AN ATTACHMENT PARENTING GROUP FOR CAREGIVERS OF ADOLESCENTS WHO SELF-INJURE

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AN ATTACHMENT INFORMED PARENTING GROUP FOR CAREGIVERS OF ADOLESCENTS WHO SELF-INJURE

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Dedication

This project is dedicated to the caregivers who have loved and cared for a child or adolescent who was struggling with self-injury, who have been dismissed and blamed as parents, yet not provided with adequate resources to support them in feeling confident in caring for their young person. This project is also dedicated to all the individuals who have struggled with self-injury during their lifetimes, to those who felt alone in their pain, and especially to those who have died by suicide after battling through trauma and mental illness.

Abstract

Collected Parenting: Using Attachment to Care for Self-Injury is an eight-week-psychoeducational counselling group that was designed to support those who are caring for an adolescent who engages in non-suicidal self-injury (NSSI). The group content was developed based off of a comprehensive literature review on self-injury and attachment informed parenting. The Collected Parenting Group was developed to provide caregivers with education about NSSI, a space for them to receive support from peers and mental health professionals, as well as education about attachment informed parenting and practical strategies for using it to care for and manage NSSI. A group leader's manual is provided to guide the organizing, content structure, marketing and facilitation of the Collected Parenting Group.

Keywords. Self-injury, parenting, attachment, attachment parenting, attachment informed parenting

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Chapter I: Introduction

The purpose of this project was to develop an eight-week psychoeducational counselling group for caregivers who are supporting a youth who engages in non-suicidal self-injury (NSSI). This chapter provides an overview of the structure of the project, its rationale and significance, and the authors statement of personal interest.

Final Project Overview

Non-suicidal self-injury is a concerning behaviour that is relatively common amongst adolescents (Cipriano et al., 2020; Voss et al., 2020). The behaviour has been researched for decades, but despite this literature there is a paucity of research on the effects that NSSI has upon those caring for the individuals engaging in it. Caregivers are often the first to discover when a youth is self-injuring and are often the ones responsible for managing the NSSI within the home, ensuring the youths safety and seeking treatment (Simone & Hamza, 2020). This is a great responsibility and one that likely comes with a lot of stress. Unfortunately, many caregivers may not receive the supports that they need during this process (Krysinska et al., 2020; Steggals et al., 2020). Indeed, caregivers identified a need for more psychoeducation and emotional support. This project aimed to address these needs by creating a group that integrates psychoeducation with elements of group therapy.

This project begins with a comprehensive literature review about NSSI and attachment, including what it is, who is at risk for it, how society and culture impact it, and the most common modalities used to treat it. This is followed by an explanation of what attachment is and how the theory can be used to inform parenting practices, specifically in relation to NSSI. Following this literature review, an overview of the

logistics of the group *Collected Parenting: Using Attachment to Care for Self-Injury* is provided, along with a manual that details the content and activity of each of the eight sessions.

Rationale

Self-injury is an alarming and complex behaviour, and one that is generally not that well understood by people. Many view it as attention seeking, and sometimes even manipulative (Duarte et al., 2019, 2020). This poses a concern, because the way we view the motives for self-injury may impact our feelings about it. When people view NSSI as being a result of drug use they were more likely to respond with anger, and viewing it as attention seeking also leads to more negative reactions in response to it (Park et al., 2021). This becomes particularly concerning when these views are held by the caregivers of people who self-injure. It may lead to the caregiver having a negative reaction when they learn of their youth's NSSI, which in turn may impede treatment seeking from the youth, instill a sense of shame and push them away from the caregiver (Park et al., 2021; Rosenrot & Lewis, 2020). On the contrary, when people view NSSI as being a way to cope with emotional pain, they are more likely to respond to it with support (Park et al., 2021).

Understandably, caregivers report feeling in disbelief when they first learn about their youths NSSI (Krysinska et al., 2020). They also report a lack of resources available to them as caregivers, along with a lack of support from professionals (Ferrey et al., 2016a; Krysinska et al., 2020; Stewart et al., 2018). Given that caregivers are identified as a crucial support for their children (Rosenrot & Lewis, 2020) and that the parent-child relationship has a strong impact on a person's well-being (Bowlby, 1969), it seems

imperative that caregivers are provided with the appropriate supports that will allow them to best care for their youth. The Collected Parenting group will meet this need by providing caregivers with a place to learn about self-injury, parenting practices that work best with it, a space with easy access to a mental health professional who is willing to answer their questions, and perhaps most importantly-peer support from other caregivers who have lived through this. As mentioned, a group format was chosen as it will be able to meet both the psychoeducational and the emotional needs that many caregivers felt were lacking. Groups have shown to be an effective format of psychotherapy, as they provide a space where people can learn new information, gain a sense of hope, and the interpersonal aspects of the group allow for the development of social skills and the processing of interpersonal conflict (Yalom & Leszcz, 2005). The in-the-moment feedback that group members receive on their interactions with others also make this a valuable format, as it can help participants to reflect upon how their communication may be affecting their children (Champe & Rubel, 2012). A similar group has already been implemented in Ireland, and has shown reductions in the psychological distress of caregivers and to increase parental satisfaction (Power et al., 2009). These factors that are included in the group—interpersonal relationships, skills training, and caregiver involvement—are crucial components to any effective NSSI treatment (Fortune et al., 2016a; Glazebrook et al., 2015). Based on these results, it is anticipated that the Collected Parenting group will have positive benefits.

Significance of this Project

Given that throughout the literature, caregivers of young people who self-injure consistently reported a need for both educational and emotional support in relation to

NSSI, I anticipate that the Collected Parenting group is a needed resource. Caring for someone who self-injures may be difficult emotionally, physically, relationally and financially (Ferrey et al., 2016b). Parenting is already a stressful endeavor, even more so when you add in the aforementioned stressors. As shown by the group implemented in Ireland, a group that provides emotional and educational support to caregivers may reduce their stress and increase parenting satisfaction (Power et al., 2009). This may then allow them to better connect with and support their young person. Connection often gets lost in the hustle and bustle of daily life-especially when the caregiver is preoccupied with concern about incidents of NSSI. It is my hope that this group will encourage caregivers to prioritize connection, which has the potential to reduce both caregiver and adolescent stress, improve the parent-teen relationship, and increase emotion regulation (Booth & Jernberg, 2010; Neufeld & Mate, 2013). By improving those factors, it has the potential to even reduce NSSI.

Statement of Personal Interest

My interest in both NSSI and attachment began early in my career within the mental health sector. I had the privilege of working within a residential treatment centre that was designed specifically for adolescents who were struggling with self-harming and suicidal behaviours. Building relationships with these teens and their families showed me both the depths of pain these teens experience that led them to self-injure, and it also showed me the profound love that these caregivers held for their children and the depths of their desire to help them. Unfortunately, the experiences of these caregivers that I worked with mirrored what I found in the literature. They were often blamed, dismissed, and provided with few parenting resources. So often I saw professionals in almost the

same boat as the caregivers-lost, and unsure what more to do for this adolescent. Meanwhile, the most powerful resource was right there—the caregiver—and I seldom saw the power of the attachment relationship used to treat NSSI. After working for one year as an attachment-informed play-therapist, I thought back on my experience at that program and was inspired to create something that would harness the power of the attachment relationship to help those who struggle with NSSI.

Chapter II: Literature Review

Self-injury is a paradox between life and death. The deliberate infliction of pain and damage upon one's own body has a common public perception of being associated with suicide. In many ways, however, self-injury is a life preserving behaviour. This is supported by theoretical and empirical evidence, which suggests that self-injury is used as a means of suicide prevention and may provide relief from painful emotions (Klonsky et al., 2015). Self-injury is a wide-spread behaviour that may occur in all age groups, and a behaviour that has a profound impact upon our healthcare systems. This literature review will provide a comprehensive overview of self-injury including how to treat it, with a special emphasis on how caregivers can be involved in the treatment process. The attachment philosophy of parenting will be drawn upon to develop a manual for an eight-week psychoeducational counselling program for caregivers of individuals who self-injure.

Non-Suicidal Self-Injury

What is Non-Suicidal Self-Injury?

Historically, there have been inconsistencies in how self-injury was defined in the literature. Some researchers included behaviours with suicidal intent, while others included indirect forms of self-injury such as food restriction or engaging in risky situations like reckless driving (Goldstein et al., 2009). There has been greater consistency of terminology in recent years, and now self-harm is known as the umbrella term under which all self-injurious behaviours fall, including those with suicidal intent and indirect forms of self-injury (Heath et al., 2008a). Non-suicidal self-injury (NSSI) has become the most used term within self-harm literature to describe self-injurious

behaviours without suicidal intent. NSSI has been defined by the International Network for the Study of Self-Injury (ISSS) as "the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned." (*International Society for the Treatment of Self-Injury*, 2018). To be classified as NSSI, the behaviour must result in immediate physical injury, which disqualifies behaviours such as food restriction and reckless driving. This term will be used throughout this project. Other terminology that is often used simultaneously with NSSI is Deliberate Self-Harm (DSH) and Self-Injurious Behaviour (SIB).

NSSI can include any intentional behaviour that results in tissue damage, but some common methods include skin cutting, scratching (with nails or another object), self-battery, burning (with a heated object, chemical, or by rubbing something abrasive on the skin), wall-punching, skin carving, self-biting, self-pinching, and bone breaking (Klonsky et al., 2015). These injuries may be inflicted upon any part of the body, but are often done on the arms, thighs or stomach (Whitlock et al., 2008; Xavier et al., 2017).

How common is NSSI?

Non-suicidal self-injury is a relatively common behaviour, and one that has been increasing (Duffy et al., 2019). In clinical samples of adolescents, rates of 21.2-55.9% have been found (Boxer, 2010; Rodríguez-Blanco et al., 2021; Sánchez-Teruel et al., 2020), while in community samples of adolescents, rates ranged from 5.03-51.7% (Buelens et al., 2019; Cipriano et al., 2020; Costa et al., 2020; Xavier et al., 2017, 2018). In samples of young adults in the community, rates ranged from 19.3-33.2% (Case et al., 2020; Gandhi et al., 2018; Voss et al., 2020). Prevalence rates also vary between countries. In the United States, 33.2-46.5% have been found (Case et al., 2020; Howe-

Martin et al., 2012; Lloyd-Richardson et al., 2007), 11.68-29.5% in Canadian samples (Glenn & Klonsky, 2010; Goldstein et al., 2009; Hamza & Willoughby, 2019; Heath et al., 2008b; Laye-Gindhu & Schonert-Reichl, 2005), 10.1% in Australia (Voon et al., 2014), 10% in Ireland (O'Connor et al., 2014), 45.3% in Brasil (Costa et al., 2020), 13.8% in Belgium (Buelens et al., 2019), 22-51.67% in Portugal (Xavier et al., 2017, 2018), 19.3% in Germany (Voss et al., 2020), 5.03% in Italy (Cipriano et al., 2020), 11.8%-38.9% in China (Gu et al., 2020; Liu et al., 2021; Xu et al., 2019), 28.3%-33.3% in Korea (Kim et al., 2021; Lee et al., 2021), and 28.5% in Turkey (Idig-Camuroglu & Gölge, 2018). The discrepancies found may be due to a multitude of factors. In some instances, it may be attributed to cultural factors. For example, researchers noted that the political climate of Ireland may have lead to a distrust of authority figures, which may have influenced the way participants responded (O'Connor et al., 2014). Another possibility is the measurement used. There is no uniformly used measure to assess NSSI, and though there are a few that are widely used, they do differ in certain regards which could impact the results. Further, some researchers don't use standardized measures at all; for instance, some researchers opt to use a single question such as 'have you engaged in self-injury in the past year?' This method in particular may impact prevalence statistics, as it would be easy to underreport or overreport NSSI based on each participants personal understanding of what 'self-injury' means. Results may also vary depending on if the researchers ask about lifetime history of NSSI, or past year NSSI. Lastly, how the researchers recruit participants may impact the results. For instance, whether they advertise the study as being about NSSI or if they advertise it as a study on

negative coping may attract differing types of people who have different experiences with NSSI.

Why is NSSI a concern?

Non-suicidal self-injury is a prevalent and growing mental health concern with numerous consequences, and for this reason the Diagnostic and Statistical Manual of mental disorders (DSM) committee identified it in the DSM-5 as an area that warrants further study (In-Albon et al., 2013). The consequences of NSSI are many, but the worst potential consequence is suicide. In a study conducted by Cooper et al., 2005, it was found that individuals with a history of self-injury were 34 times more likely to die by suicide; when partitioned by gender, females were 50 times more likely to die by suicide, and males 29 times more likely (Cooper et al., 2005).

Even in the absence of suicide, NSSI is marked by profound emotional distress. Though it is often used as a short-term coping mechanism, the long-term effects of it may include exposure to stigma and an increase in feelings of shame. This is particularly true when visible scarring occurs (Piccirillo et al., 2020). Another consequence that is often not thought about is the economic impact that both NSSI and suicide have upon society. These impacts include publicly funded ambulatory care, hospital care, and therapy. In England, a country that has similar prevalence rates of NSSI to Canada, a yearly cost of 128.6 million British pounds was estimated to have been spent on hospital services related to self-injury (Tsiachristas et al., 2020). In Ontario, Canada, each individual who presented to the hospital for self-harm was estimated to cost the healthcare system $30,388 over a five year period (Gardner et al., 2019). Using the sample size of 5661

self-injuring adolescents that was used in that study, that would equate to over $172 million dollars every five years.

Self-injury can have drastic impacts upon the individual, their loved ones, and the healthcare system. It is imperative that treatment options are developed that can support not only those engaging in NSSI, but also the people caring for them. It has the potential to save lives, as well as to save money on an individual and tax-payer level.

Who engages in NSSI?

NSSI is a widespread behaviour that has the potential to occur at any age and within any socioeconomic status, ethnicity, gender, or sexual orientation. Each of these will be discussed in greater detail.

Age. Though the onset of NSSI most commonly begins in adolescence, it has been observed in young children as well as older adults (DeVille et al., 2020; Emelianchik-Key & Guardia, 2020). Gandhi et al., 2018 found the most common age of onset to be between 14-15 years of age, and they also noted another peak during 20-24 years of age. These results were the same between community and clinical samples (Gandhi et al., 2018).

Gender. Many research results have suggested that females are more likely to engage in NSSI, but it is also important to note that many studies have a disproportionately high number of females in their sample which may impact the results. For example, in a study conducted in Portugal (Xavier et al., 2017), researchers claimed that significantly more females engaged in NSSI but failed to highlight that their sample consisted of nearly twice as many females to males (65.3% to 34.7%). The following data is taken from studies that have a more equal representation of gender in their participants.

A German study found significant gender differences in a sample of adolescents and young adults, with females being more likely to endorse NSSI thoughts and behaviours than males (Voss et al., 2020). Females were also more likely to endorse suicidal behaviours alongside NSSI, whereas males were more likely to endorse having suicidal behaviour without any co-occurring NSSI (Voss et al., 2020). Similarly, Xavier et al. (2018) explored the relationships between daily peer hassles, NSSI and avoidance-based emotion regulation strategies in a sample of Portuguese adolescents and found that females endorsed NSSI significantly more than males. The results also showed that females were more likely than males to experience brooding, experiential avoidance, and dissociation—all avoidant regulation strategies which increase the risk for depressive symptoms, which in turn elevate the risk for NSSI. Additionally, they perceived more daily peer hassles than did male students. Daily peer hassles can be a cause of distress for many people, arguably even more so in the adolescent years. These results suggest that females are more likely to manage that distress with avoidance-based emotion regulation strategies which in turn may elevate depressive symptoms and thus place females at higher risk for NSSI (Xavier et al., 2018). Lastly, a meta-analysis on gender differences in NSSI found that females were overall more likely to report a history of NSSI than were males, and this difference was particularly pronounced in clinical samples (Bresin & Schoenleber, 2015). The other gender difference that has been noted in the literature is a difference in which methods of NSSI are used. Two studies found that males were more like to use self-battery, and females were more likely to use cutting or scratching (Muehlenkamp & Gutierrez, 2004; Whitlock et al., 2008) and that as a result males were more likely to injure their hands and females their thighs or wrist (Whitlock, 2006). The

same meta-analysis mentioned previously also found that females were significantly more likely to engage in the following NSSI methods: cutting, biting, scratching, pinching, hair pulling and wound interference than males were (Bresin & Schoenleber, 2015).

Ethnicity. Self-injury does not discriminate between race or ethnicity, as demonstrated by research that shows its occurrence around the world. As mentioned in a previous section, in Brasil 45.3% of a sample reported a history of NSSI (Costa et al., 2020), in Portual 51.67% (Xavier et al., 2017) and 22% (Xavier et al., 2018), and it was also prevalent in China, Korea and Turkey. A qualitative study also indicated that the behaviour is prevalent in Ghana (Quarshie et al., 2020). Though these studies provide representation of different cultures and people of colour, there is still far more research done in primarily white societies. Further, given that these studies are done within different cultures it is difficult to make any comparisons. Studies have attempted to look at differences in NSSI between races within the same society, but a limitation to them is that they use samples that are largely White. For this reason, the results must be interpreted with caution.

Wester and Trepal, 2015., explored the relationships between NSSI, race, ethnic identity and ethnic belonging using a sample comprised of White (47.6%), Hispanic/Latino (19.5%), African American (14.1%), Multiracial (10.2%) and Asian/Asian American (7.8%) peoples. The researchers found no significant differences in NSSI engagement between Hispanic/Latino, White, or Multiracial participants, but they did find that African American and Asian American participants reported significantly less NSSI than did the other groups. Pertaining to ethnic belonging, those

who reported lower belonging and commitment to their ethnic group were more likely to have reported engagement in NSSI, and they were more likely to have utilized a variety of NSSI methods. Fitting with this, Caucasian and Multiracial participants had a lower sense of belonging to an ethnic group as compared to African American and Asian Americans, which may have contributed to their greater risk of having engaged in NSSI. The anomaly to this was the Hispanic/Latino group, who reported higher levels of ethnic belonging but also had similar histories of NSSI as Caucasian and Multiracial participants (Wester & Trepal, 2015).

Another recent study explored the interactions between mental health, race and ethnicity amongst sexual and gender minority adolescents in the USA (Fox et al., 2020). Most of the sample identified as White with 66.52%, 4.86% Black, 9.25% Latinx, 7.15% Asian and 15.57% as Multiracial. With regards to race, White participants were more likely to have reported NSSI as compared to Asian participants, and White cisgender heterosexual participants were more likely to have reported NSSI than were Black sexual/gender minority participants. These results may be due to the larger representation of White cisgendered participants, however the researchers also noted a potential race related factor that may explain the results. Due to systemic racism, many Black parents teach their children how to cope with discrimination. This could potentially lead to Black gender/sexual minority participants being better able to cope with LGBTQIAS+ discrimination, which would reduce the risk of NSSI (Fox et al., 2020).

Lastly, in a review of literature the reviewers noted that the relationship between NSSI, ethnicity and race may be mediated by other factors such as socioeconomic status (SES) and gender (Gholamrezaei et al., 2017). Of the studies reviewed, they found that

African-American university students consistently showed lower rates of NSSI, but at the high school level African-Americans from both low and high SES had a greater likelihood of NSSI. They postulated that educational attainment and the related social and economic advantage may buffer against the effects of racism, and protect against NSSI (Gholamrezaei et al., 2017). They also found through their review that Asian/Asian-American university students from low SES families are vulnerable to self-injury, and that Indigenous populations tend to have a high prevalence of NSSI in both adolescence and young adulthood. The authors proposed that generational trauma and continued systemic racism may contribute to these rates (Gholamrezaei et al., 2017).

Socioeconomic Status (SES). Studies have found that SES is related to NSSI. Baetens et al. (2014) found lower SES to be related to higher NSSI in a sample of adolescents. Interestingly, the results mentioned in the previous section—that Asian/Asian-American students from low SES families are at higher risk for NSSI—suggest that the impacts of race and SES may intersect. This same study also found that African-American highschool students from both low and high SES had an elevated risk for NSSI (Gholamrezaei et al., 2017). The last study to be mentioned was done on a Chinese sample of 'left behind children'.This term refers to children whose parent(s) have migrated for work, while the child remains at the original home. This study found SES to have a protective factor, in that children with a high SES family were less likely to self-injure even when faced with stressful life events (Wang et al., 2020)

LGBTQIA2S+. The LGBTQIA2S+ community includes those who identify as sexual and gender minorities. Identifying as part of this community elevates the risk for both NSSI and suicide (Morris & Galupo, 2019). Regarding sexual minorities, in a

college sample 62.8% of sexual minorities reported a history of NSSI (Muehlenkamp et al., 2015). The authors reported that minority stress (the experience of discriminatory events related to your sexual orientation) had a direct effect on NSSI, and there was also an indirect effect in which perceived burdensomeness on loved ones impacted NSSI. This suggests that due to identifying as a sexual minority, some individuals may perceive that they are a burden to friends and family which elevates their risk for NSSI (Muehlenkamp et al., 2015). In an inpatient psychiatric sample, 100% of sexual minorities who were admitted for suicide risk reported NSSI, compared to 88% of heterosexuals. Additionally, sexual minorities were more likely than heterosexuals to engage in more severe methods of NSSI (Peters et al., 2020). Lastly, in a recent study on mental health in gender and sexual minorities, the researchers found that sexual minorities engagement in NSSI was 2-5 times higher than that of cisgender heterosexual participants (Fox et al., 2020). This study also explored the interactions of race and ethnicity amongst this population, and the results showed that Black gender and sexual minorities reported NSSI significantly less than the other groups. The authors postulated that parenting may play a protective factor in this, as some research has shown that parents prepare Black children to anticipate racial discrimination and teach them coping strategies for managing this. These coping strategies could then be applied to sexual and gender minority discrimination (Fox et al., 2020).

Individuals who identify as a gender minority are also at an elevated risk for NSSI, perhaps even more so than those identifying just as sexual minority. This was the case in Fox et al. (2020), who found that gender minority participants were significantly more likely to have engaged in NSSI than cisgender heterosexual and sexual minority

participants. Specifically, the odds of gender minority participants having self-injured was 67% greater than that of sexual minority participants (Fox et al., 2020). Another study also found gender minority individuals to be at higher risk of NSSI and other psychopathology including depression and suicidal ideation (Becerra-Culqui et al., 2018). Interestingly, there also seems to be different levels of risk within the gender minority community as demonstrated by a study in which transmasculine participants had a higher likelihood of suicidal behaviours and NSSI compared to transfeminine participants (Toomey et al., 2018). Similarly, a more recent study showed that transmasculine and transfeminine participants were more likely to have engaged in burning, biting, sticking self with needles, carving and swallowing substances as compared to those identifying as another gender non-conforming identity. Using a variety of NSSI methods has been shown to be predictive of more severe NSSI as well as suicide attempts, which may place transgendered participants at greater risk than other gender minority groups (Morris & Galupo, 2019). An important finding from this mixed-methods study was that many participants identified reduction of gender dysphoria as the primary function of their NSSI (Morris & Galupo, 2019). However, the most used measures of NSSI do not include this as a potential function of the behaviour which suggests that these measures are not fully capturing the experience of gender minority individuals.

Functions of NSSI

Why do youth engage in non-suicidal self-injury? There is a common public perception that self-injury is done as a means of manipulation and attention seeking (Duarte et al., 2019, 2020). This belief is also held by some parents (Rana, 2019) and it is this writer's experience that the same is true in some mental health professionals. This

can be a dangerous belief, as it does not encourage empathy nor compassion and may lead to a reaction to the behaviour that is ultimately unhelpful (Park et al., 2021). As will be discussed in greater detail, self-injury has many functions, and it may even serve multiple functions for the same person (Case et al., 2020) And while eliciting attention can be one of those functions, it may be beneficial to frame it as connection seeking rather than attention seeking (Neufeld & Mate, 2013).

Research supports the functions of NSSI as being categorized into two primary categories: intrapersonal and interpersonal (Klonsky et al., 2015). Intrapersonal functions serve to regulate one's inner experience such as a thought, feeling or memory, whereas interpersonal functions are social in nature and may serve to evoke a behaviour from another person (Klonsky et al., 2015; Nock & Prinstein, 2005). These two categories have been supported by the work of Klonsky (2015). A similar model was developed by Nock and Prinstein (2005), which is known as the Four Function Model (FFM) of NSSI. In line with Klonsky's work, the FFM model distinguishes between automatic and social functions, which are interchangeable with the terms intrapersonal and interpersonal that were mentioned previously. Where the FFM diverges from the two-factor structure is in its inclusion of positive and negative reinforcement, which suggests that each of the functions serves the individual in such a way that it increases the likelihood of the behaviour recurring (Nock & Prinstein, 2005). Each of the categories is exemplified in the table below, which was based off of one found in a study on FFM (Bentley et al., 2014).

Table 1

The Four Function Model of NSSI

Reinforcement type	Negative	Positive
Automatic	Reduce aversive sensations	Increases desired sensations
Social	Reduce aversive social events	Elicits nurturing responses

Social positive reinforcement is supported by research that suggests adolescents experience a significant increase in the quality of their parental relationships, particularly with their fathers, following NSSI (Hilt et al., 2008). This is an example of why NSSI can be framed as connection seeking rather than attention seeking.

Overall, research suggests that intrapersonal functions are more commonly endorsed than interpersonal functions (Brausch & Muehlenkamp, 2018; Taylor et al., 2018; Vieira et al., 2021), and that intrapersonal functions are perceived to be more effective than interpersonal functions (Brausch & Muehlenkamp, 2018). Brausch and Muehlenkamp also found that intrapersonal functions predicted greater lifetime NSSI frequency as well as the use of more NSSI methods (2018). Further, some research results have led researchers to think that different types of self-injurers may use different functions (Klonsky & Olino, 2008). Under each of the intrapersonal and interpersonal functions are specific functions that NSSI may serve for an individual. These will be expanded upon in greater detail.

Intrapersonal Functions.

