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# Parent Treatment Manual for Adolescent Self-Harm

Miriam Mokhless Rizk

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Department of Psychology

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Parent Treatment Manual for Adolescent Self-Harm

by

Miriam Mokhless Rizk

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A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Psychology

_____

September 2022

Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Psychology.

 

_____ , Chairperson
Kendal C. Boyd, Associate Professor of Psychology

 

_____
Bryan Cafferky, Professor of Counseling and Family Sciences

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Cheers,

Miriam Rizk

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ABBREVIATIONS

DBT                 Dialectical Behavioral Therapy

DBT-A               Dialectical Behavioral Therapy – Adolescent

PARYC               Parenting Young Children

PSI                 Parenting Stress Index

ABSTRACT OF THE DOCTORAL PROJECT

Parent Treatment Manual for Adolescent Self-Harm

by

Miriam Rizk

Doctor of Psychology, Department of Psychology
Loma Linda University, September 2022
Dr. Kendal Boyd, Chairperson

This doctoral project is a treatment manual that was created for parents of self-harming adolescents. To date, no treatment manual currently exists to aide these parents in fostering healthy environments for adolescents completing Dialectical Behavioral Therapy (DBT) intensive outpatient treatments; however, the literature describes the importance of creating validating environments as an important factor in positive treatment outcomes of adolescents who self-harm. This ten-week treatment manual was designed to provide these parents with DBT skills in order to learn the foundations of providing a positive environment in the home. The results of this treatment manual are projected to reduce parenting stress and increase positive emotional support for parents whose adolescents self-harm, which in turn should, help parents learn how to support their children for favorable treatment outcomes.

CHAPTER ONE

CLINICAL IMPORTANCE OF THE PROBLEM


**Self-Harm**

Self-harmful behaviors can be defined as the "intentional poisoning or injury to oneself" (Hawton et. al, 2002). According to the Mayo Clinic (2018) examples of non-suicidal self-injurious behaviors include cutting, scratching, burning, carving words or symbols into skin, hitting/punching, piercing the skin with sharp objects, pulling hair, and persistently picking at or interfering with wound healing. Individuals engage in such behaviors in order to alleviate a feelings or emotion. Physical symptoms of self-harm include, cuts, bruises, burns, and even bald patches from pulling hair out. Self-harmful behaviors are also associated with emotional symptoms, such as depression, becoming withdrawn or isolated, eating-habit changes, low self-esteem, self-blame, and risky behaviors. The National Society for the Prevention of Cruelty to Children has deemed the reason for self-harm to include: low self-esteem, loneliness, sadness, anger, numbness, and lack of control over their lives.

Life stressors that occur in adolescence may be overwhelming, and environments invalidating. Self-harmful behaviors are often unhealthy coping mechanisms for many of these adolescents. Linehan defines invalidating environments as those which provide little time and attention to the children, where children are not able to display negative emotions, and where children are told that they should exert more self-control when dysregulated (Linehan, 2018). A systematic review conducted by Fliege and colleagues (2009) found that potential risk factors and correlates for adolescent self-harm are

sociodemographics, risk factors, individual factors, and stress/maladaptive coping.

## *Significance*

With the large number of self-harm prevalence rate amongst adolescents worldwide, treatments must focus on the reduction as well as the prevention of the behaviors. Treatments that have been adapted to target self-harmful behaviors to date focus on skills necessary to promote progress yet all the treatments overlook the importance of family dynamics. Locally, at the Loma Linda University Behavioral Medical Center, there are treatments that target adolescents who currently self-harm (RISE) and those who have previously self-harmed (SOAR), however there are no treatments which help the environments they return to at home. This treatment will be the first of its kind, in that parents will also be a part of the treatment process in order to improve interpersonal effectiveness skills and foster a validating environment for the adolescents who self-harm. This treatment is strictly a psychoeducation group, and is not a psychotherapy group. Furthermore meaning parents will receive the skills necessary to promote validating environments, but will not explicitly discuss personal family issues in the group.

