. For some research questions, some of the initial themes at this phase were also informed by, but not limited to, the literature on the topic. For example, when arranging themes to examine the impact of youth NSSI on parents, initial themes were informed by the literature suggesting that themes related to an emotional impact and a parenting impact may be present (see Arbuthnott & Lewis, 2015; Ferry et al., 2016). Similarly, the literature suggested that the needs of parents may include themes related to obtaining information, gaining parenting skills, practicing self-care, and peer-support; (e.g., Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008; Rissanen et al., 2009b). Finally, in relation to the research question asking how the Internet could be used as a medium to support parents, the literature indicates that parents use the Internet to access both information and social support (Plantin & Daneback, 2009), which suggested that themes for this analysis may include obtaining information and accessing social support.

Other themes, not informed by the literature, were selected when codes cohered around a specific topic. For example, when assessing the impact of NSSI on parents, several codes cohered around the personal or interpersonal growth that had resulted from NSSI; thus, the theme *Recognition of Growth* was selected to represent this cohesion.
Relationships between codes and between themes were considered, and codes were rearranged until a set of candidate themes (including both themes informed by the literature and other themes) were chosen.

4. In phase four the themes were reviewed and refined. Data extracts within each theme were collated and the collated data extracts were read together to ensure that they meaningfully cohered within the theme. When data extracts did not cohere, themes were revised by refining the thematic map (e.g., adding or removing themes, rearranging codes between themes). This process was repeated until data extracts cohered in meaningful patterns. Next, the entire data set was reread with the themes in mind to ensure that the thematic map was an accurate reflection of the responses in the full data set.

5. In the fifth phase, themes were named to describe the essence of the themes’ content in relation to the research question. Care was also taken during this phase to ensure that there was minimal overlap between themes, and the relation of the themes to each other and to the research question was considered.

6. In the final stage, a report was generated. The collated data extracts for each theme were organized into a coherent account and a detailed analysis of the data within the theme was written into a narrative. Thematic maps for all analyses can be found in Figures 4.1 through 4.5.

**Question 1: Impact of Youth NSSI on Parents**

Two questions on the follow-up questionnaire asked participants to reflect on the impact of their youth’s NSSI on their own mental health and wellbeing, as well as on their parenting. Responses indicated that youth NSSI may have a considerable impact on parents. These responses were analyzed using thematic analysis to better understand this impact. Four themes
Elicitation of Difficult Emotions. The first theme that was extracted from the data was that NSSI has a profound emotional impact on parents and caregivers, and parents struggle with the difficult emotions that emerge while supporting their youth. Emotional reactions to the youth’s NSSI included guilt, fear and anxiety, sadness and grief, helplessness, anger, and feeling overwhelmed or burnt out. Participants often blamed themselves for their youth’s NSSI or for not having known about their youth’s NSSI. For example, Participant 51 stated, “I struggled heavily with the idea that I wasn't there when my son needed me, despite trying to be there for him all the time. That he could be hurting so bad and yet I didn't know.” Participants describe feeling quite alarmed upon learning about their youth’s NSSI, followed by increased anxiety and worry about the youth’s safety. Some participants reported anxiety arising from having trouble differentiating NSSI from suicide, or fearing that NSSI would escalate into future suicidal behaviour or unintentional death. For example, Participant 51 shared that, “The constant fear that if self harm isn't enough or leads to suicide hangs over my head although I know the two are two
separate issues. It still frightens me to think self harm could lead to death.” Participants also reported feeling sad for themselves, for the youth, and for the youth’s difficulty in seeking help. To this end, Participant 69 said, “It makes me sad for her. I know she is worth far more than she thinks,” and Participant 109 shared, “Felt incredibly sad she was unable to come and ask for help, I thought we had a close relationship, I experienced profound grief.”

Several participants reported feeling as though there was nothing they could do to help their youth. This helplessness was sometimes associated with anger resulting from an inability to find effective help for the youth. For example, Participant 86 described her anger at the health care system as follows:

After seeking help at the ER in our local children’s hospital and leaving there with nothing more than a (useless) pamphlet… I was furious with our health care system! The hospital would only admit her if she was suicidal. This makes me SO MAD!”

Other participants reported feeling angry, but did not report the source or target of their anger. In some cases participants reported feeling exhausted and burnt out, such as when Participant 7 said, “I feel like I’m drowning.”

**Exacerbation of Mental Health Difficulties.** The second theme reflected an increase in parents’ mental health difficulties attributed to the youth’s NSSI. This extends beyond a mere emotional reaction to the youth’s NSSI, and reflects a deeper level of parent suffering and/or impairment manifesting as symptoms of mental illness. Many participants listed symptoms of depression (e.g., sleep difficulties, poor appetite, loss of interest in pleasurable activities, feelings of worthless, guilt, irritability, fatigue, lack of concentration) and anxiety (e.g., worry, hyperarousal, re-experiencing traumatic events associated with the youth’s NSSI, panic attacks) resulting from the youth’s NSSI. For example, Participant 51 said, “I went in to a deep depression, lost a lot of sleep and suffered anxiety and feelings of panic. I had panic attacks
which affected my relationships with my own support systems. I withdrew from everyone.”

Other participants described an exacerbation of pre-existing mental health challenges, such as Participant 40, who stated, “It has made my depression much worse. It has significantly diminished my feelings of self worth.” A few participants highlighted that their youth’s NSSI has brought back thoughts and memories about their own history with NSSI. For example, Participant 57, who has a history of NSSI, stated, “I’ve had to dredge up my own personal experiences and deal with them again, hoping to find a clue somewhere that I missed before.”

**Uncertainty as a Parent.** This third theme reflects that NSSI has a considerable impact on parenting, both in terms of altering how parents think about themselves as parents, and parenting behaviours. Many participants reported a general loss of confidence in their parenting ability. Participants questioned their parenting choices; for example, Participant 107 said, “I have really searched my heart to find anywhere that we have gone wrong. Whether it was something we did or said to make her feel like she deserved to hurt.” Similarly, Participant 61 eloquently described the relation between her perceptions of her ability as a parent and her daughter’s NSSI:

> Since my daughter went into what I call "the dark valley" I have had to totally re-evaluate my assessment of myself as a parent. In a world where there's really no objective measure of how you're doing as a parent and it's natural to question yourself, the best reassurance that you did a good job is turning out a well-adjusted kid. When my daughter was doing well... I gave myself props for good parenting. Now that she locks herself in her room and self-injures it's hard not to feel like clearly I've done something wrong. This is probably made worse by the fact that she won't talk to us about her emotions. Some of my friends have kids with problems, but they still have these TV sitcom moments where kid opens up to mom, mom says just the right thing, they hug, etc. My kid would rather slice up her arm than share her feelings with me, and it's pretty hard not to take that as a reflection on oneself as a parent.

For this parent, as with many other participants in this sample, the youth’s NSSI is perceived by the parent as a reflection of poor parenting.
NSSI also complicates the implementation of parenting strategies. Several participants noted an increase in conflicts with their partner regarding parenting decisions. Participant 36 said, “There is a lot of fighting in the family on how to approach the situation. My marriage is strained because we disagree.” Some participants felt they had to “walk on eggshells” around the youth for fear of triggering the NSSI. For example, Participant 55 shared, “I began watching her more closely and monitoring everything I said to her, not wanting to upset her, or cause her stress.” It was also common for participants to report hypervigilence in the form of increased monitoring and limiting the youth’s access to NSSI. To this end, Participant 35 said, “It is hard to know how much privacy to give my daughter. Initially she was very secretive about her cutting, engaging in it for a few months prior to telling us. I admit to more "barging in her room" than I used to,” and Participant 46 said, “even something normal in her room or our house i have to look at differently to determine if it could be used to cut or inflict pain.”