Affect regulation. Affect (emotion) regulation refers to an individual's ability to manage their emotional experiences, such as their ability to reduce the intensity of an emotion or perhaps to be able to sit with an emotion without engaging in potentially self-

destructive behaviours (Rolston & Lloyd-Richardson, 2015). People practice emotion regulation daily, often without even knowing it. This is accomplished by employing the use of coping mechanisms, which are a set of skills that everyone has which help them to manage stressful situations in life. Coping skills can be either adaptive or maladaptive; in some instances, the same skill can become one or the other, depending on how it is being used. For example, exercise is often recommended as a coping skill, and when used in moderation it is an adaptive coping skill to utilize. However, in the case of some individuals with eating disorders, excessive exercise becomes a means to cope with the fear of gaining weight and the guilt associated with eating (Vieira et al., 2021). In that case, it becomes maladaptive. Similarly, having a glass of wine to relax after a long day is not necessarily bad, but indulging in an entire bottle may become maladaptive. As with the previously mentioned behaviours, NSSI is a coping mechanism (Klonsky, 2007; Lewis & Arbuthnott, 2012; Rolston & Lloyd-Richardson, 2015). Though self-injury can never be considered an adaptive coping skill in the same way as exercise can, one could argue that using it to reduce feelings that may lead to suicide attempts is an adaptive strategy compared to the alternative. NSSI being used as a coping mechanism to regulate painful emotions is widely supported in the literature, with emotion regulation often being the most strongly endorsed of all the functions (Brausch & Muehlenkamp, 2018; Klonsky, 2007; Lang & Sharma-Patel, 2011; Tatnell et al., 2018; Vieira et al., 2021). This was also supported in a meta-analysis that compiled data from 46 studies on the functions of self-injury (Taylor et al., 2018).

Clinical and non-clinical populations reported engaging in NSSI to cope with feelings of depression, anger, anxiety, dissociation, and negative intrusive thoughts

and/or memories (Batey et al., 2010; Klonsky, 2007; Laye-Gindhu & Schonert-Reichl, 2005; Nixon et al., 2002). A recent study conducted a meta-synthesis of qualitative literature on the functions of self-injury and one of the main themes was "*managing my mental state"* (Bryant et al., 2021, p.5). In the interview portion of this study, participants made statements such as *"It helps me deal with trauma memories and stress,"* and *"If my emotions have got too intense it resets/lowers them"* (Bryant et al., 2021, p.5). The participants also reported an increase in positive emotions following the act of self-injury. Another participant in the Bryant et al. (2021) study stated that *"The endorphins at work…still nothing can compare with that warm enveloping sense of calm and stillness inside."* (p.7). Endorphins are an endogenous opioid, which is a naturally occurring chemical produced within our bodies that is responsible for regulating pain. It has been suggested that they play a role in the affect regulation function of NSSI (Bresin & Gordon, 2013; Kirtley et al., 2015). Neuroscience has shown that physical and emotional pain are regulated by similar areas of the brain, and result in a similar neuroendocrine response, which is the production of endorphins. Therefore, the act of self-injuring may release a surge of endorphins which then reduce both the physical pain of the injury, and the emotional pain that the individual was experiencing. It has been further postulated that individuals who engage in NSSI have lower resting levels of these endogenous opioids, which may make them even more susceptible to engaging in behaviours that increase the production of them (Bresin & Gordon, 2013; Kirtley et al., 2015).

Though there has been a great deal of research on the role of affect regulation in NSSI, a limitation of much of the research is that is has relied on retrospective, self-report data. Some would argue that the most accurate results would come from studies that

induce a negative emotional state, allow the participants to self-injure, and compare either their physiological responses throughout the study, or their pre and post self-reports of what they were thinking and feeling prior to engaging in self-injury. Of course, such methodologies are unethical, and they also come with another set of methodological concerns: they are artificial and may not even generalize to self-injury done outside of a laboratory setting. Researchers have attempted to navigate this by utilizing methodologies that assess the effect of pain or self-injury on emotions in real time, in ways that have been deemed ethical. These methods include Ecological Momentary Assessment (EMA), pain administration, and measurements of physiological response during imagined self-injury.

Ecological Momentary Assessment (EMA) is a method that gathers data on positive and negative affect states before and after an episode of NSSI (Muehlenkamp et al., 2009). Participants are given a device on which they may record if an episode of NSSI occurred, and how they felt prior to and following the act. Depending on the study, some may ask participants to simply input an entry if a particular behaviour has occurred, or they may program to device to prompt participants to input data at specific time intervals throughout the day. Many researchers combine those two methods to get a broader set of results (Muehlenkamp et al., 2009).

Researchers used EMA to study NSSI in a sample of inpatients diagnosed with bulimia nervosa. They found that prior to the act of NSSI, participants experienced a decrease of positive emotion and an increase of negative emotion. Following NSSI, they reported an increase in positive affect but there was no change in negative affect. This suggests that NSSI regulated affect simply by increasing positive emotion, but it did

nothing to regulate negative emotion (Muehlenkamp et al., 2009). Another group of researchers utilized EMA with inpatients who had high traits of borderline personality disorder. The researchers found that high levels of negative emotion predicted if the participant would engage in NSSI by the next signal, which suggests that NSSI is used as a strategy to cope with negative feelings. Increased levels of negative emotions and decreased positive emotions were reported after NSSI. This suggests that NSSI does not alleviate negative emotions, but instead may worsen them (Houben et al., 2017).

Pain induction is another method that has been used to study the role of affect regulation in NSSI. Methods of pain induction include the Cold Pressor Test, which requires participants to hold their dominant hand in a container of extremely cold water while pressing a button at the bottom of the container. Participants are free to remove their hand at any time, but the test aims to run for four minutes, and the participant is asked every 15 seconds to rate the intensity and unpleasantness of the pain. Heat induced pain has also been used. Heat is typically administered to the forearm, and participants are exposed to temperatures ranging from 40 to 50 degrees Celsius for a maximum of seven seconds, or until they can no longer handle it (Bohus et al., 2000; Bresin & Gordon, 2013). The goal of using these methods is to assess if participants who self-injure experience a decrease in negative affect following pain. These painful stimuli mimic the use of NSSI as a means of regulating negative emotion.

Another of the theories for why pain may regulate emotions is called *pain offset relief*. According to this theory, physical pain works as a regulating tool because it is easy to control—it is initiated and terminated entirely by the individual. This is contrary to emotional pain, which is difficult to control. As such, the temporary pain associated with

NSSI is considered worthwhile, due to the relief it provides from emotional pain. This theory also ties in with the role of endogenous opioids that was discussed previously, wherein due to neural overlap in the regulation of physical and emotional pain, physical pain (such as with NSSI) may regulate both the physical pain and the emotional distress (Bresin & Gordon, 2013; Kirtley et al., 2015).

Researchers in the USA studied the role of pain offset relief in NSSI. The researchers used electrical shocks as a pain stimulus and measured negative affective valence with the eye blink startle response (a defensive reflex to unpleasant stimuli that is elevated by negative affect and reduced by positive affect). Data from the eyeblink reactivity suggested that pain offset reduced negative affect and increased positive affect in participants with a history of NSSI (Franklin et al., 2012)**.** This may suggest that NSSI is engaged in to alleviate negative distress and increase positive affect.

Hamza and Willoughby (2015) conducted a review of the literature of lab-based studies of affect regulation in NSSI. They found that of the 18 studies reviewed, pain was related to decreases in negative emotion in both NSSI and no NSSI groups. However, the effect was stronger in the NSSI groups (Hamza & Willoughby, 2015). Another group of American researchers studied the role of pain in reducing negative affect in participants with and without NSSI. Participants in the NSSI and control groups completed a negative mood induction and then were randomly administered a painful or nonpainful stimulus. Negative affect was assessed prior to the mood induction, following the mood induction, and after administration of the painful/non-painful stimulus. There was no significant difference between the NSSI and control groups on negative affect reduction. There was a within-group difference in the NSSI group, wherein those who received the painful

stimulus experienced a greater reduction in negative affect than did those who were in the non-painful condition (Bresin & Gordon, 2013).

The last research methodology to be discussed is that of mental imagery of self-injury. Researchers investigated how using self-injury imagery affected physiological arousal, as measured by heart rate and respiration (Brain et al., 1998). Self-injury imagery involves the participants mentally envisioning a time they self-injured and is comprised of four stages. Stage one begins by envisioning the environment in which the NSSI occurred, and Stage 2 requires the participants to think about what was happening immediately before the episode of NSSI. Stage 3 is envisioning the actual act of NSSI, and Stage 4 is comprised of the events that followed the episode. Participants complete self-reports of their affect during the imagery, and physiological data is also collected. Using this method, individuals with a history of NSSI reported that their negative affect did not decrease until Stage 4, and those with current NSSI reported that negative feelings began to decrease during Stage 3 and continued to do so into Stage 4. The physiological readings indicated that for both groups' arousal increased during Stages 1 and 2 and decreased during Stage 3. It did not decrease further in Stage 4. These changes in arousal were not evident in the other imagery scripts employed, which included an accidental injury and the neutral event of making coffee (Brain et al., 1998). The results of this study suggest that even mentally rehearsing self-injury reduces negative affect.

As mentioned, self-report is the most common methodology used within the research. Studies using self-report data may utilize interviews or questionnaires. Some of the results found within these studies will be discussed. In a commonly cited study, 39 participants with a history of NSSI were interviewed about the functions the behaviour

served for them. They were also asked about their emotional state before and after the act of NSSI. Analysis of the interviews showed that NSSI was related to a decrease in affective arousal—participants recalled feeling overwhelmed, sad, and frustrated before the act, but calm afterwards (Klonsky, 2009). Participants were also provided with a list of common functions of NSSI and were asked to endorse which ones applied to them. "*To release emotional pressure that builds up inside of me*" was supported by 85% of the sample, "*to control how I am feeling*" by 58% of the sample, and "*to get rid of intolerable emotions*" by 56% of the sample. An interesting finding from this study was that the reduction of negative affect predicted higher lifetime prevalence of NSSI, indicating that the affect regulation function of NSSI reinforces the behaviour (Klonsky, 2009). Other studies have reported similar statements that support affect regulation as a common function (Bryant et al., 2021; Laye-Gindhu & Schonert-Reichl, 2005; Nixon et al., 2002; O'Connor et al., 2014).

In questionnaire-based studies, affect regulation has also come out as one the most endorsed functions. In one sample, 97.6% of the participants endorsed affect regulation as their primary reason for engaging in NSSI (Nixon et al., 2002), while other researchers reported that 94.8% of their self-injuring sample chose affect regulation as the primary function (Tatnell et al., 2018). A more recent studies results showed that out of the automatic negative functions, "*to avoid or suppress feelings*" was the most strongly supported (Vieira et al., 2021). The last study to be discussed did not directly look at the functions of NSSI, but it explored the relationships between mindfulness, self-compassion, and emotional regulation in self-injury (Per et al., 2021). The researchers found that emotional dysregulation completely mediated the relationship between both

mindfulness and NSSI and self-coldness and NSSI, indicating that emotional distress made it more likely for participants low in mindfulness and high in self-coldness to report a history of NSSI. These results suggest that the act of self-injury may be used as a means to reduce emotional dysregulation (Per et al., 2021).

It is clear that affect regulation is one of the main functions of NSSI, and there is quantitative and qualitative research showing the effectiveness of it (Bresin & Gordon, 2013; Bryant et al., 2021). But does it work in the long term? One's initial reaction is likely that it does not, which is supported by research. For instance, in a study on Canadian high school students, the researchers found that high negative affect was reported prior to an act of NSSI, and while there was a reported reduction in negative affect and increased feelings of relief following the act, there was also an increase in feelings of shame and guilt (Laye-Gindhu & Schonert-Reichl, 2005). Shame has been shown to increase the likelihood of NSSI, which results in many engaging in a cycle of NSSI and shame (Bryant et al., 2021). An Italian study yielded similar results but found that an individual's impulsivity may impact the effect NSSI has on them. Specifically, participants in both the low and high impulsivity groups reported experiencing high negative affect before self-injuring, but what happened following the act differed between the groups. The low-impulsivity group reported feeling relief following NSSI, but the high-impulsivity group reported an increase in negative arousal following NSSI (Di Pierro et al., 2014).

Experiential avoidance is a means of affect regulation. It is a behaviour that's driven by the goal to escape unpleasant emotions, thoughts, and sensations (Chapman et al., 2006). NSSI would be considered an experientially avoidant behaviour. A significant

relationship between experiential avoidance and NSSI was found in a sample of high school students (Howe-Martin et al., 2012). This suggests that NSSI may be used to avoid unwanted inner experiences. Additionally, experiential avoidance predicted problem behaviours, self-injury included, in an inpatient sample in the UK (Kingston et al., 2010).

Anti-dissociation. Dissociation is a feeling of detachment from one's physical and emotional experiences (Batey et al., 2010; Zetterqvist et al., 2018). It exists along a continuum that ranges from mild feelings of detachment from reality to disorders such as depersonalization disorder which is characterized by chronic and severe feelings of dissociation (Davison et al., 2008). Dissociation is common amongst trauma survivors, as it is often used as a coping mechanism when faced with overwhelming emotions (Batey et al., 2010). Research has shown a strong link between dissociation and NSSI (Batey et al., 2010; Swannell et al., 2012; Zetterqvist et al., 2018), and the following studies show that NSSI may reduce feelings of dissociation. In a recent study, reduction of dissociation was listed as the third most commonly endorsed function of NSSI, and self-injury was considered to be effective in reducing it (Brausch & Muehlenkamp, 2018). Further, in a sample of young adults, 18% endorsed *"to feel real"* as a reason for NSSI (Klonsky, 2009) and in a high school sample 34% endorsed *"I felt like I was outside of my body"* as a reason (Laye-Gindhu & Schonert-Reichl, 2005). These findings indicate that individuals used NSSI as a means to ground themselves and come back to feeling that they are in their bodies. Favazza and Conterio (1988) utilized data from a sample of young adults with a history of NSSI, who completed a survey that was mailed to them upon their request following the broadcast of a television show that featured self-abuse.

The surveys that were mailed to the interested individuals included a 173-item questionnaire on self-injury, as well as a portion in which they could write down any comments they had that they thought may help the researchers understand their experience more. One participant wrote, *"I think it is related to the phenomena of depersonalization and feeling 'not me' and feeling invisible."* (p.26).

Anti-suicide. As mentioned previously, self-injury may be a life preserving behaviour. Though the behaviour is often associated with suicide, individuals who self-injure have often cited NSSI as being a means of suicide prevention (Klonsky, 2007, 2009; Laye-Gindhu & Schonert-Reichl, 2005; Nixon et al., 2002). In fact, 41% of a Canadian high school sample supported the statement "*It stopped me from killing myself*" when asked about why they engaged in NSSI (Laye-Gindhu & Schonert-Reichl, 2005), and anti-suicide came out as the fifth most endorsed function in another study (Brausch & Muehlenkamp, 2018). This research is backed up by the statements from individuals who partook in the Bryant et al. (2021) study in which they interviewed individuals who self-injure. Participants said things such as "*One main reason I have never actually tried to quit is the fear that my urge to kill myself would get the better of me,*" and "*I only self-harm really when the urge to kill myself gets really strong I do it to not only punish myself but stop me from killing myself.*" (Bryant et al., 2021, p.5)

Self-Punishment. Self-injury is an act of violence upon the self, and it may serve as a means of self-punishment (Klonsky, 2009; Nock, 2010). In the Canadian high school sample used by Laye-Gindhu and colleagues (2005) 27% endorsed the statement "*I wanted to punish myself*", 70% *"I did not like myself*", and 63% *"I was angry at myself."* In a Northern Irish sample, 46% of girls and 38% of boys reported that wanting to punish

themselves as a motive for their NSSI (O'Connor et al., 2014). Klonsky's (2009) study showed that 69% of participants endorsed *"to express anger at myself"* as a motive of NSSI, though it was most endorsed as their secondary motive. The role of self-punishment has been supported in recent quantitative and qualitative studies as well. In a study exploring emotion regulation difficulties in self-injury, *"to punish myself"* was the most strongly endorsed of the automatic positive functions (Vieira et al., 2021). Meanwhile, self-punishment was a prominent theme in Bryant et al. (2021) study which saw participants say, *"This is true for me and I strongly agree because I feel like I need to be punished for everything*", "*When I self-harm I scratch words into my skin i.e. 'disgusting'. I do this so it scars and then I have a constant reminder of how awful I am,*" and "*I punish myself for my thoughts and how I look. I take this out on myself,*" (p.5). Interestingly, one study found potential cultural differences amongst the functions of NSSI, wherein a Chinese sample did not endorse self-punishment as often as Western samples had (You et al., 2013).

Psychodynamic model. Though the psychodynamic interpretation of self-injury is not included on the psychometric measures of NSSI functions, it is important to mention because much of self-harm research started as psychodynamic case studies. Further, it offers interpretations that may still be held by certain psychodynamic practitioners. This model argues that NSSI is an external manifestation of a person's unconscious drive towards death (Tantam & Whittaker, 1992, as cited in Rayner & Warner, 2013; Suyemoto, 1973). As mentioned before, self-injury may have an anti-suicide function. From a psychodynamic perspective, this would represent the interaction of life and death drives (Rayner & Warner, 2003; Suyemoto, 1998). It has also been viewed as a

redirection of the aggressive drive towards the self (Rayner & Warner, 2003). Psychodynamic theories have also proposed that NSSI communicates unconscious sexual desires. This is supported by participants who disclosed that NSSI is often sensual and enjoyable (Rayner & Warner, 2003) and some individuals have equated NSSI with orgasm (Harrison, 1994, as cited in Rayner & Warner, 2013). However, some individuals strongly disagree with this sentiment. For example, participants in one study made statements such as, "*…there's adrenaline/excitement but it's not sexualized, otherwise I think I would find it very unsafe and it would be an unhelpful way to cope,*" and "*There is nothing sexual about self-harm. To think that there is makes me feel dirty and very uneasy.*" (Bryant et al., 2021, p.8)

Another proposed function of NSSI from this theoretical lens is that of reinstating control over one's body. This may be particularly true for individuals with a history of sexual abuse (Rayner & Warner, 2003; Suyemoto, 1998). This is supported by statements such as "*When I cut it is the one part of my life I can control. My scars are a part of who I am,*" and "*I would try to destroy my body to its limit to show that I was a warrior and I could still continue to drag myself through life*." (Bryant et al., 2021, pp. 7-8)

Sensation Seeking. NSSI is a risky behaviour and may lead to an adrenaline rush for some people. Indeed, researchers that investigated the role of sensation seeking in self-injury found that it was predictive of engagement in NSSI (Goldstein et al., 2009). In line with this, 21% of a young adult sample stated that "*to feel exhilarated*" was a motive for their NSSI (Klonsky, 2009), while 7.1% of another sample endorsed "*for excitement*" as a motive (Nixon et al., 2002). Thirteen percent of a high school population stated "*I thought it would be fun*" as one of their motives (Laye-Gindhu & Schonert-Reichl, 2005).

This function was also supported in Bryant et al. (2021) which reported statements such as "*…there's adrenaline/excitement*" and "*…I get an emotional and physical release and feel the powerful sensation of it."* (p.8).

Interpersonal Functions.

Social Signalling. The social signalling hypothesis posits that NSSI is an escalation of behaviour designed to communicate distress. For example, if talking does not work the individual may try yelling to communicate with others. If yelling does not work, they may try crying. If that doesn't work, they may progress to NSSI (Nock, 2008). In Laye-Gindhu and Schonert-Reichl's study (2005), 30% of participants endorsed *"I wanted other people to see how desperate I was."* Similarly, 23% of girls and 26% of boys in an Irish sample endorsed *"to show someone how desperately I was feeling,"* (O'Connor et al., 2014). In a sample of young adults, 5% supported the item *"to let others know what I'm going through,"* (Klonsky, 2009). Though this function does serve to elicit a response from others, it is important to note that this goes beyond merely attention seeking. In fact, only 9.5% of participants in one study endorsed *"to get attention from others"* as a motive (Nixon et al., 2002) and another study noted that 'manipulative interpersonal motives' were the least commonly endorsed in their sample (O'Connor et al., 2014). In the qualitative study done by Bryant et al. (2021), one of the main themes to arrive from their analysis was 'communicating distress'. Participants made statements such as "*I cannot put my feelings of pain and distress into words and find that hurting myself shows others how desperate I need someone to help me,*" "*…if people saw it, they could see that I needed help and support,*" and "*Cutting was a way to displace it and to show in physical form how I felt on the inside,*" (p.5). It is important to note however that not every function will be true for everyone. For instance, many

participants in that same study spoke against self-injury being used to get attention or to communicate distress. This is demonstrated by one participant who stated, "*I keep self-harm secret…self-harm for me is about controlling internal stressors and doesn't relate to other people or their emotional reactions,*" and by another who expressed "*…I am further ashamed that anyone found out that I did it.*" (Bryant et al., 2021, p.5)

The social signalling hypothesis is also indirectly supported by a study in which adolescents who engaged in NSSI reported an improvement in their paternal relationships (Hilt et al., 2008). Though they did not necessarily engage in NSSI with that intention, the resultant change in paternal relationship could potentially reinforce the behaviour.

Peer Affiliation. Another reason that people may engage in self-injury is to increase the chance of belonging to a peer group. Similar to what was described previously in the social signalling hypothesis, self-injury may be reinforced by the attention and belonging it may elicit from a peer group (Nock, 2008). This is supported by a study which found that 82.1% of self-injurers reported having friends that also self-injure (Nock & Prinstein, 2005). Further, this study found that social positive functions of NSSI were significantly related to the amount of NSSI in an individuals peer group (Nock & Prinstein, 2005).

Signal of Strength and Fitness. This proposed function of NSSI has strong evolutionary roots. It proposes that NSSI may be engaged in as a way to demonstrate physical fitness in an effort to ward off potential predators (Nock, 2008). Further, the resultant scars may be thought of as 'battle scars' which display to others that the individual has survived hardships (Nock, 2008). This idea is exemplified by a participant who stated *"I would destroy my body to its limit to show that I was a warrior,"* (Bryant et

al., 2021, p.8). These social functions provide negative reinforcement of the behaviour, but some forms of self-harm may also be reinforced through positive reinforcement. For example, some individuals engage in peer rituals that involve the infliction of pain/injury upon themselves but are socially sanctioned behaviours that are not considered NSSI. Examples may be crushing beer bottles over ones head, and potentially even stabbing oneself in the leg (Whitlock et al., 2006).

Avoidance of Unpleasant Situations. The last social function to be mentioned is using NSSI as a means of avoiding unpleasant activities or situations. It has been proposed that the intensity of an individual's response may be increased until the aversive stimuli is removed (Nock & Prinstein, 2005). For instance, a person may go from crying to get out of going to a family gathering, when that doesn't work, they may resort to a display of anger, and when that doesn't work, they may engage in self-injury in an attempt to get out of the family gathering. This function would use negative reinforcement to reinforce the engagement in NSSI.

Risk factors for NSSI

A risk factor is something that increases an individuals chance of developing a disorder, or their chance of engaging in specific behaviours. Though risk factors may increase the likelihood of NSSI, they do not cause it. As in all research, the relationship between risk factors and NSSI is correlational in nature. The potential risk factors for NSSI may be many, from in-utero stress that causes neurological changes, to childhood adversity and maltreatment, mental illness, and our attachment relationships. Understanding these risk factors and how they impact NSSI is necessary to develop effective treatment strategies. These risk factors will be explored in detail.

Maltreatment. Childhood maltreatment can be defined as physical and emotional mistreatment, sexual abuse, neglect, and exploitation that results in harm to a child (Serafini et al., 2017; Skerrett et al., 2012). Research has shown that it is a significant risk factor for NSSI (Hong et al., 2021; Martin et al., 2017; Serafini et al., 2017; Steine et al., 2020; Xavier et al., 2016). As many as 79% of people with a history of NSSI report a history of maltreatment, and cumulative maltreatment was shown to predict lifetime NSSI (Gratz et al., 2002). Further, when combined with depression, anxiety and eating disorder symptoms it was predictive of persistent NSSI (Steine et al., 2020). Some researchers may consider maltreatment broadly, while others investigate which specific forms of maltreatment are related to NSSI. Each type of maltreatment will be explored.

Emotional Abuse. Emotional abuse may predict the frequency and severity of NSSI. The research has been consistent that emotional abuse does have an impact, but the degree to which it does has varied. For instance, two studies found that emotional abuse was most strongly related to NSSI than other forms of maltreatment (Glassman et al., 2007; Goldstein et al., 2009). In a sample of Chinese adolescents, childhood emotional abuse was found to be significantly related to NSSI. Further, these researchers found that identity confusion mediated the relationship between emotional abuse and NSSI, and that rumination further impacted this relationship (Gu et al., 2020). Emotional abuse was also found to be related to NSSI in a sample of Turkish and Chinese young adults (Idig-Camuroglu & Gölge, 2018; Xu et al., 2019).

Physical Abuse. Physical abuse has consistently been associated with NSSI in the literature (Idig-Camuroglu & Gölge, 2018; Power et al., 2016; Swannell et al., 2012; Xu et al., 2019; Zetterqvist et al., 2018), and in a comprehensive review of the literature the

researchers noted that most studies found a moderate relationship between NSSI and childhood physical abuse (Lang & Sharma-Patel, 2011). In a sample of Swedish high school students, of the participants with a history of NSSI 45.8% of them had a childhood history of physical abuse, while 76.5% of the participants who reported NSSI and sex as self-injury reported a history of physical abuse (Zetterqvist et al., 2018). Interestingly, physical abuse predicted intermittent but not repetitive NSSI in a sample 26-year-olds (Yates et al., 2008).

Sexual Abuse. The relationship between sexual abuse and NSSI has been well established, with many studies finding it to be a significant predictor of self-injury (Idig-Camuroglu & Gölge, 2018; Liu et al., 2021; Livingston et al., 2020; Maniglio, 2011; Parr, 2020; Power et al., 2016; Tatnell et al., 2017; Xu et al., 2019). In two Chinese samples of university students, childhood sexual abuse was a significant predictor of NSSI engagement and frequency (Liu et al., 2021; Xu et al., 2019), and in a sample of incarcerated adults sexual abuse was a significant predictor of NSSI in females (Power et al., 2016). As many as 11.9% of a self-injuring sample reported penetrative sexual assault, and that number grew to 46.9% for individuals who reported both NSSI and sex as self-injury (Zetterqvist et al., 2018). Recent sexual abuse/assault may also predict self-injury. One study done in Australia using a sample of adolescents reported that past sexual abuse or assault predicted NSSI, but also that a recent report of sexual assault increased an individuals chance of self-injuring by seven times, even as compared to those with historical abuse (Tatnell et al., 2017). Another study found a similar result, with individuals reporting a sexual assault in the last year being more likely to be in a high-risk group that included self-injury, suicidal ideation, depression and anxiety (Parr,

2020). In a couple of studies looking at the effects of sexual trauma on military veterans, it was found that NSSI was more common in individuals who had experienced military sexual trauma (MST) (Holliday et al., 2018; Livingston et al., 2020), and that those who had experienced MST and also self-injured were more likely to have a higher severity of PTSD symptoms, recent suicidal ideation and trauma related cognitions (Holliday et al., 2018). One of these studies noted that the likelihood of a survivor of military sexual trauma self-injuring was exacerbated when they also had a mental health diagnosis (Livingston et al., 2020).