If the manual proves to be effective it could be an essential component of DBT treatments used worldwide improving the reductions of self- harm and parents stress associated with adolescents who self-harm.

*Contribution*

This program manual will offer an extra group in the already established DBT program that Loma Linda University offers. Upon enter Loma Linda's Behavior Medicine Center adolescents will proceed through a comprehensive intake session, which will then determine their placements in either RISE or SOAR. The adolescents placed in RISE will focus on eliminating self-harmful behaviors, while the adolescents in SOAR will work on processing the trauma that once caused them to engage in self-harmful behavior. The newly added parent treatment manual will involve adding an extra component to the already established treatments and will run simultaneously with the RISE and SOAR groups. Parents will be administered the PSI and PARYC during their adolescent's intake in order to assess baseline parenting stress. It will focus on working through the DBT-A skills mentioned above, and will help give parents an understanding on what their children are learning in their groups. Upon the adolescents completing the SOAR group (processing trauma), the adolescents and parents will then attend family therapy until ready to graduate from the program as a whole. The treatment overview will look as such:
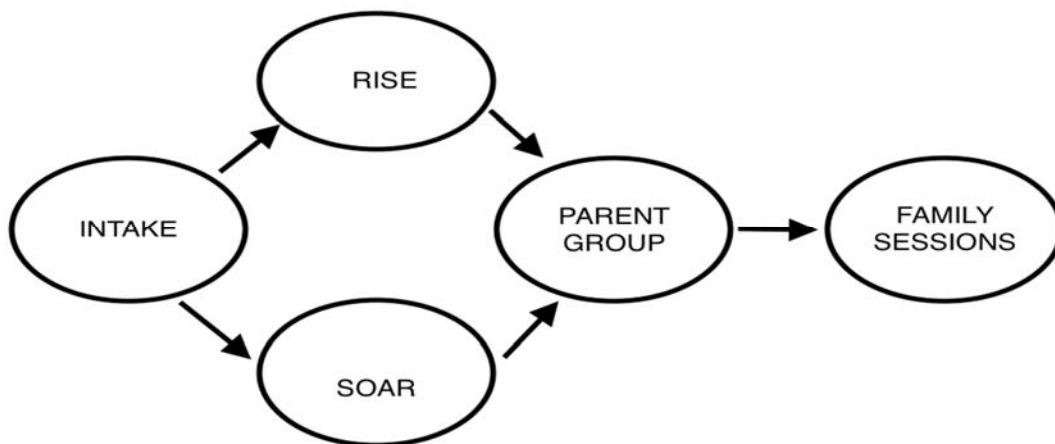


*Figure 1.* Treatment Overview

# CHAPTER TWO

# LITERATURE REVIEW

## Sociodemographic Factors

Sociodemographic factors include an individual's age, gender, ethnicity, socio-economic status, etc. In a systematic review conducted by Fliege and colleagues (2009) age and gender were deemed to be potential risk factors in deliberate self-harmful behaviors. The review found that increased rates of self-harm existed for adolescents and young adults.

In a study conducted by Monto et al., (2018) adolescents' self-harm was much more prevalent than for adults, with 17.7%-30.8% of girls and 6.4%-24.8% of boys admitting to engaging in self-harm behaviors across the United States; these results could be attributable to children's inability to fully control the environment they are placed in. One potential risk factor for deliberate self-harm was found to be gender (Fliege et. al, 2009). Results yielded females were more likely to engage in self-harmful behaviors than males. Another study conducted by Kloet et. al., (2011) found that the prevalence rates in Australia were also higher for females than they were for males. Similarly a study conducted by O'Connor and colleagues (2009) results found that Scottish female adolescents (15-16) were 3.4 times more likely to self-harm than adolescent boys. The study also found that similar rates were found in adolescents in England, with females three times more likely to self-harm than males. The reason for the higher rates in females across multiple countries may be due to the fact that females go through substantial hormonal changes and emotional phases during their adolescence, which may

make them more susceptible to negative feedback or stress they may face in their day to day lives and they tend to internalize their feelings rather than overtly express them. Socio-economic status was not found to be an associated risk factor of self-harmful behaviors (Fliege et. al, 2009).