Discipline strategies appear to be particularly difficult to navigate for parents of youth who self-injure. Participants described being uncertain about the best way to discipline a youth who self-injures, as they worry that discipline may cause the youth to self-injure. For example, Participant 107 said, “I also have had to worry about whether to give proper discipline because I find myself concerned with whether she will self-harm as a result.” Participant 26 describe the challenge of finding appropriate consequences that do not interfere with adaptive coping strategies:

The biggest effect it has is on punishments. As a parent you walk a fine line when trying to punish a child who self harms. You try not to interfere with anything used as part of a coping mechanism (for my daughter that included talking to friends and music; both of which she uses her cell phone for).

Some parents reported that worry about discipline has resulted in inconsistent parenting, such as Participant 29 who said, “When dealing with issues where our son needed to be disciplined, we
would be in constant worry that he would harm himself because of our actions. So at times, the decision was made to not follow through.”

**Recognition of Growth.** The final theme found regarding the impact of NSSI on parents is the opportunity for personal and interpersonal growth that comes from the difficulties experienced while parenting a youth who self-injures. Several participants’ reflected on coming to terms with their youth’s NSSI and accepting that they were not to blame for it. For example, Participant 111 reflected, “I know it is not my parenting that is causing her cutting, it is her lack of coping skills and all of the issues in her life being too overwhelming for her.” Some participants also commented on the opportunity for growth that emerged from learning to support to their youth. For example, Participant 29 felt her confidence had increased through communication with her son:

> I have gained even more confidence with my relationship with my son. We have had to have some very difficult conversations regarding the dark places he goes to when he self-injures and it has helped me understand him better and gain more of his trust through the process. I don't believe every parent has the opportunity to have their child confide in them, and because he has, I feel pride in my parenting skills and blessed that he can talk with me.

Finally, several participants noted that their youth’s NSSI resulted in engaging in greater personal self-care behaviours, such as Participant 108 who said, “On the positive side I'm practicing relaxing more and finding a centered space to live from.” This increased self-care may have helped them to cope with the stress associated with their youth’s NSSI.

**Question 2: Parents’ Perceived Needs**

On the Follow-Up Questionnaire, participants were asked to reflect on what they believe they need to help them better support their youth. Responses were assessed using thematic analysis to better understand parents’ perceived needs. Four themes (i.e., need for NSSI literacy, need for peer support, need for effective professional support, need for self-care; Fig. 4.2) were
identified to reflect the needs that parents expressed. In addition to these themes, a few participants also highlighted the need for a general reduction in the stigma associated with NSSI. For example, Participant 22 said, “It needs to be something that gets talked about rather than hidden,” and Participant 12 said, “Make conversation on such topics not a taboo.” However, insufficient context was provided with these responses to determine the means of decreasing stigma (e.g., potentially by better understanding NSSI) or the goal resulting from decreasing stigma (e.g., potentially to better understand the youth, or to increase peer support). Thus, it is unclear whether these types of responses fit into one of the other themes listed below, or whether the need to decrease stigma represented a unique theme in itself.

Need for NSSI Literacy. Most participants reported needing access to accurate information about NSSI, which may enable them to better understand NSSI and their youth’s experience. For example, Participant 20 reported needing, “an understanding of the causes or reasons for the behaviour.” Accurate information may also serve to dispel common misconceptions that inhibit parents from effectively responding to their youth. Some participants highlighted needing to be able to distinguish between NSSI and a suicide attempt; Participant 108 said, “It’s been very scary. It took a while for me to differentiate suicide from self harm and I’m still not sure”. Other participants needed information counteracting the notion that parents are the cause of the youth’s NSSI, such as Participant 111 who said, “I think for most parents, they need to know it is not their fault.”

Need for Peer Support. Many participants reported the need to have access to other parents who had either been through or were currently experiencing similar circumstances (either with respect to parenting in general or, more specifically, parenting a youth who self-injures).
Several participants specifically requested support groups, while others referred to more informal peer support. Participant 80 explained the benefits associated with peer support as follows:

Something that has helped me with parenting in general, and particularly since my oldest became a teen, has been discussing the challenges I’m facing with other parents, particularly those whose kids are a bit older and have been through similar challenges in the last 5-10 years. To me, having that support, having the knowledge that others have been through it, and knowing their kids have come through those difficult times, has been invaluable.

Parents reported that this peer support may provide proof that the parent is not alone in this struggle, validation of the difficulty associated with parenting a youth who self-injures, and hope that the family will get through this difficulty.

**Need for Effective Professional Support.** Participants reported needing accessible professional resources for the youth and to be involved in their youth’s care. Being able to access professionals who are knowledgeable and skilled with respect to treating NSSI was deemed a priority. For example, Participant 83 said, “I would have appreciated better access to mental health care…. Seven months is a long time to get the help she needs to move forward,” and Participant 27 said, “the knowledge of what resources are available to them, despite the long wait lists to access those services.” Several parents reported needing to be involved in their youth’s treatment. To this end, Participant 109 reflected that the youth’s NSSI affected the whole family, and thus youth’s treatment needed a family component:

Access to therapists who understand Self Harm to support the parent's coming to terms with what is going on. To be involved in the youth's healing programme however small. For the repercussion out into the family to be acknowledge and recognised. Yes the Self Harm does 'belong' to the youth but it affects everyone around them. In my experience the youth is 'treated' in isolation. A holistic approach is needed.

Professionals were perceived to be needed to coach parents to support their youth, as demonstrated by Participant 29 who said, “This would allow for some guidance to the parent
with how to react to the situation and support their teen. Often, it is the way we handle their situation that either does the most harm or the most good.” Finally, several participants reported that they needed professionals to validate their experiences and to provide reassurance of their parenting.

**Need for Self-Care.** This final theme reflects the participants’ need to prioritize self-care. Participant 20 reflected that the old adage “you put your own oxygen mask on first before assisting someone else” also applies to parents of youth who self-injure. Some participants reported that this need can be met through accessing their own therapist, while others reported that seeking out social support in general meets this need. Although the term “self-care” was used by multiple participants, none provided specific examples of self-care activities beyond having a place to talk about their feelings and to be validated.

**Question 3a: Sources of Help and Perceived Helpfulness.**

Help-seeking was first examined quantitatively by compiling the frequency of help sought from different sources, and the percentage of participants who had found each source to be “somewhat” or “very” helpful. As reported on the NSSI Help-Seeking Questionnaire, all participants had sought help for their youth from at least one source (Fig. 4.6), including both informal sources (e.g., friends, family, partner) and mental health professionals (e.g., psychologist, counsellor or therapist, psychiatrist). As shown in Figure 4.7, mental health professionals were perceived to be helpful for the youth more frequently than informal sources. School professionals were perceived to be helpful less frequently than other professionals. Although most participants indicated that at least one source had been “somewhat” or “very” helpful, a few participants indicated that nothing had been helpful (n = 3), or that only the Internet had been helpful (n = 2) when seeking help for their youth.
Most participants had sought help for themselves, with respect to their youth’s NSSI, from at least one source (Fig. 1). Participants were more likely to have sought help for themselves from an informal source (friends, partner, family) than from a health (e.g., family doctor) or mental health professional (psychologist, therapist or counselor, psychiatrist). A minority of participants had not sought help for themselves (n = 5), had not found any source to be helpful (n = 9), or had found only the Internet to be helpful (n = 4). Of note for this study, the majority of participants had sought help from the Internet (68% for their youth; 61% for themselves), and of these the majority had found the Internet to be “somewhat” or “very” helpful (62.8% for their youth; 73.4% for themselves).