Neglect. The association between neglect and NSSI has been inconsistent**,** as noted by researchers who conducted a literature review (Lang & Sharma-Patel, 2011). One study found a moderate association between physical neglect and NSSI (Glassman et al., 2007), and another study found that neglect elevated the risk for NSSI in females but not in males (Swannell et al., 2012). Individuals who were repetitive self-injurers reported higher degrees of neglect than individuals who self-injured less frequently (Di Pierro et al., 2012). A study found that alexithymia—the inability to recognize or describe one's emotions—mediated the relationship between neglect and NSSI (Paivio & McCulloch, 2004).

Mental Illness. Clinically and within the literature, self-injury is most often associated with borderline personality disorder, to the extent that up until recently the only time self-harm was mentioned within the DSM-5 is in the criterion for BPD (Levine et al., 2020). However, self-injury may be common in other disorders as well. In this section research on NSSI in various mental illnesses will be discussed.

Borderline Personality Disorder. BPD is a mental illness that is characterized by four core features: poor emotion regulation, struggles with identity, tumultuous interpersonal relationships, and impulsivity (including recurrent self harm and suicide attempts) (Buelens et al., 2020). Of all the mental illnesses, BPD may be the one that is most strongly associated with NSSI (Buelens et al., 2020). Though clinicians and researchers are seeking to move away from NSSI being considered simply a facet of BPD, it is very common in individuals with this illness. For instance, in a sample of young people aged 15 to 25 diagnosed with BPD, 75.7% of the sample had engaged in NSSI within their lifetime (Andrewes et al., 2019), and a prevalence of 61% was found in another sample of BPD presenting adolescents (Kaess et al., 2014, as cited in Buelens et al., 2020). Since the proposition of non-suicidal self-injury disorder (NSSID) in 2013, researchers have been exploring self-injury both within and outside of the context of BPD (Levine et al., 2020).

Interestingly, there may be differences in NSSI between disorders. In a recent study of psychiatric outpatients, the researchers found that individuals diagnosed with BPD were more likely to endorse cutting or burning as their preferred method of NSSI, whereas those without the diagnosis were more likely to endorse milder forms of self-injury such as skin picking, scratching, and/or wound picking (Levine et al., 2020). They were also more likely to have higher lifetime frequencies of NSSI, and to report use of a greater variety of self-harming behaviours than those both without BPD, and those presenting with borderline traits. This may suggest that BPD is a unique risk factor for NSSI and even suicidal behaviour (Levine et al., 2020). As has been discussed, NSSI and BPD are heavily entwined, which has led many researchers to wonder why the behaviour

is so common amongst this population. One reason that has been postulated involves the amygdala, which is a region of the brain that has been implicated in impulsive behaviour, the stress response system, assigning emotional valence to stimuli, and it is also thought to be involved in the neural underpinnings of NSSI (Goldstein et al., 2021). Regarding BPD, it has been proposed that overactivation of the amygdala in response to stimuli may contribute to the emotional reactivity often present in individuals with the disorder (Schulze, Schmahl, & Niedtfeld, 2016, as cited in Goldstein et al., 2021). This has been supported by research that shows increased amygdala activation in response to the repeated showing of unpleasant stimuli, whereas in non-BPD samples the amygdala habituates after the first presentation of the stimuli. That is, emotional arousal decreases after the first presentation of the stimuli in non-BPD samples but increases in BPD populations (Hazlett et al., 2012). In a more recent study, researchers explored the differences in amygdala habituation between self-injuring and non-self-injuring individuals with BPD, in hopes of finding a specific neural underpinning for self-injury within the illness. Data was gathered from a community sample of individuals with BPD who were then administered a structured clinical interview and an fMRI. The results showed that the self-injuring BPD group displayed greater amygdala activation in response to the repeated presentation of aversive stimuli (Goldstein et al., 2021). As previously discussed, one of the commonly reported functions of NSSI is affect regulation. It could be, then, that within this subset of individuals, self-injury is used as a means of regulating emotional states and calming the amygdala.

Anxiety. Anxiety is a normal physiological response to stress, however in some situations it is experienced to such an extreme that it may fall under the category of an

anxiety disorder (Davison et al., 2008). Recent research done in China on an adolescent sample explored the relationships between cyber-victimization and NSSI and found anxiety to have a mediating role between the two. This means that adolescents who were experiencing anxiety from the cyber-bullying were more likely to engage in NSSI than were those who did not experience as much anxiety from it. This relationship was particularly pronounced in adolescents who also scored low on self-control measures (Zhu et al., 2021). Some researchers have looked specifically at anxiety sensitivity, which refers to the fear of experiencing anxiety due to potential unwanted consequences. These consequences may fall into three different domains: social, cognitive, and physical (Reiss & McNally, 1985, as cited in Dixon et al., 2019). Two studies were reviewed that investigated this. One found a relationship between cognitive anxiety sensitivity and NSSI in individuals who had been diagnosed with either agoraphobia or a simple phobia, meaning that individuals who perceive, for example, that they may be 'going crazy' when their mind races with thoughts are more likely to engage in frequent NSSI (Ölmez et al., 2018). The second study that looked at anxiety sensitivity found that social concerns predicted NSSI frequency and versatility (Dixon et al., 2019). Interestingly, one of these studies found that physical concerns (e.g. concern that a racing heart means you are dying) had a negative relationship with NSSI (Dixon et al., 2019). This could potentially be because individuals who would experience fear that they are dying from a physiological anxiety symptom may be less likely to engage in a behaviour that poses risk to oneself.

Other research has also found a relationship between anxiety and NSSI. One such study found that anxiety disorders were associated with NSSI, and that specifically

generalized anxiety disorder and social anxiety disorder were predictive of more repetitive and severe NSSI (Chartrand et al., 2012). Symptoms of anxiety were also found to be common in a sample of individuals who engaged in NSSI, even when compared to a group of adolescents diagnosed with depression but with no history of NSSI (Crowell et al., 2012).

Depression. Depression is a mood disorder that is characterized by a persistent low mood (Davison et al., 2008). Studies have shown it to be associated with higher degrees of NSSI (Holden et al., 2022; Kim et al., 2021; Lee et al., 2021). This was true in a Canadian sample of university and community young adults, which also found that depression partially accounted for the relationship between childhood trauma and NSSI (Holden et al., 2022). It also held true in Asian populations. In a recent study that explored NSSI in a Chinese adolescent sample, the data showed that depression was higher in the NSSI group, particularly amongst adolescents who scored high on cognitive fusion (Hu et al., 2021). Cognitive fusion is a concept that refers to the degree to which one identifies with their thoughts and believes them to be true. Similar results were obtained in Korea (Kim et al., 2021; Lee et al., 2021). In a sample of Korean university students, depression was related to higher incidence and frequency of NSSI. This relationship was stronger amongst those who also had problematic drinking behaviours (Kim et al., 2021). Depression was also related to higher NSSI in Korean high school students (Lee et al., 2021).

Post-Traumatic Stress Disorder. Post-traumatic stress disorder is a mental illness that originates, as the name implies, from a trauma. One group that it has shown to be common in is war veterans, and much research has been done on PTSD in this group.

One study on Iranian soldiers found PTSD symptoms to be predictive of NSSI and found that this relationship was mediated by rumination and social support. This indicates that when an individual is experiencing PTSD symptoms and has a high degree of rumination and perceived low social support, they are more likely to engage in NSSI (Neyshabouri et al., 2020). A study that investigated PTSD in survivors of trauma in adulthood found that NSSI was strongly related to PTSD, but that the relationship was stronger for the arousal symptoms (e.g., hypervigilance) of PTSD than it was for intrusion symptoms (e.g., flashbacks) (Alharbi et al., 2020). Further, like the previously mentioned study, Alharbi and colleagues (2020) found that perceived low social support was related to higher NSSI. In another recent study that investigated PTSD in veterans, it was found that NSSI was more likely in veterans who had experienced trauma and had a comorbid diagnosis of PTSD (Livingston et al., 2020). Self-injury following sexual assault was also found to be predictive of more severe PTSD symptoms, and further it was related to more severe clinical presentation of PTSD (Holliday et al., 2018). In hospital samples, the intentionality of severe wrist injuries was found to be predictive of PTSD (Westermair et al., 2020), while in an outpatient sample 58.8% of veterans diagnosed with PTSD also engaged in NSSI (Cunningham et al., 2019). In yet another outpatient sample, PTSD was related to NSSI even after controlling for depression. Interestingly, nightmare severity mediated the relationship between PTSD and NSSI, suggesting that those with PTSD who experience more severe nightmares are more likely to engage in NSSI (Short et al., 2015).

Eating Disorders. Eating disorders are a serious illness that involves damaging relationships with food, eating, exercise and body image (Davison et al., 2008). There are

three disorders that fall under this category: Anorexia Nervosa, Bulimia, and Binge Eating Disorder. In a sample of individuals with eating disorders in Portugal, 33% of the sample had engaged in NSSI (Vieira et al., 2018), while a meta-analysis found that of participants with NSSI, approximately 27.3% of them were diagnosed with an eating disorder (Cucchi et al., 2016). In two recent studies, researchers found that eating disorders were related to NSSI (Perkins et al., 2020; Sagiv et al., 2019), and specifically that the binge-purge classifications of eating disorders had a stronger relationship to NSSI than did anorexia nervosa (Sagiv et al., 2019). One team of researchers also found that the self-criticism that is associated with eating disorders was a strong predictor of NSSI (Perkins et al., 2020).

Attention Deficit Hyperactivity Disorder. ADHD is a neurodevelopmental disorder that typically presents in childhood and persists throughout the lifespan. There are three subtypes of ADHD: ADHD, impulsive/hyperactive type, ADHD, inattentive and distractible type, and ADHD, combined type (Meza et al., 2020). The relationship between ADHD and NSSI has been found in a sample of veterans, which found that ADHD was strongly associated with NSSI even after controlling for PTSD (Kimbrel et al., 2017). One of the common clinical misperceptions of ADHD is that it is more common in males. Unfortunately, the truth is that many girls simply go undiagnosed due to differing presentation between genders. This is concerning for many reasons, though perhaps the direst reason is that ADHD may be strongly associated with NSSI in adolescent females. Two recent studies found that ADHD was strongly related to NSSI in adolescent girls (Meza et al., 2020; Ward & Curran, 2021). In one of the studies, 60% of the self-injuring sample had childhood ADHD, and the data also showed that individuals

who had childhood ADHD had significantly higher suicide attempts. The researchers concluded that childhood ADHD is a prominent risk factor for persistent NSSI (Meza et al., 2020). In another recent study, researchers examined data from hospital emergency room presentations and found that ADHD scores were significantly higher in individuals who presented for self-injury. The researchers suggested that girls presenting to the hospital for self-injury should be screened for ADHD as it could inform clinical treatment (Ward & Curran, 2021).

Autism Spectrum Disorder. Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that is characterized by challenges with social functioning, language, communication skills, and it is often characterized by restrictive and repetitive behaviours (Moseley et al., 2020). Research on the relationship between ASD and NSSI is sparse, and often focuses on stereotypic forms of self-injury that are found in Autistic individuals with accompanying developmental delays (Akram et al., 2017; Cassidy et al., 2020; Moseley et al., 2020). Recent research has sought to expand the literature, especially with regards to the relationship between NSSI and suicidal behaviours in Autistic people. One recent special issue that was written on the topic noted that young age and the presence of psychiatric conditions increased the risk of both NSSI and suicidal behaviours in Autistic individuals (Cassidy et al., 2020). Also of note in this issue was that autism combined with intellectual disability increased the risk for NSSI and suicide attempts, but not suicidal ideation (Cassidy et al., 2020). Two recent studies found that Autistic people had a high prevalence of NSSI compared to the general population (Cassidy et al., 2018; Moseley et al., 2020). In the first study to be mentioned, 164 Autistic adults were assessed alongside 169 neurotypical adults from the general

population. These researchers found that Autistic people were more likely to report lifetime NSSI (65% compared to 29.8% of the control sample.) Further, NSSI was predictive of later suicidal behaviours, which were found to be common in this sample of Autistic people. Indeed, ASD appeared to be a unique risk factor for suicidality; even amidst the control sample, self-reported Autistic traits were found to be related to suicidality. These relationships remained even after controlling for common risk factors for suicidal behaviours, such an unemployment and comorbid psychiatric conditions (Cassidy et al., 2018). The second study that will be discussed, authored by Moseley and colleagues (2020), assessed a group of 103 Autistic people located in the United Kingdom. In this sample, 75% of the Autistic individuals reported a lifetime history of NSSI. They also found that NSSI, particularly long term NSSI, was strongly related to suicidal ideation and attempts. However, the results suggested that while cutting was predictive of suicide risk, other forms of self-injury such as banging/hitting oneself, punching hard objects, and scratching oneself were not predictive of it. In fact, for every single point increase on the measure of suicidal behaviour, participants were 3.3 times more likely to report cutting. With regards to the function of NSSI, in this sample it appeared that it was used most to regulate low-energy states, for self-punishment, and/or for sensory stimulation (Moseley et al., 2020).

The last study to be discussed explored the relationships between NSSI and ASD in a sample of children/adolescents in Pakistan (Akram et al., 2017). Thirty percent of this 83-participant sample was found to have engaged in self-injury, with the most common method being banging/self-hitting. The researchers found that the degree to which the Autistic individual struggled with behaviours associated with Autism was a

risk factor for NSSI. Unsurprisingly, the researchers also found that early intervention reduced the risk of NSSI later in life (Akram et al., 2017).

Non-suicidal Self-Injury Disorder. As has been briefly mentioned, NSSID was proposed in 2013 with the publication of the DSM-5 (Buelens et al., 2020). Both researchers and clinicians had long noted that self-injury occurred outside of the context of BPD, and that by not distinguishing NSSI as separate from BPD there was a portion of clientele that were not being represented nor properly understood (Levine et al., 2020). The repercussions for not understanding NSSI are grave, as 50-75% of individuals with a history of it have a suicide attempt at some point in their lives (Nock et al., 2006). As such, this new diagnosis was proposed and consists of the following six criteria: NSSI must have occurred for at least 5 days in the last year; NSSI must be done to either relieve negative thoughts or feelings, resolve interpersonal difficulties, or induce a positive state; NSSI must be preceded by negative thoughts and/or feelings, conflict with others, preoccupation with the behaviour that is difficult to resist, or recurrent thoughts about the behaviour; Socially accepted behaviours are excluded, such as tattooing, piercings, cultural rites of passage or teenage fads that involve bodily harm but are not done in a self-harming context; the NSSI must cause significant distress or interference in the individuals daily life; and lastly, it should not occur solely in the context of another mental illness (Buelens et al., 2020). Because of the enmeshment of NSSI with BPD, much of the research has been focused on the similarities of NSSID and BPD. So far, results seem to support the existence of NSSID. In a recent study of 347 adolescents with a history of self-injuring behaviour, it was found that 60.87% of those with BPD also met the diagnostic criterion for NSSID, whereas only 37.14% of those meeting the criterion

for NSSID also met the criterion for BPD. This suggests that the two disorders are distinct from one another (Buelens et al., 2020). The researchers also identified bridge symptoms between NSSID and BPD, which were loneliness, impulsivity, separation anxiety, preoccupation with NSSI and the presence of negative affect prior to engagement in NSSI (Buelens et al., 2020). Another recent study also found that though those with a BPD diagnosis or traits of the disorder had higher rates of NSSI than other outpatient populations, self-injuring behaviours still did occur in the portion of the sample that had no traits of BPD. However, they did note some potential differences between the methods of NSSI used, wherein those with BPD were more likely to engage in cutting or burning, and those without it were more inclined to engage in milder forms of self-injury (Levine et al., 2020). Another recent study also found that suicide attempts were uniquely associated with both BPD and NSSID (Cunningham et al., 2021). These results both may suggest that NSSID is warranted as its own disorder, though a decision has yet to be made on if it will be included in the next publication of the DSM.

Substance Use Disorder (SUD). Substance Use Disorder is characterized by uncontrolled usage of a substance, despite harmful consequences that it may have physically, emotionally and/or interpersonally. Individuals who struggle with SUD may be preoccupied with using a certain substance (may be alcohol, tobacco, prescription drugs, or illicit drugs) to the point that it disrupts their ability to function in day-to-day life. At the most severe, SUDS become known as addictions (Davison et al., 2008). Self-injury is known to be high within this population, with a prevalence of 37.2% found in an adult sample in treatment, 52% in a sample of adolescents admitted to hospital for substance use, and 16.9% in a sample of Indigenous youths in the USA who had been

flagged for binge drinking (Cwik et al., 2018; Dixon et al., 2019; Doksat et al., 2017). In one of these studies, the researchers found that amongst their sample of individuals with substance use, polysubstance use was associated with elevated risk of NSSI. They also found that neglect was a strong predictor of lifetime prevalence of NSSI within this sample (Doksat et al., 2017). Anxiety was also shown to be strong risk factor for NSSI amongst this population, particularly anxiety regarding social situations. Interestingly, physical aspects of anxiety (e.g., experiencing fear when your heart races due to anxiety) were negatively related to NSSI risk (Dixon et al., 2019). The researchers postulated that this may be due to the high occurrence of social anxiety disorder amongst substance using populations, or potentially related to greater physiological awareness in those who have sensitivities to the physical components of anxiety, which may make them less likely to engage in a physiologically averse behaviour (harming themselves) (Dixon et al., 2019).

Parenting and Attachment. Parenting style may be a risk factor for NSSI. Studies suggest that permissive parenting, which is characterized by inadequate supervision and inconsistent boundaries, is positively related to NSSI (Bifulco et al., 2014; Burešová et al., 2015). Another study found that preadolescents who engaged in NSSI were more likely to perceive their parents as authoritarian, which entails psychological and behavioural control (Baetens et al., 2014; Xavier et al., 2016), and another team of researchers found higher prevalence of self-injury in those who reported high degrees of emotional invalidation from their caregivers (Holden et al., 2021). Other aspects that have been associated with NSSI include single-parent households (Burešová et al., 2015) and socioeconomic status (SES), with lower SES being related to NSSI

(Baetens et al., 2014). Furthermore, a study found that parental bonding, particularly the paternal bond, had a strong relationship with the development of NSSI (Hsu et al., 2013). Similar results were found in a more recent study that showed avoidant attachment with the father figure to be predictive of higher reported NSSI (Tatnell et al., 2018), and another group of researchers suggested that maternal and paternal attachment triggered NSSI in different ways (Tao et al., 2020). What these researchers proposed was that paternal attachment, because of the father's role in encouraging children to cope with challenges and emotions, had a greater effect on behavioural coping style. Maternal attachment on the other hand does not affect behavioural coping style to the same degree, because the mother's role is more aligned to emotional experience and connection. Thus, they proposed that paternal attachment impacts NSSI by means of inheriting either maladaptive or healthy behavioural coping mechanisms, and maternal attachment impacts NSSI by either increasing or decreasing negative emotions (Tao et al., 2020). It must be noted that these authors are interpreting these results based on traditional gender roles and parenting styles, which may not always be applicable. Together, these results may indicate that though relationships with both parents are important, father-child relationships may have a protective factor against the development of NSSI.

Attachment refers to the psychological connectedness an infant develops with its caregiver(s) (Bowlby, 1969). The development and maintenance of this bond is established through proximity seeking, which are behaviours that infants engage in with the purpose of maintaining close contact with the caregiver(s). How caregivers respond to these behaviours form the infant's attachment style, and also impact the development of the child's emotional regulation system (Bowlby, 1969). Mary Ainsworth was a

contemporary of Bowlby's who is famously known for her classification of attachment styles. Three primary attachment classifications were derived from Ainsworth's research: secure attachment, anxious-resistant attachment, and anxious-avoidant attachment (Ainsworth, 1979; Feist & Feist, 2009). Securely attached infants are confident in the accessibility of their caregiver, display self-confidence, and exhibit adaptive emotional regulation. When they become upset, they seek proximity to their caregiver (Ainsworth, 1979; Cooper et al., 1998; Feist & Feist, 2009). Children with anxious-resistant insecure attachment style provide inconsistent messages towards their caregiver. They become disproportionately upset when the caregiver leaves the room, and when reunited these children seek proximity to the caregiver but reject the caregivers attempts to sooth them. Lastly, children with anxious-avoidant insecure attachment appear indifferent to their caregiver; they are disinterested when the caregiver leaves the room, as well as when they return (Ainsworth, 1979; Feist & Feist, 2009). Mary Ainsworth later added the disorganized/disoriented attachment style. This attachment style is characterized by a lack of attachment behaviours. It is formed when the caregiver frightens the child yet is still the primary person the child would seek for safety. This results in confusion and may result in the child experiencing dissociative symptoms (van Rosmalen et al., 2016).

The terminology used to indicate attachment styles has changed throughout the years, though the underlying concepts remain similar. To avoid any potential confusion, one of the other commonly used terminologies will briefly be touched upon. This classification divides attachment into four styles: secure, preoccupied (also referred to as anxious), dismissing, and fearful (Molaie et al., 2019). The last three fall under an insecure attachment style, with dismissing being equivalent to avoidant attachment, and

fearful equivalent to disorganized. Attachment states of mind may also be used, which refers to the way that adults process attachment-related thoughts (Martin et al., 2017). The classifications used for attachment states of mind are: autonomous-secure (individual coherently discusses both negative and positive attachment experiences), dismissing (individual minimizes or denies the impact of aversive experiences), preoccupied (individual blames themselves or relational other for aversive experiences, or may become emotionally entangled in prior experiences), and unresolved (individual cannot maintain organized discourse regarding attachment events).

Given what has been stated about each of the attachment styles, it could be assumed that secure attachment may be protective against NSSI, while the insecure styles of attachment may pose as risk factors for the behaviour. The way in which attachment contributes to NSSI may be multifaceted, which was aptly suggested by a seminal paper which wrote that there may be many risk factors for NSSI, but that at the end of the day the behaviour is sustained by lack of secure attachments (Kolk et al., 1991). This is a powerful statement which may suggest that fostering secure attachment should be part of treatment for the behaviour. Both clinical and empirical data do seem to support the idea that insecure attachments predict self-injurious behaviours. One clinician noted a pattern of traumatic attachment in her clients who self-injure (Farber, 2008). With regards to empirical data, there are many studies that found insecure attachment styles to be related to higher prevalence of NSSI (Cassels et al., 2019; Gandhi et al., 2019; Kharsati & Bhola, 2016; Martin et al., 2017; Molaie et al., 2019; Pallini et al., 2020; Sroufe, 2005; Tatnell et al., 2017, 2018; Victor et al., 2019). The results so far have been mentioned in relation to insecure attachment, which as was mentioned previously consists of three separate

attachment styles. This may lead one to wonder if specific styles of insecure attachment are uniquely related to NSSI, and what role secure attachment may play. Preoccupied/anxious attachment has shown a particularly strong relationship with NSSI (Cassels et al., 2019; Kharsati & Bhola, 2016; Martin et al., 2017; Molaie et al., 2019). One study found that while preoccupied/anxious attachment was predictive of NSSI, avoidant attachment was not (Kharsati & Bhola, 2016), and similar findings were obtained in two other studies that were reviewed. First, in a 2017 study that investigated the relationships between childhood abuse, attachment states of mind and NSSI (Martin et al., 2017). This aforementioned study was unique in that it used longitudinal data from a pre-existing study that followed 164 children from infancy through to adulthood. Their results also suggested that it was both preoccupied attachment states of minds to caregivers, and to adulthood romantic partners that had an impact upon NSSI, and that preoccupied attachment states of mind was implicated in the relationship between childhood abuse/neglect and the later development of NSSI (Martin et al., 2017). The second study that found similar results utilized a sample of 200 adult psychiatric clients, and found that preoccupied attachment was the sole independent predictor of NSSI amongst the attachment styles (Molaie et al., 2019). Other studies however have found that avoidant attachment may be related to higher NSSI (Cassels et al., 2019; Tatnell et al., 2018). In a longitudinal study of 559 Flemish adolescents, both anxious and avoidant attachments were indirectly related to higher NSSI, wherein the attachment style predicted behavioural problems, which then predicted NSSI (Cassels et al., 2019). Similarly, an Australian study explored attachment and NSSI in an adult community

sample and found that avoidant attachment, particularly with the father, was predictive of self-injury (Tatnell et al., 2018).

Disorganized/fearful attachment has also been shown to be related to higher self-injury (Farber, 2008; Pallini et al., 2020; Tatnell et al., 2018). Within their clinical observations, Farber (2008) noted that NSSI seemed to develop frequently in her clients that had disorganized attachment styles. They speculated that instead of severing the relationship with the person they had formed the disorganized attachment with, they would instead harm themselves as a means of preserving the relationship (Farber, 2008). As for empirical results, a thirty year longitudinal study showed that self-injuring behaviours in young adults were related to a disorganized attachment (Sroufe, 2005), and in a sample of adolescent inpatients 82% of the self-injuring sample had unresolved/disorganized attachment styles while the majority of the control sample reported secure attachments (Pallini et al., 2020). Lastly, Tatnell and colleagues (2018) suggested that fearful models of attachment may lead to less goal directed behaviours, which in turn may increase impulsivity and thus lead to self-injury.

Another question that may arise when thinking about the relationship between attachment and NSSI is whether maternal and paternal attachments have differing effects on the behaviour. A study investigated relationships between maternal and peer attachment, depression and NSSI in a group of adolescents referred to mental health services. Of the sample, 71% had an insecure maternal attachment, and insecurely attached participants had significantly higher depression scores, as well as a higher frequency of lifetime NSSI (Glazebrook et al., 2015). In the six-month follow up, 78% of the insecure attachment group had a relapse in NSSI behaviour, compared to 42% of the

securely attached group. Maternal and peer attachment were predictors of NSSI relapse (Glazebrook et al., 2015). Another study investigated the relationship between parental bonding and first time NSSI behaviours. The results suggested that parental bonding was directly related to NSSI, however, the effect for paternal bonding was stronger than maternal bonding (Hsu et al., 2013). The two studies discussed used a sample of adolescents who sought help for their mental health, which limits the generalizability to individuals who have not sought help for NSSI or mental health. However, similar results have been found in non-clinical samples. One study used a university sample to explore the relationships between parental and peer attachments with NSSI, with stress as a mediating variable. Poor paternal and peer attachment had a significant relationship with NSSI, as mediated by stress, but maternal attachment was not significant (Hallab & Covic, 2010). Furthermore, research indicates that paternal insecure attachment was the strongest predictor of NSSI in a non-clinical sample of female participants (Gratz et al., 2002). These findings suggest that the father-child relationship is protective against NSSI. The protective factor of the father-child relationship is not unique to NSSI; research suggests that relationships with the father is related to a reduction in delinquent behaviours (Bronte-Tinkew et al., 2006). Of course, this is not to say that maternal attachment is not as important. Research suggests that maternal emotional neglect is a significant predictor of NSSI (Gratz et al., 2002), and the study on parental bonding did find a direct relationship between NSSI and maternal bond, despite the effect for paternal bond being stronger (Hsu et al., 2013).