## Individual Factors

Nock (2009) found that individuals engaged in self-harmful behaviors to signal distress and elicit care from those around them; Hilt et. al, (2008) found similar results, where findings found that individuals engaged in self-harmful behaviors in order to elicit social support from those around them. Skegg (2005) found that psychiatric illness, such as anxiety and depression, played an important role in self-harmful behaviors. A review conducted by Klonsky and Muehlenkam (2007) found that among adolescents who engaged in non-suicidal self-injurious behavior, there was an increase in negative emotionality, deficits in emotion skills, self-derogation, in addition to diagnosed pathology. Fliege and colleagues (2009) also found prevalent rates in psychopathology and related self-harm. The authors found that adolescents who self-harm tend to feel more frequent and negative emotions throughout the day compared to adolescents who do not engage in self-harmful behaviors. The reviews also found that adolescents who self-harmed were more likely to score higher on measures of depression, anxiety, negative temperament, and emotional dysregulation. The heightened emotions that are experienced are thought to be a potential risk factor in self-harm. The reviews also found prevalence in the inability for individuals who self-harm to understand and therefore verbally express their emotions, as well as a negative outlook of oneself. Klonsky and

Muehlenkam (2007) found that adolescents who engaged in these behaviors had a negative outlook of themselves, and often times are self-critical and direct anger towards themselves; this extreme emotion is thought to be alleviated by engaging in self-injurious behavior. Another potential risk factor found by Fliege and colleagues (2009) was the inability for these adolescents to manage stress properly; this could be due to the adolescents' inability to access resources to reduce stress, or poor coping strategies.

Although many individuals who engage in self-injurious behaviors struggle with anxiety and depression, a formal diagnosis is not necessarily warranted for individuals who self-harm. Research conducted by Klonsky et al., (2003) & Nock et al., (2006) found that within individuals with self-harmful tendencies, diagnoses may be different for individuals who share similar symptoms. Although self-injurious behaviors are thought to fall under the Borderline Personality Disorder, research conducted by Klonsky and Muehlenkam (2007) found that self-injurious behaviors are also common in individuals who have an eating disorder diagnosis, such as bulimia and anorexia, as well as substance use disorders. The authors attribute this to the physical damage caused to the body while engaging in either behavior, and therefore similar underlying processes may be guiding the behaviors.

**Distal Correlates and Risk Factors**

A review of fifty-nine studies conducted by Fliege and colleagues (2009) found that twenty-one of the studies had risk factors associated with childhood traumatic experiences in childhood in which the child could not control their own environment or situation. Further investigation found that childhood sexual trauma, parental separation,

and parental psychological problems were significant risk factors. Research has yet to bridge the gap as to whether family dynamics are a by-product of the chaos in the home, or the reason this chaos manifested in the adolescents living at home.

Parental separation at a young age, or lack of exposure to a parent in infancy was a related risk factor for children who engage in self-harmful behaviors. In a study conducted by Sourander and colleagues (2006) results found that adolescents who engaged in self-harmful behaviors attributed the beginning of these behaviors due to the fact that they did not live with both biological parents during their childhood. Interesting enough, a study conducted by Kloet et. al., (2011) found that family dynamics were among some of the reasons in which adolescents began to self-harm; in this particular study the authors looked at dynamics in the home while living with a step-parent. While conflicts exits at time in the home, the question begins to rise as to whether or not couple should stay together for their children or get a divorce in order to shield the children from the conflict in the home. In a study conducted by McLaughlin and colleagues (1996) researchers found that adolescents described an apparent reason they engaged in self-harmful behaviors was due to the severe and significant relationship issues in the home. Therefore, conflict and divorce were both significant factors in self-harmful behaviors.