**Question 3b: Barriers to Help-Seeking**

Barriers to help-seeking were assessed through thematic analysis conducted on responses to the two questions asking participants what would prevent them from seeking help for their youth and for themselves. Four themes (i.e., *inability to access effective mental health resources*, *parent negative expectations*, *youth’s resistance to receiving help*; Fig. 4.3) were found to describe barriers to help-seeking. Despite these barriers, a large number of parents responded to this question by indicated that *nothing* would stop them from seeking help for their youth if their youth needed it, even if this required considerable effort and resources on the part of the parents to organize services for the youth. For example, Participant 82 stated that, “nothing would stop me from getting help for my child as long as he continued to need it,” and Participant 22 declared, “when I feel like help is needed I will not give up until I find it.” Several participants also denied their own need for support in favour of supporting their youth. For example, Participant 27 said, “It’s not about me, I’m focused on her,” and Participant 82 stated, “I’m putting myself on the back burner.”
Inability to Access Effective Mental Health Resources. Participants indicated that the inaccessibility of mental health resources can be a significant barrier to seeking help. If parents cannot access a service, the service will be unlikely to be of benefit. Respondents here discussed myriad factors contributing to this difficulty. For example Participant 10 noted a lack of available services and wrote that there was a “lack of resources, agencies in my area”. Others described not knowing where to get services, such as Participant 51 who indicated that, “in the beginning not knowing how to get help.” Financial barriers also existed for many participants. For example, Participant 19 mentioned, “the cost of help outside of what is covered. It seems that those you pay for are much more willing to help, but we haven’t got the resources to pay.” Other barriers preventing access to mental health resources included transportation barriers, lack of childcare for other children, and insufficient time. Examples of these barriers were provided by Participant 38, who said a barrier was “Distance to and from help. Lack of transportation”, and Participant 104, who said, “Time away from work and home duties”.

Parent Negative Expectations. Many participants reported that “judgement” (e.g., Participant 30), “criticism” (e.g., Participant 68), and “stigma” (e.g., Participant 35) would prevent them from seeking help. Furthermore, the experience of receiving criticism or judgment from others when seeking help may prevent parents from seeking out further help for their youth or themselves. Participants also expressed multiple fears about the outcome of help-seeking, which may prevent help-seeking altogether. Some parents feared being blamed for the youth’s NSSI. To this end, Participant 76 said a barrier was “assumptions self harm is based on poor parenting,” and Participants 49 said, “being viewed as a bad parent.” Potential child protective services involvement or removal of the child from the home was a common fear. In align with this fear, Participant 71’s described her barrier to help-seeking as, “fear that [Child Protective
Services] would think I wasn’t a fit parent and take her away”. Other parents feared that seeking help would make the situation worse, and Participant 44 voiced this fear by describing the barrier as “the fact that [seeking help] could make the problem worse”.

**Youth’s Resistance to Receiving Help.** The youth themselves were also sometimes perceived as a barrier to accessing help for the youth, as several youth were perceived as unwilling to accept help. For example, Participant 55 said that a barrier to seeking help was “them not willing to get help.” Similarly, Participant 9 said that their “youth did not want to continue with getting help from a counsellor,” Participant 39 said that “my youth was unwilling to cooperate, and Participant 61 said that “therapy has been very unhelpful because she won’t talk.” In each of these cases, the youth’s perceived resistance was viewed as a barrier for accessing effective treatment.

**Question 3c: Helpful and Unhelpful Responses.**

Participants were asked to describe what was helpful and unhelpful when they sought help for themselves and for their youth with respect to the youth’s NSSI; thematic analysis was used to understand the factors that made responses helpful. Although participants were asked to reflect separately on what was helpful and unhelpful when they sought help, many participants discussed these simultaneously by contrasting the types of responses that they had experienced. Often what was helpful was merely the opposite type of response from what they had experienced as unhelpful. Thus, what was helpful and what was unhelpful are discussed simultaneously to provide a richer understanding of participants’ experiences. To this end, three themes (i.e., validation and connection, competent family-centered professional support, care for the parent as separate from the youth; Fig. 4.4) were identified and are discussed below.
**Validation and Connection.** A large number of parents indicated that receiving validation and feeling connected was an essential component of a helpful response. Participant 57 said it was helpful “to know there were people out there that I could turn to.” Helpful responses included those that were “understanding and not judging” (Participant 3), loving, empathetic, and when the support was willing to listen and take the topic seriously while avoiding over-reactions. Unhelpful responses included assumptions and judgments, blame, unsolicited advice, placating statements, minimization of the seriousness of the situation, and the inability to understand or relate to the situation. For example, Participant 92 shared that “Some friends and family do not understand the depth of having a child suffering from anxiety and depression, they can only offer empty suggestions and hollow empathy.” The experience of feeling less alone by connecting with others—especially others with a similar lived experience of NSSI—appears to be particularly helpful, while being socially isolated was unhelpful. For example, Participant 14 said that “realizing other parents lived with this too” was helpful. In contrast, Participant 64 shared that “my friends were least helpful. They isolated themselves from us like they needed to protect their own children.”

The availability of accurate information about NSSI may enable helpful responses, and misinformation may lead to unhelpful responses. In particular, misconceptions about the role of the parents in the etiology and maintenance of youth NSSI (e.g., that parents cause NSSI, that NSSI is an indication of reduced parenting capacity) have the potential to increase feelings of blame and isolation for parents. For example, Participant 24 said that “judgemental articles about how inattentive parents are to blame” was unhelpful. Similarly, Participant 53 found “people who believe you can control it as a parent” to also be unhelpful. In contrast, participants indicated that it is valuable to be reassured of their parenting capacity, and to have their efforts to
help their youth validated. For example, Participant 84 said, “just hearing that its not my fault” was helpful. Similarly, Participant 66 stated that it was helpful that she had, “a supportive and understanding network of friends and family who know very well that I have always done my best as a parent and am dealing with a very difficult situation that I cannot fix…”

**Competent Family-Centered Professional Support.** The professional’s approach to treating NSSI may also be perceived as either helpful or unhelpful. In general, participants found it helpful when a connection was formed with the professional, the professional specialized in the youth’s challenges, and a holistic approach to treatment was used. Some professionals were perceived to be ill-equipped to work with youth who self-injure (e.g., they lacked knowledge about NSSI, the therapist’s approach resulted in shame for the youth, the approach enabled and increased the NSSI). For example, Participant 70 described a professional working with her youth as “inexperienced causing triggering episodes,” and Participant 31 said, “the counsellor… made my son feels worse about himself.” Participants found it unhelpful when professionals used approaches that either under-reacted or over-reacted to the youth’s NSSI. Participant 26 said, “no one really listened until it became much more serious.” As an example of over-reaction, Participant 63 explained that “the tendency of mental health professionals and school staff to go on “red alert” when they learn that she self-harms has also not been helpful, because it’s caused her to shut down further.” Some participants indicated that the youth’s behaviour with the professional (e.g., perceived unwillingness to talk to a professional, perceived unwillingness to cooperate, keeping NSSI hidden, dishonesty with professionals) was sometimes unhelpful when seeking help for the youth. For example, Participant 71 stated that, “all services are voluntary for her age and she does not want help, so she looses the service offered.”
The inclusion of parents in the youth’s treatment was consistently viewed by parents as helpful. Parent/caregiver knowledge of and participation in the youth’s treatment may be helpful in decreasing the parent’s sense of responsibility for the youth’s NSSI and increasing the parents’ perception of the level of support that the youth is receiving. For example, Participant 28 said that “feeling like someone understood her and what she was going through even when I could not” was helpful. Similarly, Participant 31 said it was helpful, “knowing that if my child wasn’t 100% comfortable speaking to me, that there was another option for them to release their feelings”. Parents also reflected that their inclusion in the youth’s treatment was helpful by providing the parent with information and skills, which enhanced their ability to support their youth. For example, Participant 6 said that “the therapist who helped us communicate was very helpful. The children’s hospital who only looked at our daughter as a separate entity WAS NOT helpful.”