The research discussed so far has been on caregiver attachment, however Bowlby (1969) suggested that attachment is continuous throughout the lifespan, and that

throughout the developmental process the primary attachment figure may switch from caregivers, to peers, to romantic partners. This may make one wonder if attachment to romantic partners impact NSSI as well. One study investigated the relationships between romantic attachment, perceived intimate partner violence, and NSSI (Levesque et al., 2010). A novel aspect of this study was the inclusion of NSSI thoughts in addition to behaviours. NSSI thoughts are often overlooked, however, thoughts may lead to action (Nixon et al., 2015). The researchers found that anxiety over abandonment was related to an increase in NSSI thoughts in both genders, however it was only related to NSSI behaviours in women (Levesque et al., 2010). Another study explored the relationships between NSSI and romantic attachment, using the triarchic adult attachment model. The triarchic model of adult attachment postulates that adult attachment is comprised of three systems: the attachment system, caregiving system, and sexual system. All three of these systems are believed to interconnect and work together to facilitate romantic attachments. These researchers also explored both NSSI thoughts and behaviours and found that those who reported just thoughts about NSSI were more likely to experience attachment anxiety and avoidance, higher degrees of compulsive and controlling caregiving behaviours towards their partners, and lower self-focused sexual satisfaction (satisfaction regarding your own sexual experience). However, with regards to self-injurious behaviours, only attachment anxiety showed a significant relationship (Caron et al., 2017). These previously mentioned two studies found anxious but not avoidant attachments to be predictive of self-injury. The researchers who conducted these aforementioned studies proposed that this may be due to tendencies of those with anxious attachments to try to elicit caregiving from others, whereas those with avoidant

attachments tend to suppress their undesired emotions (Caron et al., 2017; Levesque et al., 2010). However, other researchers have found relationships between avoidant attachment and NSSI. One such study looked at the relationship between attachment and NSSI, as well as the potential mediating roles of affect regulation and dyadic coping (how couples cope with stress together). Their results supported the hypothesis that both anxious and avoidant attachment styles are predictive of self-injury, and they also found that affect regulation mediated the relationship between insecure attachments and NSSI (Levesque et al., 2017). Similar results were obtained in a study from the same year, which found both anxious and avoidant attachment to be related to higher frequencies of NSSI. As with the previously mentioned study, affect regulation mediated the relationship between these two variables (Silva et al., 2017). This may mean that though interpersonal factors play a key role in activating the feelings that lead to NSSI, it is the intrapersonal function of emotion regulation that maintains the behaviour.

Peers and NSSI

A concern that may be expressed by caregivers is that of the potential effect that peers have upon self-injury. Particularly in adolescence, attachment to one's peers gains importance and there is the potential for one's peer group to offer support and have positive impact, but there may also be the chance of negative impact. Based on the literature reviewed, the trend in results may suggest that peers do impact engagement in NSSI.

Two studies investigated peer attachment, identity formation and NSSI in a group of adolescents in Belgium, and found that positive peer attachments which are characterized by trust and positive communication may facilitate identity synthesis,

which in turn reduces self-injury (Gandhi et al., 2016, 2019). Peer alienation, on the other hand, was directly related to an increase in self-injury (Gandhi et al., 2016), as was victimization by peers (Victor et al., 2019). In another study, peer acceptance had a long-term effect on reducing NSSI. Specifically, in adolescents with low behavioural impulsivity, greater peer acceptance was related to higher self-compassion which reduced depressive symptoms, and this in turn lead to a reduction in NSSI. In adolescents with high behavioural impulsivity, however, higher peer acceptance lead only to higher self-compassion which then reduced NSSI (Wu et al., 2019). Contrary to these previously mentioned findings, one study that was reviewed found a positive correlation between peer support and NSSI, suggesting individuals who experience higher peer support may be at greater risk of engaging in NSSI (Ross-Reed et al., 2019). Having a friend who self-injures may also predict the onset of NSSI, though not necessarily the severity of it according to a longitudinal study. These researchers also found that it was adolescents who were already experiencing emotional challenges that were more at risk of NSSI onset when having a friend who self-injures (Hasking et al., 2013). More recent studies have obtained similar results. In a Chinese study of 854 adolescents, deviant peer affiliation was found to be predictive of both NSSI and depression. It is important to note the relationship with depression here, as it has also been found to be a risk factor for NSSI (Wei et al., 2021). Likewise, a Canadian study of 1483 adolescents found that knowing about a friends self-injury was related to higher frequencies of NSSI, as well as higher reported suicidal ideation and suicide attempts (Syed et al., 2020). The presence of a mental illness did not impact the relationship between knowing about a friends NSSI and one's own NSSI, which suggests that it was primarily the social factor that lead to

engagement in it (Syed et al., 2020). Though the effects of media are not the topic here, this next study will be mentioned because it ties in closely with peer relationships. A 2017 study investigated the role of Facebook on self-injurious behaviours, and their results indicated that 6.5% of respondents reported cutting more often when friends posted about self-injury (Davis & Pimpleton-Gray, 2017).

Though most studies reviewed supported a relationship between NSSI and peer relationships, one did not. In this longitudinal study, NSSI was significantly related to stressful life events and attitudes towards school, but there was no relationship found between NSSI and peer relationships (Baetens et al., 2021). The authors noted that this was an unexpected result based on their own literature review, and suggested that the lack of relationship may have been due to participants including peer-related distress under stressful life events, which their study also assessed (Baetens et al., 2021).

Contagion Effect. Another concern that is related to peers is that of the social contagion effect. This phenomenon has been widely cited as occurring in relation to suicide, but whether it is similar for NSSI has not been as widely researched (Beck et al., 2018; Syed et al., 2020; Wester et al., 2017). The contagion effect occurs when a behaviour is spread to at least two people within the same social network, within a relatively short period of time (Wester et al., 2017). Most of the studies discussed in the previous section provide support for a contagion effect of NSSI, as evidenced by results that show peer self-injury increases the odds of self-injury (Hasking et al., 2013; Syed et al., 2020). There are however several studies that investigated social contagion and NSSI specifically, which will now be mentioned. One notable study evaluated data from an inpatient mental health unit and looked for days that would be considered ‘contagion’

days; to be classified as such, three or more incident reports had to be reported for that day. Their analysis identified 45 contagion days (out of 366 days), and they found that contagion days clustered together. That is, 40% of them occurred within a 48-hour period from the initial contagion day. These results may suggest that contagion effects last for a prolonged period, though for how long the researchers could not identify (Beck et al., 2018). A couple of the studies reviewed were related to identifying and preventing contagion effects in schools, and though they did not conduct a study themselves, the authors acknowledged the presence of an NSSI contagion based on anecdotal evidence from teachers and school mental health staff (De Riggi et al., 2017; Wester et al., 2017). Anecdotal evidence for a contagion effect was also reported by mental health professionals in both community and inpatient populations (Beck et al., 2018; Papadima, 2019).

There have been multiple potential reasons for the contagion effect put forward, such as peer bonding, social learning and the assortative relating theory (Syed et al., 2020). Peer bonding proposes that an individual may choose to engage in self-injury as a means of fitting in with other peers who are already doing it, which may then lead to a perceived contagion effect. Social learning theory, originally proposed by the psychologist Albert Bandura, proposes that the behaviour is spread by individuals seeing it, discussing it, and then deciding to engage in it. Assortative relating theory, the last to be mentioned, believes that individuals with similar attitudes, qualities and vulnerabilities are more likely to form friendships. This then makes NSSI more likely to spread if one individual within the group does it, as it is already a behaviour that all individuals of the group are at risk of (Syed et al., 2020; Wester et al., 2017). The author of one article

reviewed provided a psychoanalytic interpretation of contagion (Papadima, 2019). Noting the increase in clinical self-harm referrals, the author began to think of self-harm in a novel way…as a modern manifestation of hysteria. Historically, hysteria was trademarked by what was viewed as excessive emotionality, and it afflicted primarily women. It was viewed by many psychoanalytic clinicians as an unconscious idea that is expressed physically through behaviours associated with mental illness that are common within a societal milieu. What the author goes on to suggest is that certain individuals may be unconsciously drawn towards the identity that has evolved around being a 'self-harmer', and that they respond to this unconscious desire by engaging in the popular behaviour-in this case, self-harm. Concern was expressed over clinicians focus on the emotional regulation function of self-harm, as the writer felt that by focusing primarily on that and focusing treatment on developing healthier coping skills, clinicians may be missing out on a large portion of what drives the behaviour (Papadima, 2019).

All the articles mentioned focused on NSSI contagion in the context of a peer group within a school or inpatient unit. Though a contagion effect is harmful and concerning anywhere, the rise in self-injury portrayal in the media coupled with the rising popularity of social media may make the NSSI contagion effect even more harrowing. Self-injury and media will be discussed in the next section, along with potential contagion effects of it.

Media and NSSI

Media may be another avenue through which a person learns about self-injury, or which may be sought out after the occurrence of self-injury. It is also an avenue that has garnered widespread concern in its potential relationships to many maladaptive

behaviours other than NSSI, such as aggression. Media can be consumed in many ways, such as television shows, movies and more recently, social media. There has been a sharp increase in the media portrayals of NSSI since the 1980's (Purington & Whitlock, 2010, as cited in Davis et al., 2017), with one of the most recently controversial ones being the book turned television show Thirteen Reasons Why. This story follows the tale of an adolescent female who died by suicide and left behind thirteen video tapes that revealed her thirteen reasons for choosing to die (Arendt et al., 2019). Following its release on Netflix, professionals and caregivers alike were concerned about the potential impact this content would have on adolescents, as the show displayed graphic self-harm and many felt that it sensationalized suicide. Shortly after the release of the first season, there was a marked increase in Google searches about suicide (Ayers et al., 2017), anecdotal reports from physicians that young people were creating lists of 'thirteen reasons why' they wanted to attempt suicide (Zarin-Pass et al., 2018), and there was also an increase in hospital admissions of young people presenting with NSSI and suicidal behaviours (Cooper et al., 2018). However, not all the results to come forth are so bleak. For instance, a group of researchers explored the issue after the release of the second season of the series and found that it had the potential to have either harmful or beneficial effects, depending on the viewer (Arendt et al., 2019). Individuals who stopped watching before the end of the season were found to have higher risk of NSSI and suicide, and less future related optimism. Individuals who watched the entirety of the second season, however, reported reduced NSSI and suicidal ideation, and they were more likely to report interest in helping a suicidal person. The authors postulated that those who ceased watching prior to the end may have found the content too triggering and were already

upset by it by the time they turned it off, where as those who finished the season may not have been as personally affected by it (Arendt et al., 2019). Another recent example of NSSI and suicide in the media is the Blue Whale Challenge, which surfaced around 2016 and spread throughout internet chatrooms and social media platforms (Khasawneh et al., 2020). The internet phenomena were said to consist of fifty dares, which included various acts of self-harm and finally culminated in suicide. Sadly, 130 individuals were reported to have died by suicide because of it in Russia alone before it spread virally throughout the rest of the globe. Researchers who investigated the phenomena did find that many of the comments they found on YouTube (83%) and Twitter (69%) discouraged participation in the challenge. However, there were still a lot of videos that encouraged participation (60% of videos found on YouTube). Another area of concern is that though many comments were positive, very few of them adhered to the Suicide Prevention Resource Center's Safe Messaging guidelines, which means that even well-intentioned comments may unintentionally have negative effects such as stigmatizing or normalizing self-injurious and suicidal behaviours (Khasawneh et al., 2020).

In more recent years, social media use has become prolific which also means that it represents an area of growing concern in relation to self-injury. Posts can be shared relatively anonymously and can reach people globally, and online communities may be a common place to meet like minded others. Many of these sites are criticized for having poor content filtering and poor privacy protections. Some social media platforms, such as Instagram and TikTok, have acknowledged the growing concern of self-injury content and fortunately have taken steps to make such content less accessible. Unfortunately, users have taken to utilizing tags that circumvent the platforms algorithms, and on top of

that the tags change so frequently that it is difficult for sites to keep track of them (Picardo et al., 2020). Some sources also suggest that filtering harmful content may not be enough to circumvent the potential negative effects. To elaborate upon this, a case study of a 14-year-old female in Italy will be discussed (Logrieco et al., 2021). Prior to her engagement with TikTok, this client was described as having no indications of mental health struggles. Through TikTok, she saw content that would be classified as 'anti-pro-ana' (meaning it is not in support of anorexia). Though these videos are recovery-based and discourage both eating disorders and NSSI, they still discuss methods to lose weight and self-injure—both of which could give someone who hasn't reached recovery ideas. Additionally, she reported that content creators often create a sense of competition between each other. That is, though the content is positive, there is an undertone of competition regarding who was/is the most unwell. This content drew her in and fostered a desire to physically display her own distress through NSSI and an eating disorder, and her stated intention was to end up in the hospital. Ultimately, she was hospitalized in critical condition and at the time of release was not interested in recovery (Logrieco et al., 2021). This case study illustrates the potential consequences of social media-even positive content-on NSSI and mental health in general. However, it is just that-a case study which cannot be generalized. Next, some studies using larger samples will be discussed.

Numerous studies have analysed the content that is found on social media (most often Instagram, Twitter, Tumblr). These studies have revealed some positive, but also some negative findings. Starting with the positives, posts often did not encourage NSSI (Shanahan et al., 2019), very few posts normalized NSSI (Seko & Lewis, 2018), the

majority of images did not explicitly portray NSSI (Brown et al., 2018; Seko & Lewis, 2018; Shanahan et al., 2019), and recovery themed posts were common (Picardo et al., 2020; Seko & Lewis, 2018; Shanahan et al., 2019). A sense of acceptance and community was a common benefit, with other users often providing encouragement, advice for how to stop, and how to access professional services (Brown et al., 2018; Dyson et al., 2016; Lavis & Winter, 2020). A sense of acceptance and community is important, but it may also come with a downside. For instance, some of the advice that was being passed amongst users included how to better conceal your self-injury, but also how to self-injure safely (e.g. sterilize your blades, proper wound care, etc.) (Dyson et al., 2016; Lavis & Winter, 2020). Though this is not discouraging self-injury, this harm reduction approach is arguably a benefit. Another potential negative about acceptance is the potential for normalizing NSSI (Dyson et al., 2016). In a study that interviewed 21 individuals with histories of NSSI, many of them reported that the acceptance they found through online NSSI communities lead to increases in their NSSI frequency and severity (Jacob et al., 2017). Also concerning are findings that more severe NSSI wounds that are posted receive more attention through likes and caring comments (Lavis & Winter, 2020; Picardo et al., 2020). This could potentially lead to an increase in severity of NSSI, as individuals strive to maintain the support they have found. Along with this, a past case study that was reviewed indicated that there may be a sense of competition between users to be the most unwell (Logrieco et al., 2021). This was also found in the Jacob et al. (2017) study, with some participants expressing that there was a competition to be the most unwell which lead to increased frequency and severity of self-injury.

The potential for trolling and abusive comments is another negative about social media (Brown et al., 2018; Dyson et al., 2016). Fortunately, studies have found that few comments are abusive—for instance, in one study 6.8% of comments were abusive compared to 35.1% empathetic (Brown et al., 2018; Dyson et al., 2016). While the low rate of abusive comments is promising, it is still concerning as such comments may have more of an impact on the individual than do the other comments (Brown et al., 2018). This however was not found to be the case in a study that investigated the effects of comments on YouTube. In this study, participants first completed a measure to assess attitudes towards NSSI recovery. They were then all exposed to the same NSSI video, but were then exposed to either hopeful peer comments, or hopeless peer comments (the comments were developed by the researchers). The same measure of attitudes towards NSSI recovery was readministered after viewing the comments. The results were promising. For those in the hopeful condition, they showed an increase in positive attitudes about NSSI recovery. In the hopeless condition, viewing the negative peer comments did not increase hopeless attitudes towards NSSI recovery (Lewis et al., 2018). These results are promising because they may suggest that positive comments have a greater effect than do negative ones, which could potentially ease some concern regarding the effects of negative interactions online. Of course, this was conducted in experimental conditions and does not account for real life factors. For instance, the participants had no emotional connection to the video or the individual who posted it. It is likely that the effects of the negative comments would be more pronounced if it were their own video being commented on, or even a friend's video. That being said, viewing negative and stigmatizing remarks even on impersonal content may impact the way an

individual perceives a particular behaviour. In that sense, these results still remain promising in that they suggest that viewing negative content within that context may not be harmful (Lewis et al., 2018).

A concern that some may have is whether or not being exposed to this content can lead to the onset of NSSI. A recent study that reviewed posts (Twitter, Instagram, Reddit) and interviewed individuals with a history of NSSI found that for the majority of individuals, NSSI had started prior to viewing the content online and that individuals had sought the content out in an effort to better understand what they were experiencing. Though they sought the content out for positive reasons, some of the interviewees noted that seeing the NSSI content and reading about others distress was triggering for them which at times resulted in NSSI (Lavis & Winter, 2020). Similar results were found with regards to Facebook; 6.1% agreed that NSSI content lead to urges to self-injure, and 6% reported that they got ideas for how to self-injure through Facebook. This is despite 57.4% of the sample stating that Facebook also increased their happiness (Davis & Pimpleton-Gray, 2017). Trigger warnings could circumvent this, but another study found that only 21.8% of NSSI posts contained such a warning (Seko & Lewis, 2018). This is concerning given the findings in Arendt et al. (2019), which found that 43% of their sample was exposed to NSSI content on Instagram, but only 20.1% of those viewed it intentionally. While those who sought it out intentionally were at greater risk of suicidal behaviours and NSSI, they found that those who were unintentionally exposed were also at greater risk for NSSI, suicidal behaviours, and hopelessness even after controlling for viewing such content on other platforms (Arendt et al., 2019).

Overtime, the reasons for seeking out NSSI content may change. This was exemplified in the Jacob et al. (2017) study, wherein three-quarters of the interviewees reported that their current reason for seeking out NSSI content weas because the images elicited physical sensations as they brought back their own memories of injuring themselves. Images oftentimes became part of the self-injury ritual, in that they would be viewed prior to engaging in the act (Jacob et al., 2017).

Based on this review, the effects of NSSI content on social media in a contentious issue, and one that does not have a clear answer. It perhaps depends on what social media is used for. For example, a study found that those who used social media primarily for keeping in contact with friends and family had lower rates of NSSI, while those who used it for posting updates and commenting on other peoples posts had higher rates of NSSI (Kingsbury et al., 2021). Of course it is not so simple, as even viewing positive content may have a negative impact (Jacob et al., 2017; Logrieco et al., 2021) as can accidental exposure (Arendt et al., 2019). Despite the negatives, there were also clear indications of it having a positive impact. For that reason, it should not be frowned upon entirely. However, the negative effects provide great concern and cannot go dismissed. The main positive that seems to come from social media is the sense of community, acceptance, and support that it can foster. In Lavis et al. (2020) study, the researchers postulated that teenagers may turn to online communities for support after receiving a negative reaction from a caregiver. This is pertintent to this project, which aims to build caregiver competency in responding to self-injury. The results from this study suggest that if this aim is accomplished, less teenagers may be inclined to turn online for support and instead turn to their caregivers. This is promising, but the reality is that many

teenagers will still face unsupportive reactions from their caregivers. This may speak to a need for more regulated sites that are devoted to NSSI and other mental health struggles. An older study surveyed 102 users of a self-harm discussion group, and most participants reported positive effects from engaging in the group, most notably through decreased frequency of NSSI (Murray & Fox, 2006). Similarly an app called Talk-Life seems to be beneficial, which provides regulated and real-time support for individuals experiencing mental health challenges (Pritchard et al., 2021). Indeed, many young peoples seem eager to receive professional supports (Lavis & Winter, 2020), which again speaks to the need and potential benefits of such online services.

Treatment of NSSI

The paper thus far has discussed what NSSI is and why it is a concern. Now we will move on to discuss how this behaviour may be treated. Based on what we know about self-injury, such as its role in emotion regulation, it would make sense that therapies target emotion regulation. Indeed, it is a commonality between the effective interventions. Each of the modalities will be discussed below.

Dialectical Behaviour Therapy (DBT). DBT is one of the most common treatments for NSSI. It is a manualized treatment that supports the development of mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation (Adrian et al., 2019). A review of treatments for NSSI classified it as being beneficial for treating it, though there was no indication that it was any more effective than some of the other common interventions (Glenn et al., 2015). A recent study randomized 173 adolescents into either a DBT-A group (DBT-adolescent) or treatment as usual group (which consisted of individual and group supportive therapy). Both courses of treatment

lasted six months. The results indicated that both treatment groups were effective in reducing NSSI frequency, particularly with participants who presented with higher family conflict, externalizing challenges, and other high-risk factors. The researchers did note that for participants who had higher levels of baseline emotion dysregulation and parental psychopathology, DBT may be more beneficial. This was postulated to be because DBT incorporated more family work into the intervention (Adrian et al., 2019). A more recent study conducted a meta-analysis on 21 studies that assessed the use of DBT for treating NSSI, and found that compared to the control groups, DBT showed small to moderate effects for reducing self-injury (Kothgassner et al., 2021).

Emotion Regulation Group Therapy (ERGT). This intervention was encountered frequently in the literature (Bjureberg et al., 2017, 2018; Gratz et al., 2014; Gratz et al., 2015; Sahlin et al., 2017). Emotion Regulation Group Therapy is a 14-week intervention that was initially developed by Gratz and Gunderson in 2006, specifically for treating self-injury amongst women with BPD. The developers rationale behind the treatment was to target the underlying mechanism of NSSI, which in their view is emotion regulation (Gratz et al., 2014). In one study, 61 female outpatients with BPD were randomly assigned to either receive ERGT immediately, or in 14 weeks. The results showed that ERGT significantly reduced NSSI, along with BPD symptoms, depression, stress, and it improved emotion regulation and quality of life. Additional improvements were also seen between post-treatment assessment and the 9 month follow up. This included 47% of the sample reporting abstinence from NSSI during that time period (Gratz et al., 2014). It was later noted by Gratz et al. (2015) that the mechanism of change did appear to be emotion regulation; improvement in emotion regulation may

have improved both affective and cognitive symptoms of BPD, which then lead to a decrease in NSSI. Similar findings were obtained in a sample of 95 females with BPD, though this study was not a randomized controlled trial but rather used an uncontrolled, open trial design (Sahlin et al., 2017). There was a 52% reduction in NSSI frequency post-treatment, which rose to 76% during the 6 month follow up. Reductions were also noted with NSSI versatility (the number of methods used to self-injure), self-destructive behaviours other than NSSI, stress and depression. Emotion regulation significantly improved, and all of these improvements were maintained at the follow up (Sahlin et al., 2017). This intervention was also trialled on samples of adolescents diagnosed with NSSI-D, though it was adapted into an individual therapy rather than group (Bjureberg et al., 2017, 2018). Both studies found significant reductions in NSSI frequency and versatility, and improvements in emotion regulation and global functioning. All of these improvements were maintained at the 6 month follow up, in both of the studies (Bjureberg et al., 2017, 2018). However, neither of those were randomized controlled trials, and would require more rigorous and controlled testing.

Psychodynamic Therapies. All the interventions mentioned up until this point are considered variants of cognitive therapies. Psychodynamic interventions have also shown to be effective in reducing self-injury. For example, a recent meta-analysis analyzed the results from 17 studies and found that psychodynamic therapies may be effective in reducing NSSI and suicide attempts. These improvements were maintained at 6 month follow ups, but not at 12 months. As such, the authors noted that psychodynamic interventions may be effective in the short-term reduction of NSSI, but perhaps not the long term. There is a need for further research to explore this (Briggs et al., 2019). One of

the more popular psychodynamic interventions that is used is called Mentalization Based Therapy, which is a long-term therapy that is rooted in attachment theory. It supports clients in making sense of their inner experiences and how they relate to their actions (Glenn et al., 2015). A review of NSSI treatments classified this treatment as being effective (Glenn et al., 2015), and promising results were found in a randomized control trial that compared it with treatment as usual (Rossouw & Fonagy, 2012). At the end of the 12-month treatment, the mentalization based therapy group had significantly lower NSSI than the control group, and 44% of participants had abstained from NSSI. The control group also showed improvements, but the abstinence rate was lower at 17%. These authors noted that to their knowledge, this was the first time a treatment program was more effective than treatment as usual in reducing both NSSI and depression. They posited that the reason it was effective was due to the improvements in mentalization, and the reduction in attachment avoidance (Rossouw & Fonagy, 2012). The latter has relevance to this project, as one of the aims of this group is to improve attachment between young people and their caregivers.

Family Therapies. The last modality of interventions to be mentioned are family therapies. Given what we know about the effect of family functioning on NSSI, we could predict that they would be effective. Overall, the results may suggest that family therapy is effective, but no more effective than treatment as usual (Cottrell et al., 2020; Cottrell et al., 2018; Glenn et al., 2015). The most recent of these studies found that a manualized family therapy reduced NSSI in 15–17-year-olds more so than 11-14-year-olds, and this trend was maintained at the 36 month follow up (Cottrell et al., 2020). In a large, randomized control trial (n=832 adolescents) family therapy showed no benefit over

treatment as usual in reducing NSSI. The researchers did note a trend in that when caregivers reported poorer family functioning, family therapy may be more beneficial. On the other hand, when the young person reported difficulties in expressing emotion, family therapy seemed less helpful (Cottrell et al., 2018). This could potentially be because many family therapies aim to improve communication, but if the young person is already having difficulties recognizing what they are feeling or are lacking the skills to communicate it, this aspect of family therapy may not be beneficial to them at that time. Perhaps, a combination of individual and family therapy would best suit such cases. Indeed, many of the interventions mentioned such as EGRT, DBT and Mentalization Based Therapy include family components such as parent coaching or joint sessions in conjunction with the individual treatment (Adrian et al., 2019; Bjureberg et al., 2017; Rossouw & Fonagy, 2012).