Along with conflict among caretakers, conflict between parents and children can also be a potential risk factor for individuals engaging in self-harmful behaviors. Yates and colleagues (2008) found similar results where outcomes showed that the more judgmental manner in which parents spoke to their children, the higher the rate of self-injury. Therefore it is apparent that parent-child interactions play an important role in the manifestation of self-harmful behaviors. Recent studies conducted by Emery et al. (2017)

and Pearson et al. (2018) found that children were more susceptible to self-harmful behaviors, depression, and anxiety when they felt as though they had no autonomy, and when they felt they had a dysfunctional maternal relationship with their mother, regardless of whether or not the maternal figure had a depression or anxiety disorder of their own.

Oldershaw et al. (2008) conducted on parent perspectives on their adolescent's self-harm. The results showed that parents did not know how to communicate with their children about their self-harmful behaviors; although parents reported that they were aware of their adolescent's self-injurious behaviors, they did not feel as though their communication was adequate to tackle the issue at hand. Therefore, parents did not address the behaviors in a timely manner. Another interesting finding was the fact that although parents knew their adolescent was engaging in self-harmful behaviors, they did not take any precautionary or any preventative measures to address the self-harm. This shows that both the lack of knowledge and communication/parenting skills exacerbate the problem. Therefore, parent and child interactions are of significant importance in better treatment outcomes.

Research has also indicated both direct and indirect relationships between parent stress and parenting styles. In a study conducted by Rodgers (1998) results showed that multiple stressors as well as parenting stress directly affected parenting styles. The study also found that social support was able to buffer the effects of stress. Results from a similar study conducted by Hastings (2009) found that parents of children with problem behaviors had higher levels of stress. In a later study by Baetens and colleagues (2013) found that adolescents with non-suicidal self-injurious behaviors reported that they were

better able to control their impulses when they perceived their parents as supportive. Thus, family interactions provide a crucial context and opportunity for improving self-injurious behaviors.

Adolescents should not be the only focus of treatment throughout this trying process, but parents as well. Whitlock and colleagues (2018) found that parents with children who engaged or have engaged in self-harmful behaviors experience more strain and stress in their lives than parents whose adolescents do not. Further research on parent stress and strain has found that parents are well aware of the emotional as well as mental struggles that come along with helping to support their child after becoming aware of the fact that they are engaging in self-harmful behaviors (Byrne et al., 2008). Researchers also extrapolated important themes where parents described they needed support themselves. Emotional support and support (services) were the top emerging themes, followed closely by parenting and family dynamics. Further discussion revealed that parents felt as though they lost control of the parent-child dynamic in the household, which further exacerbated other issues. Giving parents these options and offering this support should help relieve some of the stress parent's experience and create a fostering and nourishing environment in the home. This will then reduce stress and ultimately aid in the reduction and maintenance of self-harmful behaviors.

### *Adaptive Parenting Styles*

A study conducted by Gouveia and colleagues (2016) found that for parents who engaged in mindful parenting and self-compassion experienced less parenting stress, and therefore less authoritarian and permissive parenting styles. Mindful parenting was

described as a skill set of understanding moment-to-moment awareness of the parent and child relationship. Furthermore a study conducted by Baetens and colleagues (2014) found that among adolescents who self-harm, parents who engage in high support parenting and low parental control fostered adolescents who showed higher levels of adaptive psychosocial functioning.  That is, parents who are supportive and warm with their children will help their children foster better relationships with those around them. On the other hand, parents who restricted adolescent's autonomy and set more rules fostered children who were more likely to engage in self-harmful behaviors. Baetens and colleagues (2014) also found upon learning that their children are engaging in self-harmful behaviors, parents begin to increase their limit setting, which is known to have adverse effects on adolescent behavior. In another study conducted by Baetens and colleagues (2013) parental emotional support was seen as a protective factor against frequency of non-suicidal self-injury. Therefore, reducing parent stress and increasing emotional support for parents whose adolescents self-harm should in turn help parents learn how to support their children for favorable treatment outcomes. It is important to notice the parallel processes that are occurring within the context of family dynamics. While adolescents may feel loss of control, which may then lead to self-harmful behaviors, parents also experience similar losses of control, which may alter parenting stress and styles.