**Care for the Parent as Separate from the Youth.** Responses that cared for the parent as separate from the youth were generally helpful, but were unhelpful in rare instances. Participants found it helpful when they were supported in working through their own challenges in addition to supporting their youth’s treatment. For example, Participant 77 said, “I needed to have safe places to land and work through my own feelings.” Working through their feelings and separating their own difficulties and emotions from those of their youth enabled participants to care for themselves amidst their youth’s challenges. Support for self-care activities (e.g., seeking social support, reducing employment responsibilities, meditation, relaxation activities) was also viewed as helpful. For example, Participant 105 shared that her “family physician provided support to take time off work in the most intense time of crisis.” In contrast, encouragement to engage in self-care may be viewed as unhelpful when it coincided with a crisis for the youth, as
experienced by Participant 105 who said, “this was during a time of crisis and the counsellor tried to have me focus on what I needed but I was still stuck in crisis mode and not ready to deal with myself.”

**Question 4a: The Internet as a medium to Support Parents.**

Participants who took part in the Follow-Up Questionnaire were asked two open-ended questions examining the role of the Internet in the parents’ journey through their youth’s NSSI, as well as the potential role that it could have in supporting parents. These responses were analysed using thematic analysis. Most participants reported having used the Internet to obtain information about NSSI and/or to seek social support from peers or professionals; similarly, participants reflected that e-supports that they desired also fall into these domains. Thus, three themes (*information and self-help tools, connection with peers, readily-available professional support*; Fig. 4.5) were found to reflect the ways in the Internet could be used to support parents. An overarching message conveyed in the responses to these questions is that the Internet is not currently meeting all of parents’ needs; however, the Internet could be a very valuable resource for parents if the appropriate content was more easily accessible. To this end, although the majority of participants indicated that the Internet has had a very small role in their journey through their youth’s NSSI (generally centered on attaining information about NSSI), these same participants suggested a number of ways in which the Internet could be a significant source of support for parents.

**Information and Self-Help Tools.** Participants reported wanting to access information about NSSI online. Online information was most frequently sought early in the participants’ journey through the youth’s NSSI and was reported to be somewhat helpful in educating participants about NSSI and related topics. A wide range of desired topics was suggested,
including both general information about NSSI and specific information about parenting strategies and how parents can coach their youth through urges and painful emotions. Many participants also reported wanting access to stories of recovery both from other parents as well as from youth who have stopped self-injuring. For example, Participant 45 said, “most helpful to me would be a section with testimonies and reflections of folks who used to self injure and have stopped.”

**Connection with Peers.** Participants also reported that the Internet would be an ideal medium for parents to gain peer-support. Although many participants had attempted to seek peer support online, most reported being disappointed by the perceived absence of social support on the Internet. Several participants commented that when they were able to find other parents who were going through similar circumstances, they found this experience discouraging. For example, Participant 35 shared that:

> On one occasion I did look at a forum for parents. However, there were a lot of parents dealing with children who were not accepting of help, which was very different from our situation. I did not want to read about the "worst case scenarios.”

Similarly, Participant 109 said, “hardly any up lifting stories - survivor stories as you see with sexual abuse etc.” Many participants asked for a space in which they could interact with each other regarding the youth’s NSSI. In line with this, Participant 62 said, “I wish there was a networking site or forum. I feel incredibly alone with this.” Ideally this space would be moderated by a trained mental health professional with expertise in NSSI. To this end, Participant 40 asked for:

> A chat group that was mediated by a psychologist; a psychologist who interacted with the group. I think the most useful topics would be just to share stories, how to handle their youth, what works, what doesn't, be supportive and respectful to each other, and to hear the psychologist’s thoughts.”
The ability to connect with peers online may meet parent’s need for sharing their experiences with others.

**Readily-Available Mental Health Professionals.** Finally, participants reported that the Internet could be used to access support from mental health professionals. Some participants reflected that professional support online may increase the accessibility of mental health services, particularly during times of crisis. For example, Participant 107 said, “There should maybe some type of hotline for desperate parents,” and Participant 19 asked for “maybe a trained professional on the Internet available 24/7.” Other participants reflected that the availability of professionals online may bridge the gap between online resources and local resources. For example, Participant 31 stated:

> We need a more centralized location on the Internet to come together. Ideally, it would have doctors and therapists who could offer assistance and help people find what they need in their communities. It would have community outreach and resources to better understand the complexity and different disorders children who self-harm can have.

Finally, as discussed previously, there may be a role for mental health professionals to facilitate the interactions between parents who are seeking to support each other online.

**Question 4b: NSSI e-Content.**

The perceived utility of specific types of Internet content was assessed quantitatively through the percentage of participants who rated each type of e-content as most useful on the NSSI Help-Seeking Questionnaire. Having access to stories from other parents (50.9 %) was rated as the single most useful type of Internet content. Self-help resources for the youth (43.4%) were rated as the next most useful type of content, followed by opportunities to communicate with other parents (e.g., e-forums, message boards; 39.6%), self-help resources for the parent/caregiver (36.8%), and links to mental health professionals (35.8%). Videos (17%),
quizzes (to test NSSI knowledge; 22.6%), and “other” (suggestions from participants included stories from youth who engage in NSSI, and information about support groups) were rated as most useful the least often.

Participants were also asked to specify what self-help e-resource topics they would find useful or would be likely to use either for their youth or themselves. To summarize the responses, self-help e-resource topics for youth included general information about NSSI and interventions, comorbid mental illnesses (e.g., anxiety, depression, trauma or post-traumatic stress disorder), coping skills (e.g., emotion regulation skills, identifying triggers, dealing with urges, alternate behaviours, relaxation), self-acceptance and self-esteem, and relationships. Self-help e-resource topics for parents included strategies for supporting a child who self-injures (e.g., understanding NSSI, knowing what to watch for, helping the youth with emotions and urges, validating the youth’s feelings, assisting the youth to accept help for NSSI), relationships (e.g., boundaries, establishing trust, communication), trauma (both the parent/caregiver’s trauma history and that of the youth), coping skills for parents, parenting skills (e.g., skills for parenting the youth who self-harms, supporting others in the family), and self-care strategies.

Discussion

This study provides preliminary information about the impact of youth NSSI on parents, the needs of parents who are supporting these youth, from where or whom parents seek help for their youth and themselves with respect to the youth’s NSSI, and how the Internet may be used to equip parents to support their youth. These results contribute to the field of NSSI in several ways. First, it replicates and extends the limited research available describing the impact of youth NSSI on parents and the needs that these parents have while supporting their youth (e.g., Byrne et al., 2008; Ferrey, 2016; McDonald et al., 2007; Oldershaw et al., 2008). Next, it has
implications for the mental health professionals who are working with youth who self-injure. Finally, it provides evidence of the utility of the Internet in equipping parents to support their youth, and implications for developing novel e-content specific for parents of youth who self-injure.