This exploration of treatments for NSSI has shown that while there are many options, there is not really one that seems superior to the others. There may be many reasons for this. Firstly, not all studies are of the same quality. Some that were reviewed were randomized control trials, while others contained no control group. Though they yield valuable information, it is difficult to say if the treatment being investigated is any better than typical treatment when there are no comparisons done. The inconsistent quality of research may lead to misleading results as some studies may either miss potential effects or find effects that are not truly there. One group of researchers investigated this specifically in relation to CBT interventions and found that many studies had a high risk of bias. They noted a trend in which the trials that were in favor of CBT also had poorly defined treatment as usual/control groups, while the trials that were not

showing CBT to be superior had well defined control groups. They called on researchers to describe in detail the treatment the control groups receive, to ensure that they are still receiving what would be considered clinical best practice (Witt et al., 2018). Secondly, some forms of treatment are more widely researched, potentially due to funding. This is particularly true of briefer treatments because they are considered more cost effective both through the lens of public funding and insurance companies. Longer treatments, such as the year long Mentalization Based Treatment, may not receive as much funding due to the duration of it. Indeed, the meta-analysis on psychodynamic therapies noted the paucity of trials on this form of intervention (Briggs et al., 2019). Lastly, it is not uncommon within clinical research for no single therapy to come out as superior. Therapy is largely dependent upon the individual client; while CBT may work well for one, psychodynamic may work well for another. Theoretical orientation aside, across all forms of therapy the most important predictor of treatment outcome seems to be the quality of the therapeutic relationship (Herrero et al., 2020). The therapeutic relationship may certainly be playing a role in these interventions' efficacy, but there may also be some commonalities between them that are responsible for the improvements seen in clients. In a review of treatments for NSSI, the authors noted certain components that seemed to make a treatment effective. These included a focus on interpersonal relationships, particularly family relationships, skills training to foster emotion regulation, they address other maladaptive behaviours (substance use, etc.) and they are intensive (Glenn et al., 2015). Another review also noted that while there is no clear evidence on which modality may be the best, it is clear that family involvement in treatment is vital in order to most effectively treat NSSI (Fortune et al., 2016b).

Why is Caregiver Involvement in Treatment so Important? It has been this writers experience that involving caregivers in their children's treatment can be a situation that is difficult to navigate. Many caregivers already feel blamed and judged by professionals and psychoeducational materials, and may be battling with their own feelings of guilt and shame (Krysinska et al., 2020; Steggals et al., 2020). Due to these factors, when a professional suggests that they be involved in their youth's treatment, they may react defensively. They may also feel like the blame and focus is being put on them, rather than on what they view is the main problem—the self-injury, or in some cases the caregiver may view the youth themselves as the problem. However, the research shows that family involvement remains a crucial element in the treatment of NSSI (Fortune et al., 2016; Gratz et al., 2015). There may be multiple reasons for this. First, as has been discussed earlier in this paper, parenting styles and attachment may have an impact on self-injurious behaviours (Molaie et al., 2019; Pallini et al., 2020). As such, an important part of treatment could be addressing any relational and/or communication concerns that are evident in the family system. This is not to say that these concerns are the fault of the caregivers; such challenges are a normal part of any human relationship. The need to target this in treatment is evidenced by interviews with young people who self-injure, who stated that judgmental responses from their caregivers increased their distress, whereas calm, non-judgmental, and caring responses were more likely to help. Caregiver responses that involved avoiding talking about the self-injury were also viewed as less helpful by the young people (Fortune et al., 2008; Park et al., 2021; Rosenrot & Lewis, 2020; Simone & Hamza, 2020). It is particularly important that caregivers respond in a way that the youth find the most supportive because the

caregiver's response to the disclosure of NSSI may not only have an impact upon the self-injury itself, but also upon future treatment seeking behaviours. That is, emotionally charged and judgmental responses may lead to increased urges to self-injure as well as increased secrecy around the behaviour, in addition to potentially discouraging the young person from seeking further help (Curtis et al., 2018; Park et al., 2021; Simone & Hamza, 2020). Of course, it is not uncommon for caregivers to have highly emotional reactions when first learning about the young persons NSSI. It is understandable that they would. Though this is not the ideal response, it is also not cause for panic should the caregiver respond in such a way the first time. A recent review found that the ongoing attitudes and support that are received from parents are just as important and can impact the young persons decision to get treatment (Park et al., 2021).

The second reason why family involvement is so important is that NSSI effects more than just the person hurting themselves, it affects the entire family system. Siblings may feel neglected, and may become resentful about the amount of attention their self-injuring sibling is receiving from their caregivers (Curtis et al., 2018; Ferrey et al., 2016b, 2016a; Oldershaw et al., 2008). Living with and managing a child who self-injures also takes a physical and emotional toll upon the caregivers. Of all the studies reviewed pertaining to this, caregivers in every single one reported feeling immense amounts of guilt, shame, anger, devastation, confusion and self-blame after learning of their child's NSSI (Ferrey et al., 2016b, 2016a; Hughes et al., 2017; Krysinska et al., 2020; Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006; Steggals et al., 2020). Some experienced mental health challenges such as depression and anxiety (Ferrey et al., 2016b; Shah et al., 2010) as well as physical symptoms such as insomnia,

weight loss/gain, panic attacks, and chest pain (Ferrey et al., 2016b). Some caregivers also reported great marital strain because of caring for the young person. The situation emphasized differences in parenting strategies, and lack of agreement on how to handle the behaviour increased marital discord (Ferrey et al., 2016b, 2016a; McDonald et al., 2007; Oldershaw et al., 2008). Financial difficulties also became a concern for many. Some caregivers found it difficult to maintain a job, due to needing to leave with short notice when their child was in crisis or needing to attend multiple appointments with their child, most of which occur during business hours. Many felt it easier to leave their employment to stay at home full-time, where they would be able to keep an eye on the youth and be available should they need them (Ferrey et al., 2016b; McDonald et al., 2007). Amidst all this turmoil, many caregivers stated that they felt they were 'walking on eggshells' and did not feel confident in how to talk to their youth about self-injury (Ferrey et al., 2016b; Krysinska et al., 2020; Raphael et al., 2006; Steggals et al., 2020). Many expressed the need for more resources and support for parents, such as information on NSSI and how to best manage it (Curtis et al., 2018; Ferrey et al., 2016a; Hughes et al., 2017; Krysinska et al., 2020; Lindgren et al., 2010; McDonald et al., 2007; Power et al., 2009; Raphael et al., 2006; Stewart et al., 2018). A caregiver in one interview even mentioned wanting the hospital staff to provide direct feedback to her on how she was interacting with her child during visitations. She described feeling incredibly lost, and wanted someone to direct her on what to do (Stewart et al., 2018). Based on this feedback from caregivers in the reviewed studies, psychoeducation about NSSI as well as support for their emotional needs seems like a crucial part of the overall NSSI treatment. Afterall, the caregivers must first take care of themselves before they can properly care for their

children. This was a sentiment that was expressed by many caregivers (Ferrey et al., 2016a; Krysinska et al., 2020).

As was mentioned at the beginning of this section, some caregivers may meet the suggestion of being a part of treatment with resistance. It is unlikely that this comes from a place of uncaring, but rather from a place of insecurity. This is evidenced by the amount of caregivers who expressed feeling incompetent and like failures after learning of their child's NSSI (Krysinska et al., 2020; Raphael et al., 2006; Steggals et al., 2020). It is crucial that professionals speak to caregivers in a way that minimizes blame and shame and emphasizes the need and benefit of them receiving their own support.

Attachment Informed Parenting

What is Attachment Theory?

As attachment has already been discussed within this paper, it will only be mentioned here outside of the context of self-injury. Attachment theory is an ethological and psychodynamic theory that it is primarily concerned with the relationships between people, specifically parents and children. It is widely credited as being developed by John Bowlby and Mary Ainsworth, though Ainsworth was strongly influenced by her mentor William Blatz and his Security Theory so his influence should be noted as well (van Rosmalen et al., 2016). Inspired by his work with children who had been separated from their caregivers, Bowlby (1969) formed the principle that *"What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother."* (p.xi). Not experiencing this, and/or experiencing an attachment separation-even seemingly small ones-was viewed by attachment theorists as a cause for the development of psychopathology.

According to attachment theory, the bond between mother and infant forms the foundation for all social and emotional development (Bowlby, 1969). More recent research is even showing that the architecture of our brain may be impacted by early attachment stress (Blaustein & Kinniburgh, 2010). Attachment goes much further than just being about relationships; it is an instinctual behaviour—found even in non-human animals—and one that impacts the development of our social skills, and emotion regulation. Bowlby asserted that primates have an innate attachment behavioural system, which developed throughout hominid evolution as a survival mechanism. This system includes a repertoire of behaviours that serve to maintain an emotional bond with an attachment figure. One of these innate behaviours is proximity seeking, a behaviour which functions to maintain physical closeness to the attachment figure. Attachment figures are a haven for children, providing physical protection as well as emotional support and comfort. Additionally, attachment figures provide a secure base from which the children can explore the environment. Environmental exploration promotes the development of emotional self-regulation, as well as self-confidence (Bowlby, 1969; Glazebrook et al., 2015). Bowlby (1969) believed that attachment-figure availability and attunement leads to attachment security or insecurity, and to the development of self and other representations. These representations function as blue prints for future attachments and social interactions (Bowlby, 1969; Mikulincer et al., 2003).

The attachment system may also be implicated in the development of emotion regulation. Infants are born without the capacity to self-regulate. As such, they are dependent upon their caregivers to coregulate with them (Blaustein & Kinniburgh, 2010; Bowlby, 1969; Powell et al., 2013). When children become upset, they activate proximity

seeking behaviours and rely on caregivers to soothe them (Mikulincer et al., 2003; Powell et al., 2013). If they consistently receive nurturance from the caregivers, children learn that their caregivers can take care of them, their emotions are acceptable, and that distress can be tolerated (Blaustein & Kinniburgh, 2010; Bowlby, 1969). Overtime, the parent's consistent attunement to the child's distress becomes internalized as healthy coping skills which the child can utilize independently.

How Can Attachment Inform Parenting?

Being as attachment is defined as the bond between a caregiver and child, it follows that the theory can be used to inform parenting practices. Many of the practices based off of it take a 'what is natural is best' approach, and believe that caregivers have an innate instinct about how to best care for their child (Hulen, 2021; Sieben & Yıldırır, 2020). By those who support attachment informed approaches, it is often believed that while parenting from an attachment approach comes naturally, in the modern world many people have become estranged from it (Sieben & Yıldırır, 2020). This is largely due to the popularity of other parenting approaches, which will be explored in the following sections.

What is Attachment Parenting? Attachment Parenting is a parenting philosophy that was developed in the 1980's by William and Martha Sears. Their seminal book, which was marketed as teaching parents how to raise their children the way nature intended, quickly became known as the 'Attachment Parenting Bible' (Sieben & Yıldırır, 2020). This model is based off of attachment theory, which is reflected in many of the strategies. For instance, physical contact such as is found with baby wearing is beneficial, sleeping close to an infant can increase responsiveness to the infants cries for attention as

well as improve maternal sleep, and attunement and sensitivity are crucial for a secure attachment (Bowlby, 1969). It is however not without criticism. Critics of the philosophy fear that the emphasis on engaging in each of their core strategies, and on meeting their childs every need, may put too much pressure on parents. Another criticism is that not all of their strategies are supported by research (Divecha, 2018). Research does not suggest that caregivers must meet every need a child has (Powell et al., 2013), and breast feeding is not necessary for a secure attachment to develop. In fact, in her work in Uganda, Ainsworth noted that some infants were kept in proximity and exclusively breast fed, but still developed insecure attachments (van Rosmalen et al., 2016). This is because it is not just the act of feeding that forms a secure bond, but the responsiveness and attunement between caregiver and infant that occurs during the feeding process that forms it (Booth & Jernberg, 2010). Breast feeding is also a good example of where the model may create unnecessary stress, as it is heavily emphasized in the model yet many mothers struggle to or are unable to breast feed. The model has also been criticized for being misogynistic, as it emphasized the role of the mother and goes so far as to say the role of fathers is to support the mother in giving her full attention to the child. This includes being a stay at home mother, which Sear's believed was the only way to raise a secure child (Freeman, 2016). This is also not supported by research, which has shown that it is the quality of the parent-child interactions that foster secure attachment, not the quantity (Powell et al., 2013). Lastly, the emphasis that is placed upon the mother being the primary caregiver is not supported by research. Attachment with a father is just as beneficial and important, and research has shown that children will securely attach to anyone provided that they are consistent and attuned (Booth & Jernberg, 2010; Powell et al., 2013).

Overall, there are numerous positives about Attachment Parenting. It encourages sensitivity and attunement, both of which are building blocks for attachment (Booth & Jernberg, 2010; Bowlby, 1969; Powell et al., 2013). It encourages critical thinking about what parenting practices you use, and it encourages a balance between the children's needs and the parents needs. However, there are also drawbacks to the model. Perhaps the largest draw back is the lack of empirical support for what they claim develops a secure attachment, along with the pressure that it may put upon mothers.

Though 'Attachment Parenting' has been coined by this model, there are other attachment informed parenting interventions. It is important to distinguish between this one and the others, as due to the name they may get mistaken for one another. In the current parenting group, attachment informed parenting strategies will be encouraged. This group will not be in any affiliation with Attachment Parenting.

Attachment Informed Parenting. Throughout the remainder of this project, we will be referring to the parenting philosophy that is being encouraged as attachment informed parenting. This philosophy of parenting is based off attachment theory, and utilizes the concepts found within it to develop parenting behaviours that best support security. Many prominent therapies and parent interventions use an attachment informed lens, such as the Circle of Security, Dyadic Developmental Psychotherapy, Attachment Based Family Therapy and Theraplay. Renowned parenting experts Gordon Neufeld (Hold on To Your Kids), Daniel Siegel (The Whole Brain Child), Jennifer Kolari (Connected Parenting), and Gabor Maté (Hold on To Your Kids) also support attachment informed approaches. These philosophies obviously all share a common theoretical foundation: Attachment theory. But what does that mean? Attachment informed

approaches believe that caregivers should be a child's secure base, which means that they provide a consistently stable and nurturing relationship from which the child can leave to go explore the world, and to which the child can return to for safety and comfort. They are relationship focused and emphasize warm, playful, attuned and sensitive interactions that promote connection. An attachment informed caregiver pays attention to their child's behaviour and seeks to meet the need that is beneath it. The child's needs are responded to with warmth and sensitivity, emotions are met with acceptance and with a willingness to support the child in regulating the emotion (Booth & Jernberg, 2010; Kolari, 2009; Neufeld & Mate, 2013; Powell et al., 2013; Staines et al., 2019). This is done through a process called co-regulation, which occurs when a caregiver uses their vocal tone, physical proximity and touch, and presence to help the child calm down (Kolari, 2009). It is through these interactions that Bowlby (1969) initially theorized that emotion regulation develops. Co-regulation also provides structure to the child's experience, which is another component that is facilitative of a secure attachment (Booth & Jernberg, 2010; Kolari, 2009). Structure develops feelings of security, and may include physical structure (preventing a child from climbing a bookshelf), structure around their time (giving them limits around how long they can stay at the park, and supporting the transition for them), or it may be structuring and organizing their emotional experience for them (Booth & Jernberg, 2010). Children are not born into this world knowing what emotions are or what they mean, nor how to regulate them. It is the job of the caregivers to provide space for the child's emotion, and to co-regulate with them. This helps the child to learn that emotions are temporary, we do survive them, and most importantly for the attachment relationship, it shows the child that their caregivers can take care of them

even during periods of high emotionality (Booth & Jernberg, 2010; Kolari, 2009; Powell et al., 2013).

Another aspect that many attachment-informed philosophies share is the concept of attachment ruptures and repair (Booth & Jernberg, 2010; Kolari, 2009; Powell et al., 2013). An attachment rupture occurs when a disconnect has occurred between the child and caregiver, a need has gone unmet, and now there is a tear in the attachment relationship. A rupture may be caused by a big event such as abuse, but they may also be caused by small interactions such as not recognizing when your infant is hungry or dismissing your adolescents' feelings after you have had a long day at work. To some caregivers, this may seem catastrophic. However, from an attachment perspective, ruptures may be a gift. This may seem an odd stance to take, but ruptures give a chance for relationship repair which can strengthen the attachment relationship (Booth & Jernberg, 2010; Kolari, 2009; Powell et al., 2013). When a slight has been made, the act of the caregiver acknowledging what they did and how it affected the child, and then taking the chance to respond in a more nurturing way may have a positive impact upon the child. For one, it models accountability which is an important relational skill. Further, it shows the child that their caregiver cares enough to put in the effort to restore their relationship. This shows the child that they are worthy, their feelings and needs are valued, and they are loved (Booth & Jernberg, 2010; Kolari, 2009; Neufeld & Mate, 2013; Powell et al., 2013).

This brings us to one of the last common themes in attachment informed philosophies, which is that of reflective functioning. Reflective functioning refers to one's ability to think about our own and others mental states such as desires, wishes,

goals, intentions, and attitudes (Staines et al., 2019). Within the context of parenting, it is referring to the caregivers ability to reflect on both their own, and their child's internal experience (Staines et al., 2019). This is necessary for two reasons. The first is that the focus of attachment informed parenting is not on the child's behaviour, but rather the need that is beneath the behaviour (Booth & Jernberg, 2010; Kolari, 2009; Powell et al., 2013). To think about this, the caregivers must be able to think about the child's intention as well as what the child may truly be thinking or feeling. The benefit of looking at the need beneath the behaviour is that it leads to a more accurate representation of what is going on, and it also may elicit a more caring, compassionate response from the caregiver (Booth & Jernberg, 2010; Kolari, 2009; Powell et al., 2013). This is not to say that limits are not put in place for the child-as mentioned previously, structure is an important part of this philosophy (Booth & Jernberg, 2010; Kolari, 2009). What it does mean is that limits are put in place from a place of warmth and compassion, in a way that assures the child that they are loved and that their caregiver still has them.

The second reason for reflective functioning being so important is that caregivers need to have an awareness of how their child may be impacting them. One example of this may be an awareness of one's own exhaustion or stress levels, which may make the caregiver more likely to react out of anger rather than respond with compassion towards the child. Another example may be a caregiver's awareness about what is happening emotionally for themselves when their child is experiencing a big emotion (Powell et al., 2013). If a child is experiencing anger, for example, what is that making the caregiver feel? Everyone has differing comfort levels with different emotions, which are the result of how our own caregivers dealt with that emotion when we experienced it as children

(Booth & Jernberg, 2010; Powell et al., 2013). That is, if one's caregiver was uncomfortable with anger, they may have responded by stifling or invalidating that emotion in us. This may lead to a belief that it is unacceptable to show that emotion around people, and this belief may impact how people react to their own child's anger. This may then lead to the caregiver missing the child's need, and if this happens consistently the child may come to believe that their caregiver doesn't know how to handle their emotions. This would constitute an attachment rupture, and if consistently not repaired it may result in a child suppressing the emotion to make their caregiver more comfortable, and thus preserve the attachment relationship. (Booth & Jernberg, 2010; Powell et al., 2013).

The last commonality of attachment-informed approaches that will be mentioned is that they do not emphasize perfect parenting. The Circle of Security model promotes 'Good Enough Parenting'. Within their literature they emphasize that in any given caregiver-child interaction, approximately 70% of the child's needs go missed or unmet, and that is okay. So long as relational repairs consistently happen, and the overall relationship is characterized by warmth and nurturance, practitioners of this intervention assure caregivers that a secure attachment is possible by just being *Good Enough* (Maxwell et al., 2021; Muddle et al., 2021; Powell et al., 2013).

How does attachment parenting compare to other parenting models? One of the other popular parenting philosophies is behavioural parenting, which is based on the theory of behavioral therapy. Behavioral therapy is focused on observable behaviour and their determinants and utilizes learning experiences to change behavior (Corey, 2009). The consequences that result from a particular behaviour are one way that a person may

learn to change. For example, if you put your hand on a hot stove and get burnt, you are less likely to put your hand there again. In relation to parenting, those operating from a behavioral approach may utilize reward and punishment systems to change a child's behaviour. For example, when a child engages in undesirable behaviour, they may be put in a time-out, or they may be intentionally ignored by the caregiver until they cease that behavior. Similarly, when they engage in a desirable behavior, they may be given a reward in hopes of encouraging further use of that behavior (Chesterfield et al., 2020). Where it differs from attachment-informed practices is that behaviorism is concerned only with the observable behavior, not with the underlying need. Additionally, it does not utilize the process of co-regulation as attachment practices do, and instead relies on leaving the child alone or ignoring them until their undesirable behavior stops. These strategies do often work and changes in behavior are seen (Chesterfield et al., 2020; Chung et al., 2015; Högström et al., 2017). However, the underlying processes through which they work may not be beneficial for the child or the parent-child relationship in the long term (Booth & Jernberg, 2010; Neufeld & Mate, 2013). Take for example planned ignoring, which is when a person ignores an undesirable behaviour displayed by the child. Eventually, the undesirable behaviour will stop. But what may be underlying that behavioral extinction? The child may be feeling unwanted or not worthy of attention. Overtime, these feelings may become internalized into a working model of the self (Booth & Jernberg, 2010; Bowlby, 1969; Powell et al., 2013). Time-outs also may have unintended negative consequences, though this is not to say that there is not a time and place for them (e.g. if the caregiver needs a break to regulate their own emotions before attending to the child) (Powell et al., 2013). However, when a child is put in a time-out

during a tantrum, this is leaving them alone to regulate their emotions. As discussed, this is not something that children innately know how to do. They need their caregiver to co-regulate with them to develop emotional competency (Booth & Jernberg, 2010; Bowlby, 1969; Powell et al., 2013). Again, however, a child will likely eventually calm down during a time-out. The process by which they calm down however, is not attachment strengthening. They may begin to believe that their emotions are too big for their caregivers to handle, that emotions are not okay to have, or that they are only worthy of their caregiver's warmth and affection when they are behaving properly. So, they learn to suppress those emotions and may experience a sort of emotional 'shutting down' which may lead to future difficulties with emotional awareness and regulation (Powell et al., 2013). The use of rewards and punishments has also been critiqued, for it is believed to develop a moral compass based on extrinsic values (I'm not going to do this because I will get in trouble) rather than intrinsic values (I'm not going to do this because it is not fair to treat another human that way) (Neufeld & Mate, 2013). A reliance on rewards may also become problematic when you need to implement a consequence. For a relationship that was built upon rewards, a consequence may then feel like a rupture in the relationship, and it could lead to the development of the belief that they are only worthy of love when they are behaving properly (Kolari, 2009; Neufeld & Mate, 2013).

One of the more common interventions that uses this philosophy is Triple P Parenting. One of the focuses of the intervention is on supporting positive caregiver-child relationships, but it does encourage the use of many behavioural management strategies. Regarding its efficacy, a study in Hong Kong found that it reduced negative behaviours but did not reduce parenting stress (Chung et al., 2015), and a meta-analysis found it to

show moderate to large effect sizes on behavioural problems in children (De Graaf et al., 2008). The authors made an interesting note regarding the finding that Triple P seemed to show the strongest effects with males. They postulated that because, on average, males have more externalizing behaviours than do females that this provided them with 'more room to change' as a result of the Triple P intervention (De Graaf et al., 2008). This suggests that Triple P may be beneficial for controlling behaviours, but it may not impact internal factors such as self-esteem.

Efficacy of Attachment-Based Parenting Groups. A few of the more commonly used attachment informed parenting groups will be discussed, along with some smaller groups that have undergone empirical review. The Circle of Security is a manualized attachment based parenting group that encourages the identification of and responding to a child's needs, being present and allowing children to experience emotions, the caregivers reflective functioning and the rupture-repair process (Powell et al., 2013). It has shown promising results in increasing parental self-efficacy (Huber et al., 2021; Rose et al., 2018), an increase in emotionally attuned caregiver-child interactions (Mothander et al., 2018; Sundberg et al., 2020) and in reducing parenting stress (Huber et al., 2021; Maxwell et al., 2021; Rose et al., 2018). Caregivers who have provided feedback on the group have described it as providing a shift in perspective by taking the focus off the child's behaviour and onto the relationship and found that it helped them to develop greater empathy for and understanding of their child. Caregivers also consistently stated that they appreciated COS's lack of emphasis on perfection and instead on self-compassion and *good enough* parenting (Maxwell et al., 2021; Muddle et

al., 2021). It has also been shown to be applicable across cultures (Huber et al., 2021; Mothander et al., 2018; Rose et al., 2018).

Theraplay is an attachment based play therapy (Booth & Jernberg, 2010). It utilizes playful interactions and attunement to strengthen attachment, improve limit setting and boundaries, and improve child self-esteem. It has been shown to improve caregiver-child interactions (Salo et al., 2020; Smithee et al., 2021; Sundberg et al., 2020), reduce children's externalizing and internalizing behaviours (Money et al., 2020; Salo et al., 2020), along with psychiatric symptoms (Sundberg et al., 2020) including PTSD (Eruyar & Vostanis, 2020; Sepehrtaj et al., 2020), prolonged grief following the death of a sibling (Sepehrtaj et al., 2020), and anxiety (Smithee et al., 2021). Caregivers report having a better understanding of their child and a reduction in reported attachment difficulties following the course of treatment, which is typically 15 sessions (Eruyar & Vostanis, 2020; Sundberg et al., 2020).

Smaller attachment informed parenting interventions have also shown promising results. In one group called ABC which focused on nurturance and following the child's needs, a sample of 208 caregiver-infant dyads showed significant increases in sensitivity and responsiveness and a decrease in intrusive parenting behaviours (Berlin et al., 2018). A similar group was recently developed in Hong Kong, which went by the name of Love, Limits, Latitude. It promoted attunement and warm, playful interactions between caregiver and child. In this sample of 69 caregivers and children, there was a decrease in the reported intensity of the child's non-compliance and parents reported feeling more confident in managing their child's behaviours. There was also a decrease in parental stress, and an increase in the amount of positive interactions between caregivers and

children, along with an increase in overall family functioning (Ngai et al., 2021). A Nurturing Attachment parenting group was also developed, based off the principles of Dyadic Developmental Psychotherapy, which is an attachment based family therapy for children who have experienced developmental trauma (Staines et al., 2019). Similar to the Circle of Security, this group aims to improve parental reflective functioning and confidence, it encourages the caregiver to look at the need beneath the behaviour and it emphasizes the importance of repairing attachment ruptures. Playfulness, curiosity, acceptance, and empathy are considered key components to effective, attachment strengthening interaction between a caregiver and child. In a study of 29 parents, this group improved parenting self-confidence and coping, and it reduced child conduct problems (Staines et al., 2019). Another parenting model that was found during this review is 'responsive parenting', which is conceptually similar to attachment-informed parenting. It was found to lessen the impact of parental PTSD upon the child (Greene et al., 2020) and it has shown to be beneficial in developing social skills in autistic children (Caplan et al., 2019).