In a study conducted by Kashani and colleagues (1995), children who were hospitalized due to depressive symptomology reported less family cohesion and felt more disengaged or distant form their parents than the children who were not depressed. The authors also found that cohesion or closeness of family members was important between

family functioning and childhood depression. For this reason, the Circumplex Model of Marital and Family Systems will aid this treatment manual. The Circumplex Model of Marital and Family Systems focuses on three important dimensions of family structure and functioning in order to strengthen the family relationship: family cohesion, flexibility, and communication (Olson, 2000). These three dimensions have been deemed critical elements in treatments focused on family systems, and therefore will be the model this treatment manual will be derived from.

Family cohesion refers to the emotional bonding between family members, and can be assessed through emotional bonding, boundaries, and time and space among others. Olson (2000) defines cohesion as a spectrum ranging from disengaged (very far apart) to enmeshed (very close), with separated and connected being the happy mediums. Families must learn to function independently from one another (setting proper boundaries) while also being connected (time together). In order to facilitate such relationships, flexibility becomes a key component in family dynamics. The goal of family flexibility is to tolerate change in leadership roles and relationship rules, and is measured by the family's ability to balance stability and change (Olsen, 2000). Just as with cohesion, flexibility falls on a spectrum from rigid to chaotic. Rigid tendencies would include too much structure, while chaotic tendencies provide too little structure; therefore structured and flexible styles are the outcome goal. The goal is for families to have stable roles, but at times there must be room for roles to change and discussions to be facilitated amongst members of the family. In order to do so, communication becomes essential in the family dynamic.

Communication is the third dimension of the Circumplex Model, and entails

listening skills and respect and regard among others. Here the family focuses on carrying conversations while utilizing respect and regard throughout reciprocal interactions. In working with self-harming adolescents and their parents it is important to use the dimensions of the Circumplex model in order to create balance in the family system, following adversity.

The Circumplex Model consists of four dynamics that are either balanced or unbalanced. The model focuses on targeting families who are in any of the unbalanced areas, which include: chaotically disengaged, chaotically enmeshed, rigidly disengaged, and rigidly enmeshed. In a chaotically disengaged family system, family members are often emotionally separated from one another and decision-making is erratic and impulsive. In chaotically enmeshed families, members share an extremely close emotional connection and decision-making is erratic and impulsive. In rigidly disengaged family systems, members are separated from one another and one individual who is highly controlling leads decision-making. In rigidly enmeshed family systems, members are emotionally overinvolved with one another, and decision-making often becomes erratic and impulsive.

Although these family dynamics are marked as unbalanced, in some cases family structure become so in order to protect their members. For parents who are fearful of causing emotional outbursts, having chaotic relationships, remaining uninvolved in their child's life may help them to avoid conflict. For those who would like to know how their child is doing constantly in order to avoid self-harmful behaviors, being enmeshed may provide that additional comfort. On the contrary, parents who take a rigid approach to family dynamics may do so in order to prevent their child engaging in another self-

harmful episode by continuously monitoring and placing rules on their adolescent. Finally, for families who are disengaged, remaining extremely separate from other family members may help protect members from facing problems head on, and therefore creates less stress in the dynamics. Although these style my help protect the family dynamic in moments of crisis, they are often not sustainable and cause more damage in the long run.