**Perceived Impact on Parents, Parents’ Needs and Help-Seeking**

The results from this study, perhaps unsurprisingly, indicate that NSSI has a considerable impact on parents. Consistent with the literature (see Arbuthnott & Lewis, 2015; Ferry et al., 2016), youth NSSI was associated with *elicitation of difficult emotions, exacerbation of mental health difficulties, and uncertainty in parenting*. However, these results also extend this literature by providing evidence of *recognition of growth* arising from supporting the youth through the NSSI. While previous research suggests that parents want to rebuild positive relationships with their youth (Byrne et al., 2008; Ferrey et al., 2016), the results from this study indicate that this does in fact occur for some families. Similarly, while previous research has focused on the decreased ability for parents to care for their own needs while prioritizing their youth (Oldershaw et al., 2008)—and indeed, some participants reported prioritizing their youth’s needs over meeting their own needs—the results also suggest that some parents may actually gain a greater capacity for self-care through this experience. More research is needed to elucidate the ways in which parents may experience psychological growth following the very challenging experience of supporting their youth through NSSI.

The needs of parents identified in this study (i.e., *need for NSSI literacy, need for peer support, need for effective professional support, and need for self-care*) also align with those previously identified in the literature (i.e., information, self-care, peer-support; e.g., Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008;
Rissanen et al., 2009b). Interestingly, participants in this sample also indicated a specific need for effective professional support, with the desire to be involved in the youth’s treatment and to receive coaching around how to support the youth. This additional need may reflect the composition of the sample; the majority of the participants were supporting youth experiencing complex mental health challenges in addition to the NSSI, and most had already sought out professional support for their youth. Thus, parents who have sought help for their youth from a mental health professional may need specific types of support from these professionals, which may or may not be specific to the NSSI.

Across the research questions, there was a role for accurate information about NSSI in equipping parents to support their youth. Parents described a need for NSSI literacy and believed the Internet could be used to obtain information and self-help tools. Accurate information allows parents to better understand and respond to their youth. Misconceptions about NSSI may prevent parents from responding to their youth in effective ways, prevent help-seeking for the youth and for themselves, and contribute to unhelpful responses when help is sought.

One common misconception that was highlighted during this study was the belief that parents cause NSSI. When believed, this misconception may lead parents to blame themselves for their youth’s NSSI, experience shame as a result, fear potential consequences of seeking help (e.g., involvement from children’s aid society), and may be unable to receive or accept validation for their efforts to help their youth. The literature is clear that although a variety of factors associated with parents (e.g., background factors such as demographics and parent health, parent-child relationship factors, family-system factors) may contribute to an elevated risk for NSSI (see Arbuthnott & Lewis, 2015), the actual causes of NSSI are complex and include a variety of
biological, social, and intrapersonal factors that extend well beyond the influence of parents (Whitlock & Rodham, 2013).

Another common misconception observed throughout participants’ responses was the notion that NSSI is a suicide attempt. Participants repeatedly commented that being able to distinguish NSSI from a suicide attempt enabled them to better support their youth. However, concerns were raised that the line between NSSI and suicide is blurry, and more information about navigating this difference was requested. Indeed, some of the participants reported that their youth had engaged in both nonsuicidal and suicidal self-harm. The literature demonstrates a clear link between NSSI and suicide (e.g., Hamza, Stewart, & Willoughby, 2012), and NSSI may act as a gateway behaviour to later suicidal behaviour (Whitlock et al., 2013). Being able to understand the similarities and differences between NSSI and suicidal behaviour may assist parents to better understand NSSI and take it seriously, while opening communication about NSSI and suicide with the youth, and establishing plans for use in crisis.

The desire for peer-support was also found across the research questions. Parents described a need for peer support and believed the Internet could be used to obtain connection with peers. There appears to be a difference between social support (which may be met through interactions with friends and family) and support from peers (i.e., other parents who are experiencing similar circumstances). Although most participants endorsed having sought help from friends and family—often with helpful results—this study did not assess help-seeking from peers experiencing (or having experienced) similar circumstances. While the results of this study suggest that many of the anticipated outcomes from peer-support are positive (e.g., validation, connection, hope; e.g., Byrne et al., 2008), some participants reported that their experiences of peer support online have been discouraging (e.g., difficulties relating to peers due to slightly
dissimilar circumstances; lack of encouraging outcomes). More research is necessary to understand the benefits and potential risks associated with seeking support from other parents of youth who self-injure, and the extent to which peer support enhances parents’ ability to support their youth.

To date, there are no other studies formally examining help-seeking behaviours among parents of youth who self-injure. The results on help-seeking from this study suggest that parents seek help from a variety of informal (e.g., friends, partner, family, Internet) and professional (e.g., doctors, therapists) sources for their youth, which is consistent with models in which parents facilitate help-seeking for their adolescents with respect to mental health challenges (e.g., Logan & King, 2001). As an extension of the known literature, this study also found that parents use these same sources of help to obtain support for themselves with respect to their youth’s NSSI.

When help is sought, helpful responses include validation and connection, competent family-centered professional support, and care for the parent as separate from the youth. Barriers to help-seeking were inability to access effective mental health services, parent negative expectations, and youth’s resistance to receiving help. These results provide support for current literature emphasizing the quality of the client-caregiver relationship as means of facilitating parent help-seeking for youth mental health concerns (e.g., Sayal et al., 2010) and the role of negative expectations such as parental fears about the consequences of seeking help as a barrier (e.g., Sayal et al., 2010). Furthermore, these results suggest that the perceived needs of parents may need to be taken into consideration by the people from whom parents seek help, regardless of whether the help is being sought for the youth or for the parent.
Although this study provides preliminary information about help-seeking behaviours by parents in relation to youth NSSI, more research is needed to elucidate key factors surrounding help-seeking (e.g., factors prompting the decision to seek help, how parents find help, parents’ expectations of what help would look like, the relation between meeting parents’ expectations and treatment outcomes). As one study examining the role of parents in help-seeking for first episode psychosis found that the help-seeking experience itself had a considerable impact on parents (Czuchta & McCay, 2001), it may also be informative for future research to attempt to understand and distinguish the impact of the youth’s NSSI from the impact of the help-seeking process related to the youth’s NSSI. In turn, this may suggest avenues for intervention with parents, and ways to facilitate help-seeking for both the parent and the youth.

Implications for Mental Health Professionals

These results also suggest a number of ways in which parents could be more effectively supported by mental health professionals when professional support is sought; these recommendations align with current guidelines for treating NSSI in adolescents (e.g., Klonsky et al., 2011; Lewis & Heath, 2015; Muehlenkamp, 2006; Plener et al., 2016; Washburn et al., 2012). First, the connection established between the parent and the professional is paramount to facilitating a helpful response. Mental health professionals need to be understanding, nonjudgmental, and empathetic of the parents’ experiences. Experiencing validation and connection with a professional may ensure that parents feel supported to help their youth. Clinical competence and expertise in treating youth who self-injure may be essential not only towards providing effective services to the youth, but also in maintaining an alliance with the parent.
Next, the professional’s approach to treating NSSI may be most helpful when it includes the parent in the treatment plan. This is consistent with evidence-based treatments for self-injurious thoughts and behaviours, which indicate that the more effective treatments include a parent component (Glenn, Franklin, & Nock, 2015). Ideally the youth will consent to having parents involved in their treatment, and mental health professionals should work with the youth to help them understand the benefits of parent involvement. However, many parents indicated that their youth’s resistance to accepting help was a barrier to seeking help altogether. Although gold-standard treatments for youth NSSI involve the youth in treatment (Glenn et al., 2015), several parent education programs have been developed for parents of youth who engage in self-harm which do not require the youth to be involved (Pineda & Dadds, 2013; Tambourou & Gregg, 2002; Power et al., 2009). These parent education programs may be beneficial for some parents of youth who self-injure, particularly when the youth is not in treatment or when the youth does not consent to having the parents involved in their treatment.