Attachment Informed Parenting with NSSI

The above section offered a comprehensive literature review on what attachment theory and attachment informed parenting is. This section will draw from the previous section to provide strategies on how caregivers can respond to their adolescents NSSI in an attachment informed way. The approaches being drawn upon will be Circle of Security (Powell et al., 2013), Theraplay (Booth & Jernberg, 2010), Dan Hughe's Dyadic Developmental Parenting (Staines et al., 2019), Gordon Neufeld's attachment-based

developmental approach and Gabor Mate's compassionate inquiry (Neufeld & Maté, 2013), and Jennifer Kolari's Connected Parenting (Kolari, 2009).

What to do during an NSSI episode

Self-Regulation. Disbelief and devastation may be common reactions when a caregiver first learns about their child's self-injury, and it may not be uncommon for the caregiver to react with high emotionality (Krysinska et al., 2020). Though perfectly understandable, it is important that the caregiver maintains their own self-regulation. Adolescents who have self-injured expressed that their caregivers remaining calm and responding with understanding, acceptance and empathy was most beneficial (Curtis et al., 2018; Rosenrot & Lewis, 2020; Simone & Hamza, 2020). A few strategies that may be used to regulate one's emotions include deep, mindful breathing, as well as grounding techniques such as repeating a mantra or keeping a physical object on one's person that can provide tactile stimulation and soothing (Erford, 2015). Proprioceptive input may also have a regulating effect and can be accomplished by pushing one's arms against a wall or door frame, or their legs against the ground (Booth & Jernberg, 2010). Appendix A has an example of strategies that would be presented to caregivers in this group. It is important to note that it is okay for the caregiver to step away for a moment to regulate themselves (Booth & Jernberg, 2010; Powell et al., 2013). It is recommended that before they do so, they affirm to the adolescent that they are cared for but that they need a moment to collect themselves before discussing the incident further (Kolari, 2009).

How to communicate with the child. It may be difficult for a caregiver to know what to say after learning that their child is self-injuring. A parent in one study stated that "I just felt like anything I said would be the wrong thing to say," and a feeling of

‘walking on eggshells’ was a common theme (Steggals et al., 2020, p.274). Communication breakdown was also a commonly reported occurrence after an NSSI disclosure (Steggals et al., 2020). The principles of attachment informed parenting can provide guidance, as can the voices of young people themselves. As stated previously, calm and nurturing communication with no judgment is expressed as most helpful by adolescents and many said that it plays a role in their decision to seek treatment (Curtis et al., 2018; Rosenrot & Lewis, 2020; Simone & Hamza, 2020). This is consistent with attachment informed communication, as warmth and acceptance are most likely to preserve the relationship. Two specific attachment informed approaches will be drawn upon here, as they provide caregivers with concrete steps for communication. The first is drawn from Dyadic Developmental Parenting, which encourages caregivers to approach children with an attitude of playfulness, acceptance, curiosity, and empathy (PACE) (Staines et al., 2019). With NSSI, this may look like avoiding the use of shaming language and tone, reassurance that the adolescent is loved and that the caregiver will support them through this, an acknowledgment of the pain the adolescent must be experiencing that lead them to harm themselves and curiosity about what lead to such distress. The second technique is known as CALM and is taken from Connected Parenting, which provides caregivers with steps for how to help their children through emotional distress (Kolari, 2009). The first step is to connect (C), which can be done by actively listening, making eye contact, and using physical touch and vocal tone to communicate that the child has your undivided attention. The second step is to match your child’s affect (A) by means of your facial expression, body language and vocal tone. This is to communicate to them that you understand their distress. Next, listen (L). Listen

without judgment, and paraphrase what you are hearing them say. Truly seek to understand the situation from their perspective. When all three of these are done together, mirroring (M) has occurred. Mirroring is a behaviour that activates the mirror neuron system in our brains and facilitates the process of co-regulation (Kolari, p.4).

Within the group, examples will be demonstrated by the facilitators and role-plays amongst the members will be done to support the caregivers in practicing these forms of communication.

Risk Assessment and First Aid. It goes without saying that NSSI is a risky behaviour, and that it is necessary to assess for risk after an individual has harmed themselves. This includes assessment of if the immediate injury requires medical attention or can be treated at home, as well as suicide risk. Being as this group will not be facilitated by medical professionals, medical advice will not be provided. Basic first aid principles will be discussed however, including sterile strips, bandaging and wound cleanliness. Our recommendation would be that if the caregiver is unsure about if the wound requires stitches, they should call the provincial health line to consult and/or go to urgent care.

The caregiver will also need to assess for suicide risk. They can do this by directly asking the youth if they are having thoughts of attempting suicide. Many caregivers may worry about asking about suicide or self-injury for fear of putting the ideas in the youth's head. However, asking about suicide or self-injury is unlikely to do this. A recent review and meta-analysis sought to answer that exact question: is it harmful to ask about suicide or self harm? Their results suggested that it is not related to any increases in suicidal behaviours, self-injury, nor psychological distress (Polihronis et al., 2020). The

caregivers will be further advised to consult with resources that can support them in completing a full risk assessment, especially if the youth answers that they are thinking of attemptiong suicide. Such resources will be provided within the group.

What If the Caregiver Reacts Instead of Responds? Given the high stress nature of NSSI, it is not uncommon that a caregiver would have a highly emotional reaction to discovering it (Ferrey et al., 2016b; Krysinska et al., 2020; Park et al., 2021). Perhaps the caregiver responds with anger, judgment, and/or a response that evokes shame within the youth. As we know, many adolescents already experience a great deal of shame regarding their self-injury (Rosenrot & Lewis, 2020), and such reactions from caregivers can prevent future disclosures while also exacerbating their distress and thus the NSSI (Curtis et al., 2018; Park et al., 2021). What we also know is that the caregivers ongoing response to the self-injury is just as important as their first reaction (Park et al., 2021) and that attachment ruptures can be repaired and through repair they can even strengthen the relationship (Booth & Jernberg, 2010; Kolari, 2009; Neufeld & Maté, 2013; Powell et al., 2013). But how does one repair such an attachment rupture? A proper repair includes an acknowledgment of what happened, how it may have affected the youth, and what will be done differently in the future to prevent such a rupture again (Kolari, 2009; Powell et al., 2013). The principles of PACE may be utilized here, by having the conversation in a way that conveys acceptance (minimizing judgment about the NSSI), curiosity (what was the experience of the rupture like for them? How would they feel most supported?) and empathy (focus on the feeling beneath the NSSI) (Staines et al., 2019). It may be appropriate to express concern about the NSSI and the youth's distress, while affirming that they are loved and will be supported through this.

Threats of NSSI

Self-injury is a frightening behaviour, and one that may leave caregivers feeling at a loss for what to do. Some caregivers reported a shifting in the power balance within the home, with the self injuring adolescent now holding more power than the caregivers. One caregiver described feeling like a hostage to the NSSI (Ferrey et al., 2016b, 2016a). This may be exacerbated when youth use threats of the behaviour to avoid tasks or situations, or to be allowed to do something. For instance, some youth may threaten self-injury when the caregivers attempt to monitor them more for their safety, when they aren't allowed to go out with friends, or if they are trying to get out of going to an undesirable family function. Caregivers in some studies expressed that when their youth first began self-injuring, they feared doing anything that may trigger an NSSI episode. They initially felt they acquiesced to the youths demands, but that over time they became more assertive (Ferrey et al., 2016a; Krysinska et al., 2020). Some methods of responding to these threats, and how to implement appropriate limits will be discussed.

How to Respond to Threats of Self-Injury. The first and most important part to remember when responding to a threat of NSSI is to keep yourself regulated. This is echoed by the voices of caregivers who have lived through such experiences, and emphasize the need to remain calm and communicate openly (Krysinska et al., 2020). If the caregiver is not calm, it is unlikely that they will be able to respond from a place of acceptance, curiosity, and empathy (Staines et al., 2019). When calm enough to do so, responding to threats will follow to same communication guidelines that were recommended in a previous section, so they will not be discussed in detail here.

Something important to remember here is to focus on the feeling/need beneath the behaviour (Booth & Jernberg, 2010; Kolari, 2009; Neufeld & Maté, 2013; Powell et al., 2013; Staines et al., 2019). That is, when communicating with the youth, do not focus on the threat. Take for instance an adolescent who is threatening to self-injure because they don't want to go to a family dinner. Looking at the feeling beneath the threat may look something like this: "You sound really upset about coming with us to this dinner. Can we talk about why that is?" The caregiver could then use their knowledge of the youth to wonder about reasons why they don't want to go. Perhaps they experience anxiety being around groups, or there is a family member in attendance who makes them uncomfortable. It is likely that a teenager may respond to such a question with "Because I just don't want to!" which may open an opportunity for playful engagement. More examples will be offered within the group, along with role-play scenarios to give caregivers the chance to practice.

Setting limits. Structure is an integral part of attachment informed parenting, as it provides safety and comfort in the knowledge that the caregiver knows how to take care of the youth (Booth & Jernberg, 2010). Setting boundaries and limits within the context of NSSI however is likely frightening for caregivers, as evidenced by accounts of them saying they feel like they are walking on eggshells and feel as if they are held hostage by the NSSI (Oldershaw et al., 2008; Steggals et al., 2020). Before setting limits, it is important to ensure that the types of limits being set are appropriate and consistent with attachment principles. Strategies such as removing the youth's door or taking away their phone may be touted as good limit setting; however, such punitive strategies may have the opposite effect (Neufeld & Maté, 2013). If we listen to the voices of adolescents who

have self-injured, they tell us that such strategies are more distressing than helpful, but what does help is talking about what is going on for them (Curtis et al., 2018; Rosenrot & Lewis, 2020; Simone & Hamza, 2020). Throughout the literature, many caregivers reported initially using such measures but over time learned that they were not effective (Curtis et al., 2018; Ferrey et al., 2016a). Their voices are corroborated by the work of Dr. Neufeld and Jennifer Kolari. Dr. Neufeld (2013) noted that coercive methods of behavioural control such as rewards and punishments may indeed lead to a compliance in behavior, but that compliance only exists so long as the reward or consequence does. The implication of this is that the youth is not developing an intrinsic desire to engage or not engage in a particular behaviour. Dr. Neufeld also noted that following the use of these methods, there is often an increase in non-compliance. Both he and Jennifer Kolari (2009) believe that non-compliance is a result of a weakening attachment. Therefore, compliance is best achieved through strengthening the attachment relationship.

These approaches will be used to inform how caregivers can put in limits with their youths. Using the communication strategies that have been discussed, limits can be placed with compassion, empathy, and love. Using the previous example of a youth not wanting to attend a family dinner, setting a limit may look like this: “You’re so anxious about going to this dinner. I know it sucks having to do things that you don’t want to. Maybe we can find a way to ease your anxiety about it together.” Note that this is not focusing on the threat, validates the youths’ feelings, and maintains the expectation while offering the caregivers availability for support. If the youth does carry through on their threat, proceed with the strategies on responding to NSSI. If appropriate, the expectation may still be held after the NSSI is tended to (going to dinner), but regardless of what

happens, connection should be used to further strengthen the attachment bond (Kolari, 2009; Neufeld & Maté, 2013). This may seem backwards to many, but in line with Dr. Neufeld's work if the youth is being defiant towards the caregivers the remedy is strengthening the attachment bond which will lead to greater compliance in the future.

A consideration when dealing with self-injury is that sometimes setting a limit may involve taking the young person to emergency services. Take a situation where the young person locks themselves in their room, is refusing to come out and is continuing to threaten self-injury. If the caregiver feels the risk is too much, it may be appropriate to tell the young person that if such threats persist, then emergency services will be called. It is key that if this limit is set, that the caregivers are prepared to hold it (Booth & Jernberg, 2010; Kolari, 2009) which may involve one or both caregivers having to stay back with the youth.

Monitoring the Adolescent

After an incident of NSSI, a common reaction from caregivers is to increase monitoring of the youth and to adopt a sense of hypervigilance (Ferrey et al., 2016b, 2016a; Krysinska et al., 2020; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006; Steggals et al., 2020). While understandable, and necessary, it's important that it doesn't become too extreme (removing bedroom doors, helicopter parenting, etc.). There are multiple reasons for this. First, that degree of hypervigilance is exhausting on the caregiver and has been associated with increased guilt (McDonald et al., 2007). It is important for the caregiver to take the best care of themselves as they can, for caregiver exhaustion and burn out is not conducive to being available as a caregiver (Krysinska et al., 2020; Powell et al., 2013). Secondly, it may be more distressing/irritating to the youth

which may lead to increased NSSI, and it also may lead to more sneakiness around the self-injury (Rosenrot & Lewis, 2020; Woodley et al., 2020). This was also found when caregivers took away self-injuring instruments such as blades (Woodley et al., 2020). Finding a balance in how much control should be implemented is a daunting task for caregivers. In this group, it will be recommended that deciding on how much monitoring and control will be in place should be a collaborative process between the caregivers and youth. Using the communicative practices already discussed, caregivers can express their concerns, hear the youths' concerns and their input on what they would find supportive, and work together to decide on what supervision in the home will look like. Such an agreement may include the caregiver physically checking in on the youth every half-hour when they are alone in their room or bathroom. Safety around self-injury may also be monitored, such as checking-in with the youth to ensure that if they do self-injure, they use clean instruments and practice proper wound care. Many youths are already mindful about safety around their own self-injury, so a conversation about it along with the potential risks of it may be something they are open to (Woodley et al., 2020). It could also be helpful to agree to show the caregiver the injuries so that they can decide if medical attention is required. Lastly, monitoring may also include check-ins regarding the youth's emotional state, including asking about any NSSI thoughts. There will be more on this in the next section.

Ongoing communication about NSSI

Self-injury should not just be talked about following a crisis. It is important to keep communication open about it at all times (Krysinska et al., 2020; Steggals et al., 2020). This may include open discussion about NSSI urges, and the motives for self-

injuring. Youth identified caregiver support as integral in their decision to begin recovery (Rosenrot & Lewis, 2020), and ongoing communication can be an important aspect of that support. By consistently checking in with the youth about it, this may foster a sense of acceptance, facilitate emotional bonding, and thus increase the chances of the youth coming to the caregiver for support in the future (Park et al., 2021; Rosenrot & Lewis, 2020; Simone & Hamza, 2020). In cases where it may be difficult for the youth to communicate verbally about it, the family can get creative with communication strategies. Perhaps there is a journal that the youth and caregiver could write to each other in, or a code word could be developed to indicate when the youth is not doing well and would like some support. It should be arranged before hand what sort of supports the youth would find helpful—do they prefer to be distracted, or to talk about what is bothering them?

Can future episodes of NSSI be prevented?

Unfortunately, there is no single intervention that could be offered that would cure NSSI. What may be more helpful to focus on is maintaining safety even if the youth is self-injuring, and on strengthening the attachment relationship through connection. Though strengthening attachment may not stop the NSSI, it is more likely to result in the youth coming to the caregivers rather than peers for support and it increases the likelihood of the youth seeking treatment (Rosenrot & Lewis, 2020; Simone & Hamza, 2020). Through the benefits that attachment has upon emotion regulation and over all well being, it may also have the potential to reduce the NSSI as well.

What will be discussed below are some ways that caregivers can foster connection throughout their daily lives. Afterall, for attachment to truly be strengthened it needs to

be exercised consistently-not just when the youth is at risk (Booth & Jernberg, 2010; Kolari, 2009; Neufeld & Maté, 2013; Powell et al., 2013).

Collecting the Child. Collecting your child is a term that was coined by Dr. Gordon Neufeld. In the book *Hold On to Your Kids*, he describes this process as *"drawing them under your wing, making them want to belong to us and with us."* (p.179). He goes on to note that, *"…we need to make a habit of collecting our children daily and repeatedly…"* (p.179). To do this, he suggests that we rely on our instinctive attachment behaviours. In what he refers to as the *attachment dance*, humans engage in instinctual behaviours that naturally draw children in. For example, making cooing sounds at an infant and engaging them through facial expressions. According to Dr. Neufeld, society and culture may cause us to lose touch with our instincts. This may especially be the case in societies that emphasize behavioural parenting over attachment informed parenting, as some behavioural approaches go against instinct (e.g. letting an infant 'cry it out' rather than soothe them). Another possibility is that the attachment dance becomes less natural as children get older, especially because of the notion that adolescents are supposed to attach more to their peers as a part of healthy development. This however is not the case, and Dr. Neufeld's work suggests that peer orientation is what is weakening the caregiver attachments. To remedy this, caregivers may collect their children and woo them back. This can be accomplished by giving your undivided attention to the youth, and showing genuine interest in them as a person (Neufeld & Maté, 2013). Often with the daily hassles of life, joy and playfulness get put to the side and caregiver-child interactions become focused on correcting the youth's behaviour, or about mundane life topics (Booth & Jernberg, 2010). It may be beneficial to give the

youth attention for other reasons, such as truly hearing about their day or about their new favorite show. Caregivers can offer physical affection at their child's comfort level, which is a powerful attachment tool. Additionally, though many caregivers veer away from any baby like interactions, research shows that it may be beneficial to dote on and to treat your adolescent as if they are still your little baby at times (Booth & Jernberg, 2010; Kolari, 2009).

Building Connection Into the Day. Amongst the busyness of daily life, it can be easy for genuine connection to get pushed aside. Caregivers may find themselves focusing on just physically caring for their kids—feeding them, getting them to school, ensuring they do their homework, taking them to extra-curriculars—and moments of playful engagement and connection may become few and far between. A wonderful way to strengthen attachment is to build moments of connection into the family's daily routine (Booth & Jernberg, 2010; Kolari, 2009; Neufeld & Maté, 2013). These could be incorporated into wake up/sleep routines and can be interspersed sporadically throughout the day. Examples could be a spontaneous hug coupled with a verbal affirmation of their strengths and how cared for they are, or sitting with the youth and asking about something they are interested in such as a favorite musician, fandom, or show.

Chapter IV: Overview of the Collected Parenting Group

Group Goals and Objectives

The past chapters have elucidated that caregivers of individuals who self-injure have identified a need for education about NSSI, as well as parenting advice and emotional support (Krysinska et al., 2020). The literature review has also indicated that the way a caregiver supports their young person who is self-injuring has a large role in the adolescent's desire for recovery (Rosenrot & Lewis, 2020; Simone & Hamza, 2020), and that caregiver involvement in formal treatments is valuable (Booth & Jernberg, 2010; Fortune et al., 2016a; Gratz et al., 2015). The Collected Parenting group aims to meet these needs by offering psychoeducation about NSSI and attachment informed parenting, as well as offering emotional support both from the facilitators and the peer group. By providing these supports to caregivers, they may feel more confident in supporting their adolescent which may then lead to beneficial outcomes for the young person. The primary goal of the Collected Parenting Group is to increase caregiver confidence and competence in their ability to parent and support a youth who is self-injuring. This goal will be accomplished by first providing caregivers with comprehensive knowledge about self-injury, and then by teaching and practicing attachment informed parenting strategies that can be used to manage self-injury and its associated behaviours within the home. As this group aims to provide emotional support in addition to psychoeducation, process work will be integrated into the psychoeducational format. In 2012, Champe and Rubel published an article on guidelines for integrating process work into psychoeducational groups. These guidelines were used to inform the construction of this group.

The remainder of this chapter will expand upon the overall structure of the Collected Parenting Group. This includes the process that potential members will go through to become enrolled, what information will be collected from the members, an overview of the measures that members will be asked to complete, and a brief overview of the Collected Parenting curriculum.

Group Membership

To participate in the Collected Parenting Group, members are required to be at least 18 years of age and must be in relationship with an individual who is self-injuring. Membership will not be exclusive to caregivers, as the information provided within the group could be helpful for other family members or friends who are seeking to best support a young person who is struggling with NSSI. For example, grandparents, aunts and uncles, a family friend or a friend of the individual struggling with NSSI. The relationship will be determined by asking the potential member who they are seeking to support and what lead to their interest in attending the group. Members must be able to speak English and to provide informed consent to participate in the group.

Group Screening

The purpose of group screening is to ensure that the Collected Parenting Group offers a safe environment for all members, and that the group material is relevant to all participants. While all levels of diversity are welcome in the group, there are some traits (e.g., hostility) that may disrupt the group. In such instances, other resources may be more valuable to them.

Potential members first point of contact will be a group facilitator. Once they have contacted them to express interest, the facilitator will send them a form to complete

which solicits information about the eligibility requirements along with what they are looking for from the group (see Appendix A). The information collected within the Intake Form is used only for the purpose of establishing goodness of fit between the individual and the group. Once the form has been reviewed and eligibility has been established, the facilitator will contact the potential member to arrange a time for a video call (Corey & Corey, 2006). At the start of this video meeting, confidentiality and informed consent will be explained. Verbal consent will be sought to proceed with the remainder of the screening questions, with an emphasis placed on the individuals right to pass answering any specific question that is asked of them. The screening questions were tailored by the facilitator (see Appendix B) and will be used as a guideline for the conversation. They seek information such as the potential members biggest challenge in supporting someone who self-injures, what their current approach to managing the behaviour is, and how they currently cope with stress in their lives. This information is sought so that facilitators can gain an understanding of where each member is at so that the group can be tailored to meet individual needs. This meeting will also serve to provide information to the potential member about the group, better assess the goodness of fit between the potential member and the group, and for the facilitator and potential member to get to know one another. This will also give the facilitator an opportunity to assess the potential members temperament and how well they may fit into a group setting. If the facilitator and potential member agree about going forward with enrolment, a consent form for participation in the group will be emailed to the participant. The form must be signed and returned prior to the first session. Additional details on the group, such as confirmation of meeting times and locations, will be emailed prior to the group's commencement.

Reasons for a potential member to be deemed ineligible for group participation are those who (a) are not in relationship with a youth who is self-injuring, (b) the youth they are in relationship with engages in primarily suicidal behaviours but not NSSI, (c) are not able to commit to attending and/or being punctual to all sessions, (d) are aggressive or hostile within the intake meeting. The facilitator would explain the reasons for the decision that the Collected Parenting Group may not be the best fit for them at this time.

Measures

The only questionnaire administered throughout the group is the Session Evaluation form. Participants will be asked to complete it at the end of every session. The purpose of the session evaluation will be discussed with participants during the initial screening phone call, and again during the informed consent process in the first session of the group. It will be emphasized that completion of it is not mandatory, and that a decision to not complete them will not impact their participation or treatment in the group. Participants can consent to participate in the group sessions, but not consent to complete the evaluation.

The purpose of the session evaluation is to assess the participants satisfaction with the facilitators, the relevance of the content, and how they are feeling about the group thus far. There will be space for the participants to offer any additional feedback, such as anything they would like changed or added into the group. Due to the virtual nature of the program, the evaluations will be emailed to facilitators which makes anonymity not possible. To mitigate this, at the end of each session the facilitators will emphasize that their feedback will not impact their service in anyway, and that the purpose of the

feedback is to help the facilitators best support the participants. Evaluations will be reviewed following each session, and feedback will be implemented. If necessary, the feedback will be discussed in the following session while protecting everyone's anonymity.

Forms

Included within the group manual are resource sheets that the facilitators may choose to provide to group members. These forms include the Session Evaluation Form, and the DBT T.I.P.P strategy. These forms are copyrighted material, and prior to their use a group facilitator must contact the respective authors to obtain permission to use them within the group.

Structure and Organization of the Group

Group Design

The Collected Parenting Group aims to provide psychoeducational and emotional support to individuals who are supporting a young person who self-injures. To achieve this, a group that allowed for group process and psychoeducation was required. Group process pertains to the interactions amongst group members, such as how they communicate, make decisions and deal with emotions. Using group process involves paying attention to and addressing member interactions and emotions that arise as a result of them (Champe & Rubel, 2012). This type of group was chosen for multiple reasons. The primary reason is that throughout the literature review, caregivers expressed a need for both education about NSSI as well as emotional support (Krysinska et al., 2020). The other reason is that because of the sensitive and personal nature of the content, it is likely that discussion of it will evoke strong emotions. To neglect these emotions may not be in

the best interest of the members, especially when emotion plays a critical role in learning (Champe & Rubel, 2012). Lastly, as was explored in the literature review, how a person responds to the individual who is self-injuring has a role in the individual's willingness to be open about NSSI as well as their desire for recovery. Groups provide ample space for interaction, which provides the facilitator with insight into how members may interact with others in the world. Providing in the moment feedback about how one's communication impacts others may support members in gaining insight into how their communication may be impacting the young person.

Champe and Hubel (2012) noted a dearth in information to guide facilitators in providing a group that would utilize process and psychoeducation. The eight sessions of the Collected Parenting Group were designed with consideration of the principles for integrating process work with psychoeducation that they put forth (Champe & Rubel, 2012; Mills & McBride, 2016). This involves an understanding of the stages of group development, an understanding of group process techniques and how to utilize this knowledge to best facilitate learning within the group (Champe & Rubel, 2012; Mills & McBride, 2016). The key components for integrating process work with psychoeducation will first be discussed, followed by how specific group process techniques will be used to achieve this.

Champe and Hubel (2012) spoke to the delicate balance between process and content in psychoeducational groups. They noted that these groups are often time limited, and facilitators must cover a large amount of information in them. Due to these constraints, there are two risks: the facilitator may over-focus on process, or on content. The first steers the group towards therapy and missing out on the educational component,

while the second risks passive learning and limited opportunity to connect the material with one's personal life (Champe & Rubel, 2012). The facilitators task is to balance time spent on process and content in such a way that the group process can provide its own source of learning while also complementing the learning of the educational content. To achieve this, they identified four key facilitator tasks: creating a safe environment, engaging members in one another's learning, exploring members relationship to the content, and a quick return to the content (Champe & Rubel, 2012; Mills & McBride, 2016). These four tasks are achieved using group process techniques, which will now be discussed.

Group process techniques will be used throughout the group to enhance member learning. In particular, there are four key components of process work that have been discussed by experts in the field and will be used within the group. These include an understanding of the stages of group development (Corey & Corey, 2006; Yalom & Leszcz, 2005), a here-and-now focus (Corey & Corey, 2006; Yalom & Leszcz, 2005), the use of process commentary (Yalom & Leszcz, 2005) and the use of silence (Harris, 1998, as cited in Mills & McBride, 2016). Knowledge of group development was incorporated in the development of the curriculum which will be explored shortly. As for the remaining three components, facilitators will use them by focusing on what is happening between and within individuals in the moment, making comments about those dynamics as they occur, and by using silence to provide time to process or rest.

Additional group process techniques will be used to facilitate the previous four components (Mills & McBride, 2016). One of these techniques is scanning, which is paying attention to changes in body language of members or shifts in the feeling of the

group dynamic. Part of the process commentary that could be used after noticing a change is amplifying subtle messages which would involve commenting on changes in body language or dynamic. Other process commentary could involve pointing out similarities between members feelings or thoughts, redirecting a message to encourage I language and speaking directly to one another rather than through vague implications, as well as toning down strong messages (Mills & McBride, 2016). Toning down strong messages would involve keeping a focus on how something is impacting the individual rather than putting the blame on others.