### *Treatments*

A study conducted by Shapiro (2008) furthered the investigation on non-suicidal self-harm and found that early intervention was a key component to keeping the adolescents safe and provided better chances for them to recover. A meta-analysis conducted by Ougrin and colleagues (2015) reviewed 19 therapeutic interventions used to prevent self-injury in adolescents without the use of medication; results found that across the 2,176 adolescents enrolled in the 19 interventions, the treatment group had lower self-harm rates post intervention than the control group did. This highlights the importance of therapeutic intervention for adolescents who self-harm. Unfortunately, there are no evidence-based treatments to date that are used to specifically target parents whose children self-harm. An adaptation of Lineham's Dialectical Behavior Therapy (DBT), which was originally developed as an intervention for Borderline Personality Disorder patients who engaged in self-injurious behaviors, has been adapted for use with non-suicidal self-harming adolescents, referred to as DBT-A. The treatment focuses on five skills, which are essential to the reduction and termination of self-harmful behaviors. The skills include mindfulness, interpersonal skills, walking the middle path, distress tolerance, and emotion regulation. According to Dimeff and Linehan (2001), Stage one of

DBT-A is used in order to learn and apply the skills in order to stop the self-harmful behaviors, while Stage two is focused on processing the trauma, which brought forth the self-harmful behaviors, as well as implement the skills during these emotionally activating times. Stage two of DBT-A also includes components of individual and group therapies, in which the adolescents delve deep into the trauma with their therapist. The group component focuses on the five skills mentioned above: distress tolerance, emotional regulation, interpersonal effectiveness, mindfulness, and walking the middle path. Although all of these components prove to be of extreme importance to the progress of the adolescent, many people fail to recognize that invalidating environments are one of the main initial reasons the adolescents self-harm. Therefore, interpersonal skills are only as effective as the environment the adolescents are placed in again once treatment is over. Family dynamics play another major role in the manifestation of self-harmful behaviors. This further places importance on supporting parents so they are able to work with their adolescents to produce the best possible treatment progress.

To summarize, the articles we have found in the literature highlight how dysfunctional family dynamics are one of the leading causes of self-harmful behaviors among adolescents. This study is a proposal of a treatment manual for parents whose children engage in or have previously engaged in self-harmful behaviors.

**Aims**

Self-harmful behaviors are widespread among adolescents across the United States, as well as internationally. Although client safety is a main priority, self-injurious behaviors affect more than just the individual engaging in these behaviors. Parents,

caregivers, and family members may encounter distress during an adolescents struggle with self-harm; often this distress infiltrates into family relationships, further distressing the adolescents. The specific aim of this manual is to help parents or caregivers of self-harming adolescents learn the parenting skills needed to foster a validating environment, which will foster a supportive and non-judgmental environment where the adolescents will be able to utilize the DBT skills learned in group and individual therapy sessions. The treatment manual will be structured around Byrne and colleagues' (2008) findings after interviewing parents and assessing their needs during this difficult time. The treatment will focus on aiding parents with emotional distress and strain associated with having a child who self-harms, as well as offer skills to better understand their child's treatment and regain control of the family dynamic. Therefore, the purpose of this treatment manual is to help parents learn effective parenting skills in order to foster a positive home environment for an adolescent who engages in non-suicidal self-harm.

# CHAPTER THREE

# METHOD

## Included Materials and Techniques

The manual will focus on teaching the adaptive parenting skills that are associated with lowered instances of self-harmful behaviors. The skills, which will be facilitated by a graduate student from Loma Linda University's School of Behavioral Health, will focus on engaging parents in the implementations and applications of the skills. Each week the treatment group will learn an adaptive parenting skill such as healthy boundary setting, emotional support, and proactive skills; in so doing they will also receive emotional support themselves.

In order to assess progress throughout the duration of the treatment, the Parent Stress Index, or PSI, (American Psychological Association, 2019), a self-measure index used to measure the parent-child system, will be used pre and post treatment. The index contains 120 self-report questions to measure three domains of stress: child characteristics, parent's characteristics, and situational/demographic stress. The test is broken into domains between parent and child, and includes subscales such as competence, isolations, attachment, and health. Some example items include, "I feel trapped by my responsibilities as a parent", "I feel alone without my friends", "My child is not able to do as much as I expected"; the parents respond with responses ranging from strongly agree to strongly disagree. According to the American Psychological Association (2019) the PSI's chronbach's alpha is .96 for both domains as well as the stress domain, therefore reliable for use in clinical settings. The reliability coefficients for

the children's measure fell between .78-.88, the parent measure between .75-.87. In order to assess progress, parents will be administered the PSI on two occasions throughout the program, once upon entering the program and once upon completing the program.