Similarly, participants repeatedly asked for access to parent coaching from professionals, with the expectation that this would equip parents to respond to their youth in more effective ways. Parent programs that focus on attachment principles (e.g., Connect Program; Moretti, Braber, & Obsuth, 2009) or which directly coach parents to respond to the youth’s emotions (e.g., Emotion Focused Family Therapy; Lafrance, Robinson, Dolhanty, & Greenberg, 2015) may meet parents’ needs in these areas. Further research is needed to validated these parent interventions for use with NSSI specifically.

Parents may benefit from professional support for themselves as well as for their youth. Mental health professionals need to be cognizant of boundaries in their relationship with the youth and the parents, and may need to refer parents to their own therapists to ensure that parents
receive adequate support to work through their own challenges. However, clinicians should also be aware that referring parents elsewhere could consume the family’s resources (e.g., money, time) and actually prevent parents from accessing the services to which they are referred.

Similarly, although participants advocated for self-care, there were times where the encouragement for self-care was interpreted as unhelpful (e.g., when the youth is in crisis), and participants rarely specified the self-care activities in which they engaged. Parents may need to be given an explicit rationale for engaging in self-care activities—particularly when it appears inconvenient such as during times of crisis—and may need assistance to identify the self-care activities that they may find most useful.

Finally, a large number of parents indicated that being unable to access professional mental health services was a significant barrier to seeking help for their youth or for themselves. This speaks to the need for a greater availability of accessible mental health services. Unfortunately, demand for local mental health services regularly exceeds capacity, and participants may experience long waitlists, or may need to travel to access specialized care.

There is a shortage of free services for treating NSSI, and many parents cannot afford the financial cost associated with fee-for-service treatment. The provision of resources for parents on the Internet may be one means of supporting many parents simultaneously in a manner that is both accessible and financially affordable for parents.

The Role of the Internet as a Medium for Supporting Parents

The results from this study showed that parents desire to use the Internet as medium to access information and self-help tools, connection with peers, and readily-available mental health professionals. This aligns with previous research indicating that parents use the Internet to
access both information and social support (Plantin & Daneback, 2009). It also extends the literature to include the desire for professional mental health services online.

Participants believed that they would find it helpful to have access to self-help resources both for their youth and themselves on a wide range of topics pertaining to NSSI and parenting. Such information may already be available online, as participants reported that NSSI e-content was generally adequate in meeting their informational needs. However, not all information about NSSI on the Internet is credible or accurate (Lewis, Mahdy, Michal, & Arbuthnott, 2014), and it can be difficult for parents to find the information they are looking for. Thus, it may be useful for parents to have access to a single credible website that vets e-information about NSSI and provides links to the types of information that parents are seeking. For example, the Self-Injury Outreach and Support (www.sioutreach.org) and Cornell Research Program on Self-Injury and Recovery (www.selfinjury.bctr.cornell.edu/resources.html) websites provide both information about NSSI to parents, and lists vetted credible resources for parents. Equipping mental health professionals with information about these websites may be one way to assist professionals to share these e-resources with parents. Other ways to promote these websites may include search engine optimization, the use of targeted advertising on social media (e.g., Facebook) and different parenting websites, and advertisements in health and mental health facilities. Future research examining the how parents use the Internet to obtain mental health information would be valuable in ascertaining the best approach for disseminating NSSI information to parents via the Internet.

Participants described that although they would like to obtain peer support online, it is difficult to find support from parents going through similar experiences. Over half of the participants reported that stories from peers would be very useful, and over one third of
participants reported that it would be useful to be able to interact with other parents through forums or message boards. Such opportunities for peer support may be most valuable when moderated by a mental health professional. Although this type of e-space does not yet exist for parents of youth who self-injure, there are several websites that provide this type of support to parents of youth with other mental health concerns (e.g., schizophrenia, autism spectrum disorder). While there is some research suggesting that Internet parent support groups are beneficial for parents of children with complex medical needs (Baum, 2004), more research is needed to understand the impact of these interactive websites on parents seeking support for their youth’s mental health challenges.

Furthermore, participants reported that it would be useful to be able to obtain professional mental health services via the Internet. Unfortunately, Internet-based mental health services are still in their infancy, and services like those that participants are asking for are not yet widely available. The development and provision of such services online may reduce the barriers associated with difficulties accessing local mental health services (see Ybarra & Eaton, 2005), and may provide parents with additional support in times of crisis. While the provision of information is a key first step towards treating NSSI, more individualized approaches may be necessary for many families; here, clinicians may be able to bridge the gap between resources available on the Internet and referrals to local services.

**Limitations and Future Directions**

This study has methodological limitations that should be considered when interpreting the results. First, several limitations associated with participant demographics are outlined in Chapter Three, and also apply to this study. A further limitation related to demographics arises from the recruitment procedure. Participants were recruited from an advertisement on a social
media site, and thus participants self-selected to be involved in this study. It is unclear to what extent these participants’ experiences reflect the experiences of all parents of youth who self-injure. Many participants reported that their youth were experiencing complex mental health challenges in addition to the NSSI, and their experiences and needs may thus differ from those of parents whose youth engages in NSSI without comorbid challenges. It is also unclear to what extent the results from this study may be applied trans-diagnostically to describe experiences of parents of youth with mental health challenges in general, of which NSSI is included.

Next, in order to answer the specific research questions posed in this study, the survey contained leading questions clearly related to the kind of information that the researchers were seeking. For example, when asked to reflect on the impact of the youth’s NSSI on their parenting or wellbeing, this was the type of response that participants generally gave. As a result, a theoretical and semantic approach was used for data analysis, and the research questions were ultimately analyzed individually. Richer descriptions of participants’ experiences may have been obtained through less direct questions and an inductive thematic analyses conducted across the entirety of participants’ responses.

There is unavoidable subjectivity in conducting thematic analyses, and the researcher approached these analyses from the perspective of a mother with a professional background in child and adolescent clinical psychology and with a specific interest in NSSI; while another researcher approaching these analyses from a similar background is likely to find similar themes, other researchers may find different themes in the data. To this end, it is important to note that this study did not assess reliability of these thematic analyses. This omission is supported by the view that traditional testing of reliability is not necessarily applicable to thematic analyses (e.g., Golafshani, 2003; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Vaismoradi, 2013), as multiple
researchers can apply the same biased perspective in coding for reliability (Loffée & Yardley, 2004). Rather, reliability in thematic analyses may be dependent on validity, which itself depends on the trustworthiness with respect to the extent that the analyses adheres to the rigour of the approach (Golafshani, 2003; Morse et al., 2002; Vaismoradi, 2013). The researcher’s adherence to the prescribed approach is outlined in the methods.

Finally, this study also makes the assumption that meeting parents’ perceived needs would result in greater capacity for parents to support their youth. However, there is not yet research available to support this assumption. While a recent treatment efficacy review (Glenn et al., 2015) suggests that including parents in the youth’s treatment for NSSI, as participants desired, does indeed lead to better outcomes for the youth, it is unclear to what extent the perceived needs of parents are met through these interventions. More research into the role of parents in treatment for youth NSSI is needed.