An understanding of the stages of group development is crucial for creating a safe environment (Champe & Rubel, 2012; Mills & McBride, 2016). This is largely done by planning the group in such a way that tasks involving more risk happen during times when members are more likely to feel connected and safe within the group. This was considered during the development of the curriculum. Activities within the sessions were planned according to which stage the group would theoretically be at during that session, with an understanding that group stages are not linear, and adjustments may need to be made during the group facilitation. To elaborate upon this, in the first session the group would be in the Forming Stage of group development. Activities planned during the first session are low risk (not involving significant emotional exploration, nor expecting spontaneous group interaction), they are aimed at building connection amongst members and partner pairings would be decided upon by the facilitators rather than the members (Mills & McBride, 2016). As the group progresses to the Storming Stage, activities that involve slightly more risk such as having members pick their own partners and encouraging deeper emotional exploration of the content and how it relates to the

members. Higher risk activities that involve more group interaction and emotional exploration are used in later sessions, where the group may be in either of the Norming or Performing Stages of group development. Higher risk activities may include exercises that encourage reflective functioning by asking the members to reflect upon their experience with learning that someone they care for was self-injuring, and then asking them to reflect upon how the experience may have been for the young person. As the group draws to a conclusion and moves into the Adjourning Stage, activities will again become lower risk as the facilitators move to focusing on review of materials and preparing for the groups ending (Mills & McBride, 2016).

Curriculum

Session	*Topic*	*Activities*	*Homework*
Session 1	-Informed consent -Introduction -Group overview -Goal setting	-Collaboration on group rules -Partner discussion about how they feel being in the group	-Reflect on their goal for the group
Session 2	-NSSI characteristics, demographics, functions	-*Myths About NSSI* sheet -Small group discussions (facilitator chooses groups) on why people self-injure -Large group discussion on the same topic -Reflective functioning exercise: reflect on a time you were seeking attention and why	-Find one new self-care activity and do it
Session 3	-Peers and NSSI -Media and NSSI -NSSI Treatment	-Small group discussion on impact of peers on NSSI	-Pick a behaviour of your child's that challenges you, and

		-Group discussion on how media/technology is managed in households -Group discussion on experiences with treatment	reflect on why they engage in it
Session 4	-Emotion regulation -Self compassion -Regulation strategies for NSSI	-Guided meditation -Group discussion on a time emotions were not handled well -Watch a video on self-compassion -Reflect on a time they did not show themselves compassion, and reframe the experience using self-compassion	-Use a regulation or self-compassion activity with your youth
Session 5	-Caregiver experiences with NSSI -Attachment informed parenting	-Group discussion on how members identify their current parenting approach -Watch video on Attachment Parenting -Group discussion/debrief on how they feel about attachment informed parenting	-Reflect upon the first time you learned about your youths NSSI. Use regulation and self-compassion strategies to care for yourself during this activity
Session 6	-Using attachment to care for NSSI -Managing an NSSI episode	-Watch video on Shark Music -Role playing in small groups the skills discussed in group	-Practice these skills with your youth at least twice -Find at least one way to connect with your child
Session 7	-Monitoring NSSI -Responding to threats of NSSI -Prepare for last group	-Group discussion on how to balance safety and relationship -Group discussion on how members think attachment principles	-Think of ways to build connection into the day

		could be used to respond to NSSI -Roleplay to practice the skills learned -Group discussion on feelings about the group ending -Seek members input on how they want to spend the last session	
Session 8	-Review -Flex time	-The final session is left to review or discuss anything the members want to go over	

Program Length

The Collected Parenting Group is an eight-week group that is comprised of weekly two-hour group sessions. The sessions will run from 6:30 p.m. to 8:30 p.m. to allow for flexibility with the typical work schedule.

Set-Up

Due to the ongoing Covid-19 pandemic, the group will be offered via doxy.me which is a secure, virtual meeting platform. It follows HIPAA (Health Insurance Portability and Accountability Act), PHIPA (Personal Health Information Protection Act), and PIPEDA (Personal Information Protection and Electronic Documents Act) guidelines.

Group Characteristics

Members of the group will be at least 18 years old and are in relationship with a youth who engages in NSSI. They may be a primary caregiver, a grandparent, an aunt or uncle, or a friend. The relationship between adult and young person will be considered by the facilitator during the intake process. The group is open and welcoming to members of

all cultural and ethnic groups, though fluency in English is a requirement for participation. The group practices from an anti-oppressive framework and is accepting of all marginalized groups. There will be a maximum of 15 members in the group.

Group Expectations

The group expectations will be reviewed with members during the intake process, but there will also be a discussion regarding them in the first session. The facilitators will collaborate with the members to create a set of group expectations and rules that can help each member feel safe and comfortable, as well as help them to get the most out of the group. Such expectations include the importance of regular attendance and punctuality and how the group will manage potential conflict. The facilitators will discuss confidentiality, including when the facilitators may have to break it for ethical or legal reasons, and the limits of it within a group setting. Prior to the next session, the facilitator will email a list of the collaborated upon expectations to all group members.

Enhancing Attendance

It is the hope that soliciting regular participant feedback-and implementing said feedback-will maintain group attendance by continuously cultivating a culture of safety. However, there are many other factors that may lead to missed attendance. One of which may be the general busyness of life, as well as the added stress of caring for an individual who is struggling with NSSI. It is not uncommon for people to forget appointments amidst the busyness. To mitigate this as a potential factor for missed attendance, an email reminder will be sent out two days prior to the group session.

File Storage and Maintenance

Individual files will be kept on each group member. Each file will contain the Intake material and any other notes that may be made throughout the course of the group. For example, if there is a safety situation that arises with the member or someone they know, this would be documented within their file. Files will be made and kept digitally, and will be stored on a password protected external harddrive, which will be stored within a locked filing cabinet. The filing cabinet is stored within a locked office. Any paper documents will be stored in a locked filing cabinet which will remain within a locked office. All files will be kept by the lead facilitator. The groups file storage system complies with HIPAA (Health Insurance Portability and Accountability Act), PHIPA (Personal Health Information Protection Act), and PIPEDA (Personal Information Protection and Electronic Documents Act) guidelines.

All files will be kept for a minimum of 11 years, in accordance with the College of Alberta Psychologists Standards of Practice. There are a few exceptions to the 11 year guideline, which include if the file is for a disabled person who may be unable to make reasonable decisions independently (as defined by the *Limitations Act*), or if the client was involved in some way in a serious crime (e.g. victim of sexual abuse). In these cases, the files will be kept indefinitely following the same secure storage guidelines. For files that do not fall under these exceptions, they will be destroyed after the 11 year period. Paper files will be destroyed using a confidential and secure shredding service, and digital files-including any backups-will be deleted from all electronic devices on which they were stored. This will be done directly by the facilitator that has stored the files.

Facilitators

The Collected Parenting group will be run by two facilitators. This is required as utilizing process-oriented techniques may be easier when there is a facilitator who can watch the members reactions while the other speaks or is attending to another member. It also allows the group to benefit from the skills of two individuals rather than one, and the collaborative relationship between them can help manage group participation and dynamics (Corey & Corey, 2006). It is also advantageous to have two facilitators for the purpose of debriefing reactions to the session or to members, which may include countertransference reactions. Due to the nature of the group, it is also possible that a risk situation may arise in relation to one of the members youths, and consultation between two facilitators would be beneficial in such a case. In the event that such a situation does arise, one or both facilitators would conduct a risk assessment. If necessary, they may support the caregiver in contacting emergency services and/or refer them to any other appropriate services. It is also possible that a situation may arise in which the facilitators have concerns about the youths safety within the home. An example of such a situation may include but not be limited to if the youth is engaging in serious forms of self-injury and the caregivers are not accessing medical care. If this is the case, the *Child, Youth and Family Enhancement Act* guidelines will be adhered to to ensure the youths safety. This may involve making a report to Child and Family Services.

Facilitators of the Collected Parenting Group may be any gender, they are not required to be a parent themselves, and at least one of them should be at least a master's level clinician. This is because of the nature of the group which may require risk assessment, and due to the hybrid psychoeducational-counselling nature of the group it is

necessary to have someone skilled in guiding individuals through emotional processing. It is required that facilitators be receiving regular supervision from a registered therapist to discuss any potential issues that arise in the group and to discuss their own reactions to the group.

Preparation and Debrief

Group facilitators should schedule time every week to prepare for the upcoming session. This may include procuring the materials necessary for the session, reviewing the session content and any activities that will be used. After each group session, the facilitators should schedule time to check-in with each other and discuss anything that came up for them, or that they noticed between members in the group. This is particularly important given the content of the group, as members may be sharing emotional stories about their experiences with self-injury and there may be a risk of countertransference.

Group Fees

The Collected Parenting Group will cost $480 per individual, though members who are attending from the same household (e.g. a caregiving duo) will be charged as one unit. This fee was based upon the Psychologist Association of Alberta's recommended fee for group therapy, which is currently suggested at $60 per session. Finances should not be a barrier to accessing the service, so a sliding scale fee schedule will be offered. In this case, the rate would be negotiated between the client and facilitator.

Marketing the Group

The Collected Parenting Group will be advertised through two means: social media, and a referral system. Advertisements will be posted on popular platforms such as Instagram, Facebook and Twitter. The facilitators have connections with many mental

health providers, who will be asked to refer the group to any clients they have that they feel would benefit from the group. A flyer will be made and provided to the therapists, which they can give to the clients they are referring.

Ethical Standards

The Collected Parenting Group will adhere to the ethical standards of the Canadian Counselling Association, the Canadian Psychological Association, and the American Group Psychotherapy Association. As part of their ethical responsibility, the facilitators will be knowledgeable about the stages of group development and group process techniques.

Diversity and Inclusion

The Collected Parenting Group honours all disability, ethnic, racial, cultural, sexual and gender diversity. The facilitators are committed to anti-oppressive practices. To show respect and honour this the facilitators will:

-Start each session with a land acknowledgement, to honour the Indigenous communities and lands that they are living upon

-Introduce themselves with their pronouns, and encourage members to do the same

-Be continuously mindful about their own implicit biases that may arise in various situations, and actively work on dismantling them

-If the facilitator is white, they will acknowledge that they exist within a position of privilege and they will be mindful about how this may alter how members interact with them

-Be mindful of cultural differences in parenting, and work with participants on how the attachment-informed principles being taught can co-exist with their pre-existing values

-Ensure that all educational materials provided (handouts, etc) represent reality, including people of colour, same sex couples, trans and other gender non-conforming individuals, and disabled individuals.

Chapter IV: Conclusion

Strengths and Limitations

An extensive literature review was performed to develop this group, and the most used and widely supported attachment-informed parenting resources were drawn upon. This ensures that the content delivered in the group reflects evidence-based parenting practices, and the comprehensive literature review on NSSI ensures that the facilitators will have an extensive knowledge base to draw upon when working with caregivers.

The literature that was synthesized and presented in the literature review included qualitative, quantitative (cross-sectional, longitudinal), systematic reviews and meta-analyses. Drawing upon various research methodologies ensures that the topic has been explored from multiple angles, and that it includes statistics along with the voices of real people who have lived through these experiences.

A lot of the research on NSSI has been done in Westernized countries (Canada, USA, Australia, UK) and many samples consisted primarily of White people. The research thus reflects a specific demographic. Research samples are also primarily female, and there is often not a lot of LGBTQIA2S+ representation within them. This presents a limitation, as the research that was drawn upon may not be reflective of POC populations, other ethnic or cultural groups, or other marginalized groups. Further, there was already not a lot of research available on caregiver experiences, and what was available was done in Westernized countries. This presents another limitation, as this group may not reflect the experiences or needs of caregivers who are of a different demographic. The parenting strategies that are recommended within the group may also be vastly different than parenting strategies utilized in some cultures. This may present a

limitation as these practices may not reflect cultural values. The facilitators will be mindful of this and collaborate with such caregivers to develop strategies that remain consistent with the values of the group and respect the families' cultural values.

Recommendations for Future Research

The limitations mentioned in the last section signify some gaps in the literature. Overall, more research needs to be done on NSSI in marginalized groups such as disabled people, POC, LGBTQIA2S+, and in different ethnic and cultural groups. Such expansion also needs to occur in the research that is done on the caregiver's experience of parenting a youth who self-injures. This research would allow supports to be developed that directly address the needs of those groups.

Significance of the Project

Self-injury is a growing concern, particularly amongst adolescents. It places cost and strain upon our health care systems, and strain upon families. Most of this strain is placed upon caregivers, who find themselves juggling the responsibilities of managing physical safety, perhaps parenting more than one child, managing the strain it places upon other relationships and in some cases, it may even limit their ability to maintain employment (Ferrey et al., 2016a, 2016b). Adolescents express that their caregivers support is one of the biggest factors in their decision to seek treatment and recovery (Rosenrot & Lewis, 2020), but many caregivers express feeling lost in knowing what to do to help their young one who is self-injuring (Stewart et al., 2018). As one caregiver put it, "When you're that lost, you need a map in front of you." (Stewart et al., 2018). Unfortunately, many caregivers find themselves without a map, and have difficulties finding anyone to provide them with one (Krysinska et al., 2020). Power et al. (2009)

provided caregivers with such a map through the creation of a group similar to this one. The group lowered parental psychological distress and perceived challenges, and increased parenting satisfaction. It is my hope that the Collected Parenting group can be one such map, one that can guide people through the confusion and fear that many caregivers experience. By improving caregivers confidence in their own ability to care for their children, we may be one step further in tackling the complex behaviour that is NSSI.

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Appendix A: Intake Form

Intake Form

Collected Parenting Group

Date: _____

Name: _____

Address: _____

Phone Number: _____

Email: _____

Preferred method of contact: _____

What is your relationship status? _____

How did you hear about the Collected Parenting Group? _____

_____

_____

_____

Eligibility

You must be at least 18 years old to participate in the Collected Parenting Group. You must be in close relationship with a child or adolescent who is engaging in non-suicidal self-injury. This relationship may be a primary caregiver, a grandparent, or another family member or close friend who wishes to improve their understanding of self-injury for the purposes of best supporting a young person who is struggling with it. It is important that you can speak English and can provide informed consent for participation in the group.

How old are you? _____

Do you know a young person who is struggling with non-suicidal self-injury? _____

If so, what is your relationship to them? _____

What method of self-injury does the young person use? _____

Are you fluent in English? _____

Thank you for your interest in the Collected Parenting Group!

One of the group facilitators will review your Intake Form and be in contact with you to set up a time for a phone call to discuss the group in more detail. This will help you and the facilitators decide if the group is the best fit for you and your family.

Appendix B: Screening Questions

Screening Questions

Collected Parenting Group

Name: _____

Date: _____

Facilitator: _____

Are you able to attend the group every week? _____

Why do you wish to join the Collected Parenting Group? _____

_____

_____

_____

What do you hope to gain from the group? _____

_____

_____

_____

What would you say is your biggest challenge in supporting a young person who self-injures? _____

_____

_____

_____

What makes it difficult to support the young person who is self-injuring? _____

_____

How do you currently approach the subject of self-injury with the young person? ___

How would you describe your current parenting approach? _____

How would you describe yourself in a group setting? _____

What do you currently do to cope with the stress in your life? _____

Do you feel that you have adequate social supports? _____

Appendix C: Session Rating Scale

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____

ID# _____ Sex: M / F

Session # ____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

Relationship:

I did not feel heard, understood, and respected

I----------I

I felt heard, understood, and respected

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk about

I----------I

We worked on and talked about what I wanted to work on and talk about

Approach or Method:

The therapist's approach is not a good fit for me.

I----------I

The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today

Overall, today's session was right for me

I----------I

Institute for the Study of Therapeutic Change

_____

www.talkingcure.com

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 1 Plan:

Introduction to the Group

Collected Parenting: Using Attachment to Care for Self-Injury

Session 1 Plan: Introduction to the Group

Session Objectives

1. Begin the process of developing rapport and comfort amongst group members and facilitators (M. S. Corey & Corey, 2006)

2. Review informed consent and confidentiality along with the limits of confidentiality (when a facilitator may have to breach it, and the risks of confidentiality in a group setting)

3. Explore the members expectations of the facilitators, of other members, and of the group itself (Yalom & Leszcz, 2005)

4.Create the group rules and expectations (Yalom & Leszcz, 2005)

5.Provide an overview of the group, including its purpose, structure, and content

6.Identify goals

Preparation and Materials

- Facilitators should review the previous chapters of this project to ensure they are familiar with the content and group process
- Email the link for the virtual session to all participants
- Each participant will be asked to have paper and a writing instrument available to them
- Prior to the session, group members will be emailed all materials for the session. These include a copy of the Parental Stress Scale, the Outcome Rating Scale (ORS) and the handout *What to Expect from Collected Parenting*
- Post-group, links will be emailed out for the Session Rating Scale (SRS)

Time	Session Objectives	Activity	Notes	Materials and Preparation
10 minutes	1.Begin to develop rapport and comfort 5. Overview of group	-Introductions: facilitators introduce themselves (include pronouns) -Land acknowledgment -Provide an overview of the group structure, and the purpose of this session -Provide an agenda for the session	-Give members an opportunity to ask the facilitators questions -Set the precedent that participation is welcome at anytime during the group	-Be familiar with the previous chapters of this project -Be familiar with the stages of group development, and group process (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
5 minutes	2.Review confidentiality and informed consent	-Facilitators will explain when they may have to breach confidentiality, as well as risks of confidentiality in a group setting	-Set the precedent that what happens in the group, stays in the group	-Be familiar with the limits to confidentiality
20 minutes	1.Begin to develop rapport and comfort	-Introduction & Check-In: invite members to introduce themselves and share briefly how they are feeling about being in the group	-Utilize attachment strategies to facilitate connection with members (eye contact, body language, tone, delight, etc.) -Comment on any	

			similarities that arise between members feelings	
15 minutes	3-Explore expectations	-Invite participants to offer their expectations for other members, for the facilitators, and for the group -Facilitators offer their input on expectations, and emphasize the importance of maintaining a culture of safety	-If a member has an unrealistic expectation regarding something, address it in the group	
10 minutes	BREAK!			
20 minutes	3-Explore expectations 4-Develop group rules (Yalom & Leszcz, 2005)	-Review the handout *What to Expect from Collected Parenting* -Collaborate on making a set of group rules that are committed to by each member and facilitator	-Ensure that permission is obtained to give feedback, and decide on a way to offer feedback that is agreed upon by all members	-Copies of *What to Expect from Collected Parenting* (emailed prior to session) -Record the group rules as they are developed
20 minutes	5-Overview of group structure and purpose 1-Begin to develop rapport and comfort	-Explain the purpose of the ORS, SRS, and PSS -Get members to complete the		

	amongst members and facilitators	ORS, and the Parental Stress scale		
10 minutes	1-Begin to develop rapport and comfort amongst members and facilitators	-Members will be paired off into dyads to discuss their feelings/thoughts around the PSS or ORS		-Know how to utilize this function on the meeting software
5 minutes	1-Begin to develop rapport and comfort amongst members and facilitators	-Invite members to discuss what transpired in their small groups -Ask members to reflect on a goal they would like to work on over the course of the group. Ask that they write it down and keep it for reference	-Briefly discuss what a SMART goal would look like to ensure members make realistic goals	-Know what a SMART goal looks like
5 minutes	5-Overview of group purpose, structure, and content	-Facilitators will tell members what to expect from next session -Space will be given for any questions from the members	-Ask members to complete the SRS following the session, a link to which will be emailed to them	-Post-session, email the link to the SRS to all participants

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)

- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen?
- How well did we work as co-facilitators? How might we improve?
- Once the SRS's are received, review feedback and discuss how to address/implement it

What to Expect from the Collected Parenting Group

Facilitators Commitment

As the facilitators, we commit to you that we will cultivate a culture of safety. All members deserve to feel accepted, seen and heard. We will not tolerate disrespect, or any discrimination. We commit to being open to your feedback and using it to best support you. Lastly, we commit that we will come prepared to each session to deliver you the best service possible.

What do we expect from you?

Attendance and punctuality are necessary for you to get the most out of the group. We understand that sometimes life happens, but if missed attendance or tardiness becomes a chronic concern, the facilitators will address it with you individually.

Participation!

Connected Parenting is a group that involves a lot of participation. We understand that it can be difficult to engage in groups, but it will become easier as you practice. Group facilitators will do their best to encourage engagement from all members.

Feedback-It will happen!

Giving and receiving feedback can be tough. In Connected Parenting, we commit to providing feedback with kindness, and expect that all members will do the same. We encourage members to provide us with feedback about what you like or don't like about the group. This gives us an opportunity to better tailor the group to best suit you!

Facilitators or other members may also provide you with feedback on what you are saying or doing in group. We know this may be uncomfortable, but it will also provide you with information that can help you to make positive changes in your own communication skills.

Practice, practice, practice

Some of the strategies we will be recommending may feel strange at first, simply because you may not be accustomed to it. With practice, they will

become easier. Facilitators may be assigning small challenges throughout the week that can help you to practice these new strategies at home.

Confidentiality

The content being discussed in this group is heavy, and it may be difficult for some people to talk about. To help everyone feel safe enough to share, we can all commit to keeping what is said in the group, in the group. There is the risk that a member will share what you said in group with others, so it is important that you only share what you feel comfortable with.

Facilitators follow a code of ethics that bind us to confidentiality. We will only share information about the group with our supervisor, whose job it is to make sure we are best supporting you.

There are some instances where we may have to share your information for reasons of safety. These instances include:

-If a group member is at risk of hurting themselves, or hurting someone else

-If we have reason to believe that a child, or a dependent adult, is in danger

-A judge or a lawyer is legally requesting your information

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 2 Plan:

Introduction to Non-Suicidal Self-Injury

Collected Parenting: Using Attachment to Care for Self-Injury

Session 2: An Introduction to Non-Suicidal Self-Injury

Session Objectives
1. Continue to develop rapport and comfort between group members and facilitators (M. S. Corey & Corey, 2006) 2. Foster group development (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005) 3. Explore members expectations of the group, which will lead into discussion of the goals made last week 4. Identify goals 5. Provide education about NSSI, including what it is, who does it, its relationship with suicide, why people do it 6. Begin to develop reflective functioning

Preparation and Materials
-Prior to the session, email members a link for the ORS -Prior to the session, all relevant handouts for the session will be emailed to the members. These will include myths about self-injury, facts about self-injury -A visual aid to use for the check-in at the beginning of the session -Post-session, email a copy of the SRS

Time	Session Objectives	Activity & Learning	Notes	Materials and Preparation
10 minutes	1. Continue to develop group rapport and comfort	- Land acknowledgment -Check-in using the visual aid		
15 minutes	4-Identify goals	-Invite members to share their goal with the group	-Provide feedback on goals, and if necessary, discuss expectations about the group	-Record members goals as they share them
10 minutes	1-Continue to develop group rapport and comfort 5-Provide education about self-injury	-Complete the *Myths about NSSI* activity	-Make note of members perceptions about NSSI, and use them to facilitate discussion	-Prior to the session, email a copy of the Myths about NSSI sheet to members -Have a copy available via screen share to facilitate doing the activity together
10 minutes	1-Continue to develop group rapport and comfort 5-Provide education about self-injury	-Invite members to discuss 'What do you know about self-injury?' and 'What do you want to know about self-injury?'	-Use this discussion point to ensure the group curriculum aligns with what members want to learn and tailor it as necessary	-Facilitators will be familiar with process-oriented techniques and how to use them to integrate process work into the psychoeducational material
15 minutes	5-Provide education about self-injury	-Facilitators will discuss statistics, demographic information, risk factors, and the relationship between NSSI and suicide	-When discussing the relationship between parenting and NSSI, set the precedent that there is no parent-blame in this group	-*Facts About Self-Injury* handout -Power-point slides will supplement the material, which will be based off Chapter 2 of this project

10 minutes	BREAK!			
10 minutes	1-Continue to develop group rapport and comfort 2-Foster group development (M. S. Corey & Corey, 2006)	-Pair members off into dyads to discuss 'Why do you think people self-injure?'	-During this time, facilitators will jump around the breakout rooms to check-in on people	-Be familiar with how to use this function in the software
10 minutes	1-Continue to develop group rapport and comfort 2-Foster group development 5-Provide education about self-injury	-Facilitate a large group discussion about what the dyads spoke about	-Facilitators should be mindful to scan and watch the members reactions as this material may be difficult to discuss	
20 minutes	1-Continue to develop group rapport and comfort 2-Foster group development 5-Provide education about NSSI 6-Develop reflective functioning	-Discuss public perceptions of NSSI motives -Get members to reflect upon a time they may have been seeking someone's attention, and why (start developing reflective functioning) -Discuss what the research tells us about the motives of NSSI	-Reframe 'attention seeking' as 'connection seeking' -Reframe NSSI as a coping mechanism	-Ppt slides will supplement the discussion, which will be based off Chapter 2 of the project -Facilitators will be familiar with process-oriented techniques and how to use them to integrate process work into the psychoeducational material
10 minutes	1-Continue to develop group rapport and comfort	-Invite members to ask questions -Give members their 'challenge of the week'		-Challenge of the Week: find one new self-care activity and do it

		-Let everyone know what next weeks session will cover		

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)
- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen? Did they seem to understand the material presented?
- How well did we work as co-facilitators? How might we improve?
- How well are we doing in implementing process-oriented techniques with the psychoeducational material?
- Once the SRS's are received, review feedback and discuss how to address/implement it

Myths or Fact?

NSSI Edition

1. Only teenage girls self-injure MYTH or FACT
2. Self-injury is a suicide attempt MYTH or FACT
3. Self-injury is practiced in other species MYTH or FACT
4. People who self-injure do it for attention MYTH or FACT
5. Social media can be beneficial for NSSI MYTH or FACT
6. People who self-injure have a mental illness MYTH or FACT
7. Self-injury is a mental illness MYTH or FACT
8. Self-injury is a trend MYTH or FACT
9. People who self-injure can lead fulfilling lives MYTH or FACT
10. Emo-music leads to NSSI MYTH or FACT
11. Only teenagers self-injure MYTH or FACT
12. Self-injury is just a phase MYTH or FACT
13. Self-injury is treatable MYTH or FACT
14. Self-injury is rare MYTH or FACT
15. All people who self-injure have been abused MYTH or FACT
16. Teens usually self-injure to fit in MYTH or FACT

Facts about NSSI

What is NSSI?

"Directly and intentionally inflicting damage to one's own body tissue without intention of suicide and not consistent with cultural expectations or norms."