**Conclusion**

Youth NSSI has a considerable impact on parents (Byrne et al., 2008; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). This study outlined the ways in which youth NSSI impacts parents, the needs that parents have while supporting their youth, where or from whom parents seek help with respect to the youth’s NSSI, and the ways in which the Internet may be useful in meeting parents’ needs. Indeed, parent involvement may be paramount to supporting a young person’s recovery through NSSI (e.g., Arbuthnott & Lewis, 2015; Glenn et al., 2015). Meeting parents’ needs may better equip them for this role. These results have implications for ways in which parents may be supported by mental health professionals and via the Internet, which may in turn equip them to more effectively support their youth through NSSI.
Figure 4.1. Thematic map for the impact of youth NSSI on parents.
Figure 4.2. Thematic map for parents’ perceived needs for supporting their youth.
Figure 4.3. Thematic map for the barriers to help-seeking.
Figure 4.4. Thematic map for what makes a response helpful when help is sought.
Figure 4.5. Thematic map for the Internet as a medium to support parents.
Figure 4.6. Rates of help-seeking from various sources for the youth and for the participant, with respect to the youth’s NSSI.
Figure 4.7. Percentage of participants who had sought help for their youth or for themselves, with respect to their youth’s NSSI, who indicated that the source had been “somewhat helpful” or “very helpful”.

Source of Help
Chapter Five

Concluding Discussion

This dissertation focused on understanding the ways in which parents may be equipped to support their youth, and the potential role of the Internet in supporting parents for this role.

Chapter Two presented a systematic literature review which synthesized the literature on parent factors implicated in youth NSSI risk, the role of parents in help-seeking and interventions for youth NSSI, and the impact of youth NSSI on parent wellbeing and parenting. The results indicated that parents have a key role in the prevention and treatment of NSSI, and that youth NSSI has a significant impact on parents.

Chapter Three presented a model linking adolescent mental health challenges to parent wellbeing through parenting self-efficacy within a sample of parents of youth with a history of NSSI. Results indicated that parenting self-efficacy partially mediated the relation between young people’s mental health challenges and parent wellbeing (i.e., symptoms of depression, anxiety, perceived stress, and life satisfaction). Furthermore, parent emotion dysregulation mediated the relation between NSSI literacy and parenting self-efficacy, as well as the relation between social support and parenting self-efficacy.

Chapter Four examined the perceived needs of parents of youth who self-injure, from where or whom parents are seeking help to meet these needs, and the potential role of the Internet as a medium to support these parents. Thematic analyses were used to identify salient themes regarding the impact of youth’s self-injury on parents (i.e., elicitation of difficult emotions, exacerbation of mental health challenges, uncertainty as a parent, recognition of growth), parents’ needs as they support their youth (i.e., need for NSSI literacy, need for peer support, need for effective professional support, need for self-care), and the ways in which
parents think the Internet could be used to meet their needs (i.e., information and self-help tools, connection with peers, readily-available mental health professionals). Sources from which parents seek help (i.e., both informal and professional supports, including the Internet), the barriers to seeking help (i.e., inability to access effective mental health services, parent negative expectations, youth’s resistance to receiving help), and what it is about these sources that make them helpful (i.e., validation and connection, competent family-centered professionals, caring for the parent as separate from the youth) were also assessed.

**Integrated Implications and Future Directions**

The results from each of the three studies had unique and self-contained theoretical and clinical implications, which were discussed in each chapter above. Although each study had a unique focus, three topics were prominent throughout the entirety of this dissertation: the interaction between information, support, and parenting self-efficacy; the key role that parents may play in the youth’s recovery from NSSI; and the potential for the Internet to support parents for this role. Implications integrating the results across studies, as well as future direction for research, are discussed below.

**Information, Support, and Parenting Self-Efficacy**

The provision of accurate information about NSSI is a first step towards educating parents about NSSI and reducing stigma—including parents’ self-stigma. Efforts to educate both professionals (i.e., medical, mental health, and school professionals) and the general public need to be continued, as the ways in which professionals respond to youth and their parents have a significant impact on parents and may affect parents’ ability to support their youth. NSSI is a common issue among youth; however, many parents report feeling alone and blamed.
Parent shame and blame may be inhibiting parents from supporting their youth and interfering with parenting self-efficacy. Receiving validation and support when seeking help was deemed to be particularly helpful. Receiving validation in response to disclosures of their youth’s NSSI may allow the parent to validate their own experiences, and thereby help them to more effectively regulate their emotions through self-compassion. Self-compassion has been linked to lower levels of parenting stress and higher levels of effective parenting (Gouveia, Carona, Canavarro, & Moreira, 2016). Self-compassion may contribute to greater parenting self-efficacy and help parents more effectively support the youth. Thus, in addition to obtaining information about NSSI, experiencing validation may be needed to contradict self-blame. Future research may consider exploring the role of self-compassion in parent wellbeing among parents of youth who self-injure, and how self-compassion can be fostered for these parents.

Another variable emerging from this project as a possible factor affecting parenting self-efficacy may be acceptance. The ability to accept the situation as it is, without the need to change it, may provide parents with a little more space in which they can choose their parenting behaviour in accordance with their values and goals. Indeed, several parents highlighted that the process of relinquishing responsibility for their youth’s challenges and accepting the situation resulted in their own psychological growth. These results suggest that parents may benefit from fostering mindfulness skills, which may not only promote acceptance of the parents’ situation, but may also enhance emotion regulation skills (Coffey, Hartman, & Fredrickson, 2010; Rutherford, Wallace, Laurent, & Mayes, 2015) and reduce parents’ stress and psychopathology (Bögels, Hellemans, van Deursen, Römer, & van der Meulen, 2014). Mindfulness has been linked to greater self-compassion and more effective parenting (Gouveia, Carona, Canavarro, & Moreira, 2016; Rutherford et al., 2015), and mindfulness skills have been taught to parents of
youth experiencing mental health challenges (e.g., Bögels et al., 2014; Coatsworth et al., 2015). Future researchers may consider exploring the role of mindfulness in parenting self-efficacy and parents’ capacity to support youth among parents of youth who self-injure specifically.

There may also be a role for peer-support in increasing parenting self-efficacy. Although social support (as a more general variable) was not found to be a unique predictor of parenting self-efficacy, the measure used in this study did not include peer support specifically. Seeing others get through a similar difficult situation may provide parents with hope for a successful outcome, as well as guidance for how to get through it. Thus, parents may gain self-efficacy through vicarious experiences through their peers. Indeed, many parents indicated that it was extremely beneficial to meet other parents going through the same thing and to learn that they are not alone. These results have implications for the development of peer support networks for parents of youth who self-injure. Future research needs to explore the influence of peer-support in supporting parents of youth who self-injure specifically, and parents of youth with mental health challenges more generally.

Although this project was intended to assess the ways in which parents may be equipped to support their youth through NSSI, the results also may be applicable to parents of youth experiencing other mental health challenges. More research is needed to extend these results to other mental health populations. Further research is also needed to distinguish the extent to which these parents need NSSI specific supports beyond general mental health literacy and peer-support. The stigma attached to NSSI may make it even more challenging for parents to find adequate support for NSSI specifically. Given the high comorbidity between NSSI and other mental health concerns (Janis & Nock, 2009; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), it is unclear whether there is a difference in parents’ needs when they are
supporting a youth with complex mental health challenges that include NSSI in comparison to supporting a youth experiencing NSSI without other challenges.

**Parent Involvement in Treatment for Youth NSSI.** The results from this project indicate that not only do parents feel that they need to be involved in their youth’s treatment, but their inclusion (when not contraindicated) may actually be conducive to helping them support their youth. This is consistent with current evidence-based treatment for NSSI; treatments with the greatest evidence of efficacy include a parent component (Glenn, Franklin, & Nock, 2015).

Given the link between emotion dysregulation and NSSI (Andover & Morris, 2014), one clinical focus for youth with NSSI is on interventions involving the teaching of emotion regulation skills (see Glenn et al., 2015; Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015). However, as a link was found in this study between parent emotion regulation skills and parenting self-efficacy, it may be quite logical for parents to be included in the youth’s psychoeducation and emotion skills training. Learning to regulate their own emotions may allow parents to model effective emotion regulation strategies for their youth, and to coach their youth through difficult emotions (Rutherford et al., 2015). Several others ways in which parents can be included in the youth’s treatment have already been explored throughout the previous chapters. It is important to note that while it is important to have parents involved in the youth’s treatment, clinicians need to balance parent involvement with respect for the youth’s sense of autonomy within the therapeutic context.

Most interventions assume that the youth engaging in NSSI is involved in treatment. However, a significant barrier to seeking help identified in this study is the youth’s unwillingness to access help. This may cause parents to feel helpless, and to avoid seeking help altogether. There needs to be support available for parents even if their youth are not willing or able to
accept professional help. Participants have identified that they need professional supports both to deal with their own issues and to teach them to respond to their children’s emotions effectively. Meeting these parents’ needs does not necessarily require the youth to be in therapy. Several parent psychoeducation programs have been found to be beneficial in increasing parents’ ability to support their youth who self-harm (e.g., Pineda & Dadds, 2013; Power et al., 2009; Tambourou et al., 2002). Improvements in parent wellbeing and parenting self-efficacy may alter parenting behaviours, which may in turn reduce the youth’s mental health challenges. Thus, working with the parent alone to increase parenting competence may result in improvements in youth’s symptoms as well as parents’, even without the youth’s presence in treatment.

Just as the youth may be unwilling or unable to participate in treatment, there may be cases where a parent cannot participate in the youth’s treatment, or may not be able to participate to the level that the parent would prefer. Indeed, parent mental health challenges may reduce parents’ capacity to support their youth (e.g., Reupert & Maybery, 2007). Treatment providers may need to be cognizant of the family’s resources and capacities, and to tailor the degree of parental involvement to a level that is most effective for meeting the needs of both the parent and the youth. Where appropriate, parents should be referred to their own mental health supports to address mental health challenges that may interfere with their ability to support the youth.

This project focuses on supporting parents as they support their youth, with the assumption that meeting parents’ perceived needs would better equip them to support their youth. However, sometimes the perceived needs of parents may not align with factors that are beneficial to the youth. Indeed, parents and youth may experience contradictory or competing needs. In some cases it may be more appropriate to treat the youth without parental involvement. This project does not take into account what youth want from their parents, what they believe
they need from their parents, and how they experience their parents’ involvement in their treatment; understanding the dynamics between parent and youth needs surrounding parent involvement in treatment is an avenue for future research. Similarly, as youth mature, their needs and their parents’ needs may change to reflect the youth’s increasing autonomy. More research is needed to understand the changing role of parents in supporting their youth as their youth mature from preteens into young adults.

Further clinical research also needs to be conducted to understand the link between inclusion of parents in treatment for youth NSSI and treatment outcomes for both parents and youth. Topics to explore may include the extent to which parenting self-efficacy increases through involvement in the youth’s treatment (e.g., through the acquisition of skills, reduced self-blame), changes in parenting behaviours (e.g., discipline strategies, parenting consistency), alterations in family functioning (e.g., alliance, communication), and untargeted improvements in parents’ functioning resulting from the acquisition of skills and knowledge that the parents may apply to themselves as well as to their youth. Linking youth outcomes to parent outcomes may provide insight into how altering parent functioning and family dynamics may promote healing for the youth.

The Internet as a Medium to Support Parents. The Internet may be one of the first places where parents look for resources regarding their youth’s NSSI. Seeking professional support may require considerable resources, and not all youth who self-injure may need specialized professional mental health services. Similarly, local professional supports may be limited or difficult to access. It may be useful to tailor the level of intervention to the specific needs of the youth and the family. Some parents may be able to find what they need on the Internet, and may not need professional support to help them support their youth. To this end, it
is essential that information about NSSI on the Internet be accurate and accessible, and that it covers the range of topics that parents need information about (e.g., information about mental health in general, NSSI specific information, parenting information, self-care information). Unfortunately, this is not necessarily the case, as information on the Internet is laden with misconceptions and relevant e-material can be difficult to find (e.g., Lewis, Mahdy, Michel, & Arbuthnott, 2014).

Furthermore, given the link between emotion regulation and parenting self-efficacy found in this project, it may also be helpful for parents if credible NSSI websites provide links to online programs that teach emotion regulation skills within the context of parenting challenges associated with parenting youth. Unfortunately, such programs are difficult to find online, tend to focus on parents of young children rather than youth, often assume that parents already have the emotion regulation skills and merely provide a rationale for using them, and sometimes come across as judgemental and blaming of parents for the child’s difficult behaviours. Parents may not, in fact, have the skills they need to regulate their own emotions, and may need more concrete coaching in how to implement emotion regulation skills as they learn them, as well as how to use these skills during stressful parenting moments. Thus, an e-program specific to these parents’ needs may be beneficial.

The Internet may also be useful in meeting parents’ need for peer support through the development of opportunities for parents to interact with each other (e.g., forums, chat room). However, the advantages and risks of such networks for parents are not yet understood. For example, while online interactions among individuals who self-injure may have some peer support benefits, there are also considerable risks that may reinforce and maintain the NSSI behaviours (e.g., Lewis, Heath, Michal, & Duggan; 2012; Lewis & Seko, 2016). It is unclear
whether peer support online may have unintended negative consequences for parents (e.g., increasing feelings of helplessness) in addition to potential benefits (e.g., feeling less alone).

Several participants in this study who had sought peer support on the Internet found that the peer support available online was woefully inadequate and discouraging. It may be instrumental for a mental health professional to moderate online interactions between parents. Further research is needed to understand peer support among parents on the Internet.

Parents may gain the same level of support from reading stories from peers without necessarily having the ability to interact with each other. Having access to a wide range of stories about recovery from NSSI from both other parents and their youth may increase parents’ self-efficacy vicariously, provide hope that they and their youth can overcome this challenge, and reduce parents’ sense of isolation and shame. Although some NSSI websites already provide stories for individuals who have recovered from NSSI (e.g., Self-Injury Outreach and Support; http://sioutreach.org), the inclusion of parents’ stories may be very beneficial for parents.

**Final Thoughts**

Supporting a youth who self-injures can be extremely challenging for parents. The results from this dissertation make it clear that NSSI has a significant impact on parents, that parents have a key role to play throughout the youth’s recovery process, and that parents themselves need appropriate supports as they support their youth. While mental health professionals may be able to provide some of this support—particularly through the inclusion of parents in the youth’s treatment plan—the Internet may also have a unique role in providing information and peer support to parents. While some resources currently available online are adequate in meeting some of parents’ needs, there is room for improvement. It is my hope that the results from this
dissertation will further the support available to parents, which may in turn better equip them to support their youth.
Bibliography