Common methods of NSSI:

-Cutting

-Scratching

-Burning (with fire, chemicals, or friction)

-Wall punching

-Self hitting or biting

-Bone breaking

-Sticking objects beneath one's skin

-Skin picking (this may also be indicative of another illness known as dermatillomania)

-Hair pulling (this may also be indicative of another illness known as trichotillomania)

Who Self-Injures?

It most commonly begins around 14 years old

It can occur in any age group, from young children to older adults

It is common in all genders (male, female, gender non-conforming)

Self-Injury is Common

Many studies have found that around 20% of teenagers self-injure at some point

Similar rates have been found in young adults

Risk Factors

Identifying as a member of the LGBTQIA2S+ community may elevate a person's risk of NSSI

Bullying & discrimination

Substance use

Abuse (sexual, emotional, physical, neglect)

Some mental illnesses may increase the likelihood of an individual self-injuring

NSSI is most commonly associated with Borderline Personality Disorder, but it is also seen with

-Depression

-Anxiety

-Post traumatic stress disorder

-Eating disorders

-Autism Spectrum Disorder

-Attention Deficit Hyperactivity Disorder

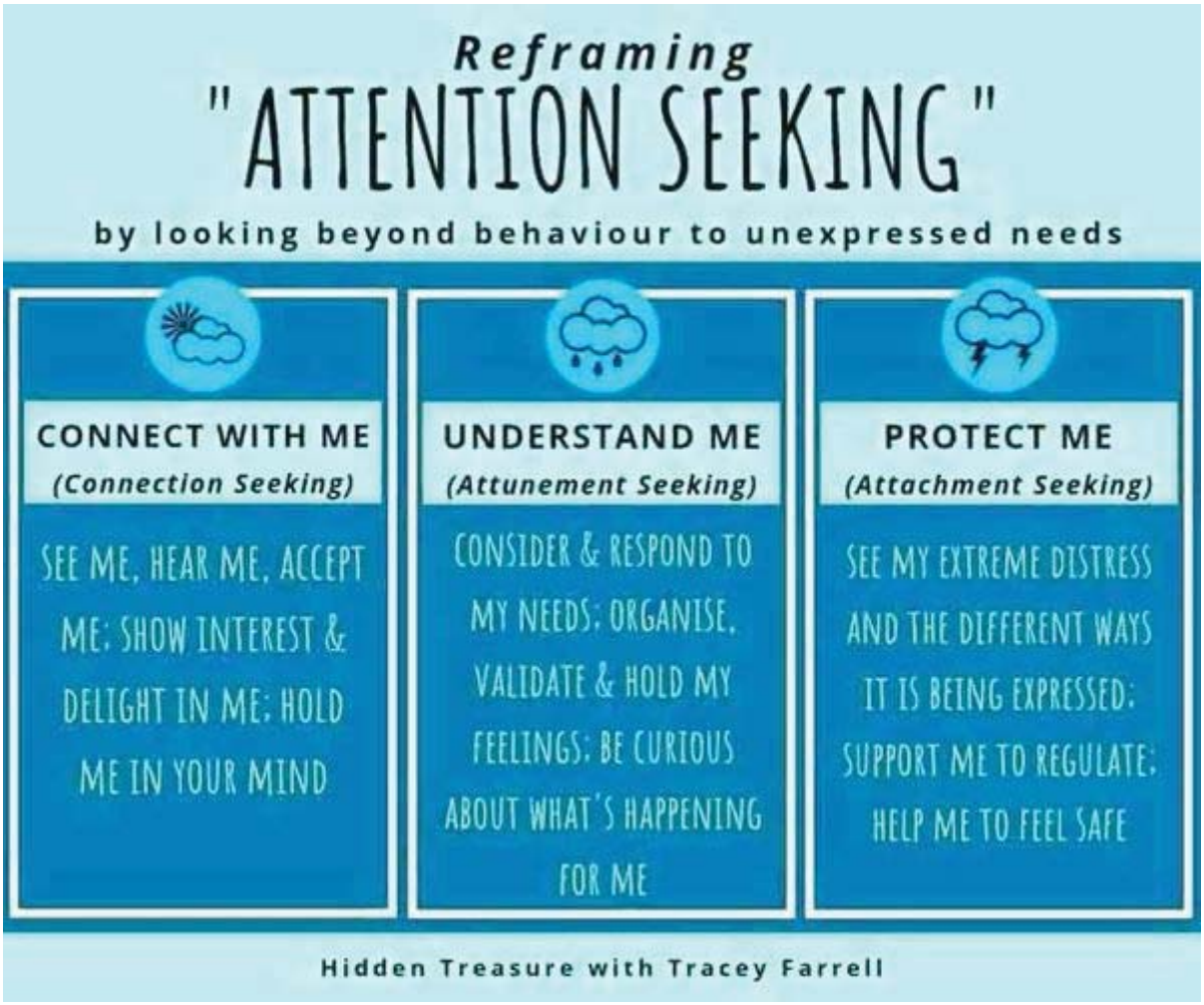
-Substance Use Disorders

Why do people do it?

It is not true that NSSI is an attention seeking behaviour

There are many reasons that people may self-injure, but the most common one is to control their emotions and make themselves feel better

Handout for Reframing Attention Seeking



Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 3 Plan:

Peers, Media & Treatment

Collected Parenting: Using Attachment to Care for Self-Injury

Session 3: Peers and Media

Session Objectives
1. Continue to develop rapport and comfort between group members and facilitators (M. S. Corey & Corey, 2006) 2. Foster group development (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005) 3. Psychoeducation: the impact of peers on NSSI, the impact of media on NSSI

Materials and Preparation
-Prior to the session, email members a link for the ORS -Prior to the session, all relevant handouts for the session will be emailed to the members. -A visual aid to use for the check-in at the beginning of the session -Post-session, email a copy of the SRS

Time	Session Objective	Activity & Learning	Notes	Materials & Preparation
10 minutes	1-Continue to develop rapport and comfort amongst group members and facilitators 2-Foster group development	- Land acknowledgment -Group check in -Challenge of the week check-in		-Have a visual aid for a check-in
5 minutes		-Overview of what we will be covering today		-Session agenda will be displayed on a ppt slide
10 minutes	1-Continue to develop rapport and comfort amongst group members and facilitators 2-Foster group development	-Create groups of three for a small group discussion about "Do you feel that peers and/or the media impacted your young persons NSSI? What role do peers play in your young persons life?"	-Facilitators will jump between the break-out rooms	
10 minutes	1-Continue to develop rapport and comfort amongst group members and facilitators 2-Foster group development	-Ask one representative from each group to summarize what they discussed	-Facilitators will comment on the members insight without delving into it	
15 minutes	3-Psychoeducation 2-Foster group development	-Discuss the impact of peers on NSSI -Discuss social contagion -Discuss the impact of media on NSSI		-Facilitators will be familiar with integrating process-oriented techniques with psychoeducation
10 minutes	BREAK!			

15 minutes	2-Foster group development 3-Psychoeducation	-Group discussion: what are some ways that you currently manage technology and social media in your family? -Discuss ways of mitigating the potential negative effects of peers & media	-Strategies suggested: be aware of trends that are going around (e.g. like the tide pod challenge), communicate openly about peers and media, mental health support apps	-Powerpoint slides will supplement the discussion
15 minutes	1-Continue to develop rapport and comfort 2-Foster group development	-Ask members to each pick one word that describes their experience with getting treatment for their young person -Group discussion about family's experiences with treatment	-Ask them to reflect upon what the experience may have been like for the young person (reflective functioning)	
15 minutes	2-Foster group development 3-Psychoeducation	-Discuss the various treatments for NSSI -Discuss why caregiver involvement is so important for treatment		-Power point slides will supplement the discussion
5 minutes	3-Psychoeducation	-Discuss what makes an effective treatment, and how to choose one that is right for your family		-Power point slides will supplement the discussion
10 minutes	1-Continue to develop rapport and comfort	-Allow time for members to ask any treatment		-Send members the SRS following the

	2- Foster group development 3- Psychoeducation	related questions, or share their experiences -Provide an overview of what will be covered in the following week -Assign the challenge of the week		session, remind them to complete it -Challenge of the week: Pick a behaviour of your child's that you find challenging, and reflect on why they engage in it

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)
- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen? Did they seem to understand the material presented?
- How well did we work as co-facilitators? How might we improve?
- How well are we doing in implementing process-oriented techniques with the psychoeducational material?
- Once the SRS's are received, review feedback and discuss how to address/implement it

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 4 Plan:

Self-Regulation and Compassion

Collected Parenting: Using Attachment to Care for Self-Injury

Session 4: Self-Regulation & Compassion

Session Objectives
1. Continue to build rapport and comfort amongst group members and facilitators 2. Foster group development 3. Psychoeducation: self-regulation and compassion 4. Practice self-regulation and self-compassion

Materials and Preparation
-Prior to the session, email members a link for the ORS -Prior to the session, all relevant handouts for the session will be emailed to the members. -A visual aid to use for the check-in at the beginning of the session -Post-session, email a copy of the SRS

Time	Session Objective	Activity & Learning	Notes	Materials & Preparation
5 minutes	1-continue to build rapport and comfort	- Land acknowledgment -Ask members to provide one word that describes how they are doing	-Facilitators will validate their feelings without delving deeply into them	-Have a list of suggestion words available if needed
10 minutes	4-practice self-regulation & compassion 1-continue to build rapport and comfort	-Activity: guided beach meditation -Debrief the experience of the guided meditation	-Facilitators will scan the members to watch for any reactions they may be having to the activity	-Have the link to the video prepared
10 minutes	3-psychoeducation 1-continue to build rapport and comfort 2-foster group development	-Discuss what self-regulation is and why it is important -Discussion point: "do you remember a time where you did not handle your emotions very well? What about a time that you handled them well?"		-Power point slides will supplement the discussion
15 minutes	3-psychoeducation 1- continue to build rapport and comfort	-Discuss what is happening in the brain and body during dysregulation, how trauma impacts the brain -Discussion point: How might this be related to NSSI?	-Handy model of the brain as an example	-Be familiar with the stress and trauma responses -Power point slides will supplement the discussion
10 minutes	3-psychoeducation	-Discuss factors that impact our ability to self-regulate		-Power point slides will supplement the discussion

10 minutes	3-psychoeducation 4-practice self-regulation & compassion	-Discussion point: Do you feel that you practice good self-care? How do you practice it? -Discuss ways that we can self-regulate	-Draw upon DBT distress tolerance and emotion regulation, and proprioception	-Power point slides will supplement the discussion -Email copies of the handouts to members prior to session
10 minutes	BREAK!			
10 minutes	3-psychoeducation	-Discuss what self-compassion is and why it is important -Watch a video on self-compassion -Discussion point: invite members to discuss their thoughts on the video, and ask them if they think they are kind to themselves		-Have video ready to play
10 minutes	1-continue to build rapport and comfort 2-foster group development	-Ask members to recall a time where they failed, were embarrassed, or felt they did something wrong. Invite them to reflect on what thoughts were going through their mind. -Invite members to share their experience	-Mention common themes in thoughts that arise between members -Ask that they write down the thoughts that they remember having	-Facilitators will be familiar with process-oriented strategies

15 minutes	3-psychoeducation	-Discuss ways that we can practice self-compassion		-Email copies of the relevant handouts
15 minutes	4-practice self-regulation and compassion	-Using the previously recalled instances, change your thoughts and reactions to the situation using the strategies just discussed	-If members are struggling, facilitators will guide them	
5 minutes	3-psychoeducation	-Provide examples of coping skills specifically for NSSI		-Handout: TIPP
10 minutes	1-continue to build rapport and comfort 4-practice self-regulation and compassion	-Challenge of the week: Use a self-compassion activity with your child	-Check-in with each member to see how they feel about the activity, as well as the make sure they have a plan for which skills they will practice.	

Links required:
Guided beach meditation: https://www.youtube.com/watch?v=6TywQETck8E
Heart focused breathing: https://www.youtube.com/watch?v=Q8-oMrOEEl0
Self-compassion: https://www.youtube.com/watch?v=BTQP7XzDxjI
Self-Compassion Break: https://self-compassion.org/exercise-2-self-compassion-break/

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)
- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)

- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen? Did they seem to understand the material presented?
- How well did we work as co-facilitators? How might we improve?
- How well are we doing in implementing process-oriented techniques with the psychoeducational material?
- Once the SRS's are received, review feedback and discuss how to address/implement it

Proprioceptive Activities

- Joint compressions
- Stretching
- Wall push ups
- Squeeze ball
- Run, jump, skip.
- Lifting , carrying, push/pull.
- Chew, suck, blow.
- Vacuum, sweep.
- Leap frog, tug-of-war, wheelbarrow walking.
- Hit, kick, bounce, throw ball.
- Climb, crawl, scoot, pull self.
- Rolling/kneading dough or clay.
- Outdoor work (raking, sweeping, mowing).
- Rough housing, wrestling.
- Crashing on bed, beanbags.
- Pillow fights
- Weighted vests, lap pads.

DISTRESS TOLERANCE HANDOUT 6 (Distress Tolerance Worksheet 4)

TIP Skills: Changing Your Body Chemistry

To reduce extreme emotion mind *fast*.

Remember these as **TIP** skills:

T

TIP THE TEMPERATURE of your face with COLD WATER*
(to calm down fast)

- Holding your breath, put your face in a bowl of cold water, or hold a cold pack (or zip-lock bag of cold water) on your eyes and cheeks.
- Hold for 30 seconds. Keep water above 50°F.

I

INTENSE EXERCISE*
(to calm down your body when it is revved up by emotion)

- Engage in intense exercise, if only for a short while.
- Expend your body's stored up physical energy by running, walking fast, jumping, playing basketball, lifting weights, etc.

P

PACED BREATHING
(pace your breathing by slowing it down)

- Breathe deeply into your belly.
- Slow your pace of inhaling and exhaling way down (on average, five to six breaths per minute).
- Breathe *out* more slowly than you breathe *in* (for example, 5 seconds in and 7 seconds out).

PAIRED MUSCLE RELAXATION
(to calm down by pairing muscle relaxation with breathing out)

- While breathing into your belly deeply tense your body muscles (*not* so much as to cause a cramp).
- Notice the tension in your body.
- While breathing out, say the word "Relax" in your mind.
- Let go of the tension.
- Notice the difference in your body.

***Caution:** Very cold water decreases your heart rate rapidly. Intense exercise will increase heart rate. Consult your health care provider before using these skills if you have a heart or medical condition, a lowered base heart rate due to medications, take a beta-blocker, are allergic to cold, or have an eating disorder.

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 5 Plan:

Attachment Informed Parenting

Collected Parenting: Using Attachment to Care for Self-Injury

Session 5: Attachment Informed Parenting

Session Objectives
1. Continue to build rapport and comfort amongst group members and facilitators 2. Foster group development 3. Psychoeducation: attachment and attachment informed parenting

Materials and Preparation
-Prior to the session, email members a link for the ORS -Prior to the session, all relevant handouts for the session will be emailed to the members. -A visual aid to use for the check-in at the beginning of the session -Post-session, email a copy of the SRS

Time	Session Objective	Activity & Learning	Notes	Materials & Preparation
5 minutes	1-continue to build rapport and comfort	-Land acknowledgment -Visual check-in		-Have a visual aid ready (theme: weather)
10 minutes	1-continue to build rapport and comfort 2-foster group development	-Challenge of the week check-in -Discuss how it went for everyone	-Facilitators will provide feedback as appropriate	
15 minutes	3-psychoeducation 1-continue to build rapport and comfort	-Psychoed: Discuss what the research shows caregivers go through. -Discussion point: discuss if members relate to it, or how their own experience differed. How do they think the experience was for their youth? -Give members space to share their journey with caring for someone who self-injures		-Facilitators will be familiar with integrating process-oriented techniques with psychoeducation
15 minutes	3-psychoeducation	-Psychoed: discuss what attachment is, why it's important, brief history of the theory, types of attachment		
10 minutes	3-psychoeducation 1-continue to build rapport and comfort 2-foster group development	-Discuss the differing parenting approaches -Discussion point: how would they	-Facilitators will comment on strengths that they hear	

		describe their parenting approach?		
5 minutes	3- psychoeducation	-Provide a disclaimer on "Attachment Parenting" (Sears) to avoid any potential confusion		
10 minutes	BREAK!			
5 minutes	3- psychoeducation	-Watch video "Mayim Bialik on Attachment Parenting"		
15 minutes	3- psychoeducation	-Mention common attachment informed approaches -Discuss the commonalities between these approaches (Playfulness, sensitivity, curiosity, nurturance, acceptance)	-Emphasize that the groups focus on attachment is not implying that they are bad parents -Normalize the occurrence of attachment ruptures	
15 minutes	3- psychoeducation	-Continue discussing the commonalities between attached informed approaches (secure base, safe-haven, rupture and repair, reflective functioning, good enough parenting)		
10 minutes	3- psychoeducation	-Discussion point: Check-in about how they are feeling about		

	1-continue to build rapport and comfort	the approach so far -Discuss the benefits of attachment informed parenting		
10 minutes	3-psychoeducation 1-continue to build rapport and comfort 2-foster group development	-Invite members to ask questions -Assign Challenge of the Week -Overview of next session	-Facilitators will help members choose an activity for the COW if needed	-Challenge of the week: reflect upon and write about the first time you discovered your youths NSSI. Use the regulation and self compassion strategies we discussed today to care for yourself during this.

Required links:

Mayim Bialik on Attachment Parenting:

https://www.youtube.com/watch?v=2jCYyXVQQPI

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)
- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen? Did they seem to understand the material presented?
- How well did we work as co-facilitators? How might we improve?
- How well are we doing in implementing process-oriented techniques with the psychoeducational material?
- Once the SRS's are received, review feedback and discuss how to address/implement it

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 6 Plan:

Using Attachment to Care for NSSI

Collected Parenting: Using Attachment to Care for Self-Injury

Session 6: Using Attachment to Care for NSSI

Session Objectives
1. Continue to build rapport and comfort amongst group members and facilitators 2. Foster group development 3. Psychoeducation: specific strategies from attachment-informed parenting approaches that can be used specifically with NSSI 4. Practice attachment-informed strategies

Materials and Preparation
-Prior to the session, email members a link for the ORS -Prior to the session, all relevant handouts for the session will be emailed to the members. -A visual aid to use for the check-in at the beginning of the session -Post-session, email a copy of the SRS

Time	Session Objectives	Activity & Learning	Notes	Materials & Preparation
5 minutes	1-continue to build rapport and comfort 2-foster group development	- Land acknowledgment -Group check-in		-Have a visual aid prepared for the check-in (theme: colours)
5 minutes	1-continue to build rapport and comfort 2-foster group development	-Challenge of the week check-in		
10 minutes	3-psychoeducation	-Introduce the Circle of Security -Discuss how this is relevant for adolescents		
10 minutes	3-psychoeducation 1-continue to build rapport and comfort 2-foster group development	-Introduce *Shark Music* (COS) with the video -Discussion point: when do you feel shark music? When do you feel when parenting? -Discuss why shark music is important, especially in relation to NSSI -What can we do when we feel shark music?	-Facilitators will guide the discussion more than usual, as shark music is a concept that requires a lot of reflective functioning and one that many seem to struggle with	-Have the Shark music video ready
10 minutes	3-psychoeducation	-Introduce CALM communication and discuss why it is beneficial (Kolari) -Facilitators will provide an example of what it looks like in practice		-Email copies of the CALM handout prior to the session

5 minutes	3-psychoeducation	-Introduce PACE (Hughes) and the concept of 'Collecting your Child' -Discuss why 'collecting your child' is especially important during adolescence -Reminder of 'looking beneath the behaviour'		-Email copies of the CALM handout prior to the session
15 minutes	3-psychoeducation 4-practice	-Facilitators will give a demonstration of these all in practice (CALM, *looking beneath the behaviour* and collecting a child) -Members will be separated into two smaller groups, one facilitator with each. Time will be provided to practice these skills.	-Facilitators will provide feedback and guidance on their application of the skills, as well as encouragement if it doesn't feel natural to use them	
10 minutes	BREAK!			
15 minutes	3-psychoeducation 4-practice	-Discuss 'what to do when your youth has just self-injured' -Break down steps for how caregivers can manage a NSSI episode	-Elicit members ideas and encourage them to use the attachment principles to think about what to do -There will be discussion on risk assessment & resources will be	-Be familiar with the relevant parts of this project

			provided that can support them in assessing risk	
10 minutes	3-psychoeducation 4-practice	-Invite members to voice any questions or concerns they may have, such as how to use these strategies in their own circumstances		
20 minutes	3-psychoeducation 4-practice	-Facilitators will demonstrate using these strategies to manage a NSSI episode -Members will be broken off into two smaller groups to practice, with one facilitator in each group	-Facilitators will provide feedback, guidance, and encouragement	
5 minutes	1-continue to build rapport and comfort 2-foster group development	-Give the Challenge of the Week -Overview of next weeks content		-Challenge of the week: practice CALM communication with your youth at least twice. Find one other way to connect with your youth (facilitators will help brainstorm if needed)

Required links:

Shark Music (COS): https://www.youtube.com/watch?v=Vy3EwAQ0lwo&t=7s

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)
- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen? Did they seem to understand the material presented?
- How well did we work as co-facilitators? How might we improve?
- How well are we doing in implementing process-oriented techniques with the psychoeducational material?
- Once the SRS's are received, review feedback and discuss how to address/implement it

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 7 Plan:

Monitoring NSSI & Responding to Threats of NSSI

Collected Parenting: Using Attachment to Care for Self-Injury

Session 7: Monitoring NSSI & Responding to Threats of NSSI

Session Objectives
1. Continue to build rapport and comfort amongst group members and facilitators 2. Foster group development 3. Psychoeducation: setting limits, monitoring for safety, handling threats of NSSI, discipline 4. Practice

Materials and Preparation
-Prior to the session, email members a link for the ORS -Prior to the session, all relevant handouts for the session will be emailed to the members. -A visual aid to use for the check-in at the beginning of the session -Post-session, email a copy of the SRS

Time	Session Objectives	Activity & Learning	Notes	Materials & Preparation
5 minutes	1-continue to build rapport and comfort	-Land acknowledgment -Group check-in		-Have a visual aid ready for the check-in
5 minutes	1-continue to build rapport and comfort	-Challenge of the Week check-in		
15 minutes	3-psychoeducation	-Discuss the concept of setting limits -Provide examples of how it may look -Invite members to bring up their own examples and as a group work on strategies of how to set a limit in that situation	-Facilitators will provide feedback as required -Limits may include taking a youth to the hospital	-Power point slides will supplement discussion
15 minutes	3-psychoeducation 1-continue to build rapport and comfort	-Discussion point: how did your monitoring change when you discovered your youths NSSI? What did you find worked or did not work? -Discuss a method of deciding what monitoring will look like		-Be familiar with the strategies discussed within this project for monitoring
20 minutes	3-psychoeducation 1-continue to build rapport and comfort 2-foster group development	-Give members space to discuss how they have responded to threats -Using the strategies discussed, as a group think of ways that you		

		could respond to threats		
10 minutes	BREAK!			
15 minutes	3-psychoeducation 1-continue to build rapport and comfort 2-foster group development	-Continue discussion about responding to threats -Discuss expectations for outcomes of responding to threats (these strategies will not "fix" behaviour but are simply a way of managing it)		-Facilitators will be familiar with implementing process-oriented techniques into psychoeducational material
20 minutes	3-psychoeducation	-Discuss discipline and attachment informed ways of implementing it		-Power point slides will supplement the discussion
15 minutes	1-continue to build rapport and comfort 2-foster group development	-Reminder that there is one last session, discuss how members feel it would best be spent -Discuss feelings about the group ending -Assign challenge of the week		-Facilitators will be familiar with using process-oriented techniques -Challenge of the Week: what are some ways that you can build connection into your day?

Post-Session Reflections for Facilitators:

- Take note of who was involved in today's session, and who may not have been as involved. What are some reasons for their levels of involvement? How can we increase engagement, or manage over-engagement of these members? (M. S. Corey & Corey, 2006)
- How do the stages of group development seem to be proceeding? Are members seeming to build trust in one another and the facilitators? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)

- Overall, did members seem engaged in today's session? Are there any potential barriers foreseen? Did they seem to understand the material presented?
- How well did we work as co-facilitators? How might we improve?
- How well are we doing in implementing process-oriented techniques with the psychoeducational material?
- Once the SRS's are received, review feedback and discuss how to address/implement it

Collected Parenting Group:

Using Attachment to Care for Self-Injury

Session 8 Plan:

Final Notes and Group Wrap-Up

Collected Parenting: Using Attachment to Care for Self-Injury

Session 8: Final Notes and Group Wrap-Up

Session Objectives

1. Foster group development
2. Psychoeducation: can you prevent future incidents of NSSI?
3. Group summary
4. Complete the Parental Stress Scale

Materials & Preparation

-Prior to the session, email members a link for the ORS

-Prior to the session, all relevant handouts for the session will be emailed to the members.

-A visual aid to use for the check-in at the beginning of the session

-Email out a copy of the Parental Stress Scale

-Post-session, email a copy of the SRS

Time	Session Objectives	Activity & Learning	Notes	Materials & Preparation
10 minutes	1-foster group development	- Land acknowledgment -Group check-in		-Have a visual aid prepared for the check-in
5 minutes	1-foster group development 2-psychoeducation	-Challenge of the Week check-in	-Speak to the importance of continuing these activities	
20 minutes	2-psychoeducation 3-group summary	-Discussion point: can you prevent future incidents of NSSI? -Discuss practices that you can build into your daily life that will foster connection	-Emphasize that there is no technique that will eliminate NSSI. What can be done is strengthening the relationship so that youth feel safe going to caregivers, increase the likelihood of them seeking recovery	
10 minutes	1-foster group development	-Give members space to discuss any concerns they have about the strategies just discussed		-Facilitators will be familiar with using process-oriented techniques
15 minutes	4-complete the Parental Stress Scale			-Prior to session, email out copies of the PSS
10 minutes	BREAK!			
45 minutes	2-psychoeducation 3-group summary	-This is flex time that will be used at the facilitators discretion to review materials that members seemed to be struggling with, to answer questions	-Prior to the session, facilitators will seek members input regarding any concepts they are struggling with, something they want more	

		members may have, or for general discussion amongst members and facilitators	information on, and generally how they feel this last session would best be spent.	
5 minutes	3-group summary	-Closing comments by facilitators		

Post-Session Reflections for Facilitators:

- How did we do in guiding members through the stages of group development? What did we do well, and what could we have done better? (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005)
- Overall, how did members seem to receive this group overall?
- How well did we work as co-facilitators? What did we do well? What could we do better next time?
- How well did we do in implementing process-oriented techniques with the psychoeducational material?