In addition to the PSI, the Parenting Young Children (PARYC), will be administered once at the beginning of the program, and once at the end of the program to assess progress. The PARYC is a self-report measure that is used to measure parental supportive behaviors, limit setting, and proactive parenting (McEachern et.al., 2012). The PARYC has been proven to be a reliable in measuring parenting behaviors, receiving a chronbach's alpha of .73 (McEachern et.al., 2012). The scale will be administered at the end of the parent treatment program in order to assess whether the skills taught are being transferred into the home environment.

### Clients, Admission Criteria, and Organization Running Treatment

The participants involved in this study will be the parents of adolescents who are currently enrolled in Loma Linda University's Behavioral Medicine Center. These adolescents are enrolled in either RISE (DBT-A Stage 1 Treatment, which focuses on the skills needed to regulate emotions) or SHIELD (DBT-A Stage 2, which focuses on processing the trauma while maintaining skills) for intensive outpatient DBT interventions, and meet once a week for group interventions for their respective groups. During these weekly meetings, the parents will also meet for their own group intervention. Parents who have adolescents enrolled in either RISE or SOAR group will be in the same group. The groups will meet once a week for two hours. A licensed clinical psychologist will supervise the graduate student running the group. The parent

group will be added to a program that is already up and running at the Behavioral

Medical Center.

# CHAPTER FOUR

# TREATMENT MANUAL

## Schedule of Parent Practice Skills

The manual will focus on teaching application skills, which research has shown to be beneficial for parents or caregivers whose children self harm. The parenting practice skills will focus on helping parents navigate interactions with their children and how to set boundaries and regain control of the family dynamic. Parents will have a chance to engage in role-plays in order to practice these skills with one another. The program will rotate skills on a 10-week basis, which is also the length of the adolescent groups. Parents will be able to enroll into the group at any time, but will need to complete a 10-week cycle in order to receive each skill to graduate. During the adolescent's initial interview, parents will also be asked to complete the PSI and PARYC. Following the assessments, parents will sit with a clinician for 30-45 minutes in order for them to understand the basis of the Circumplex Model, as well as touch base with which skill is learning for that week. The skills that the group will focus on will be geared towards parenting skills and adaptive coping skills to create family cohesion and flexibility, and will also serve as a structured emotional support group at large. Each of the skills has been found to foster improvement in parent-child relationships and will be taught as shown in Table 1:

**Table 1.** Weekly Parenting Skills

| Week | Skills |
|---|---|
| Week 1: | Parental Emotional Support |
| Week 2: | Mindful Parenting |
| Week 3: | Limit Setting |
| Week 4: | Boundaries |
| Week 5: | Proactive Parenting |
| Week 6: | Flexibility |
| Week 7: | Listening/ Speaking Skills |
| Week 8: | Respect |
| Week 9: | Emotional Bonding |
| Week 10: | High Support/ Low control |

**Identified Knowledge, Skills/Behaviors, Attitudes for Each Skill**

Week One will focus on providing emotional support and group cohesion to the group members. In a study conducted by Byrne and colleagues (2008) parents of adolescents who self-harm expressed that support would be emotionally and socially beneficial; therefore this manual will focus on creating an atmosphere that will help foster emotional support, as well as an area where parents may share their struggles with other parents who are also facing the same challenges. Upon successful completion,

parents will know the importance and value of creating group cohesion and finding group support. Parents completing this week will be comfortable with speaking about sensitive topics and become open to receiving group support form other members.

Week Two will focus on teaching mindful parenting skills. These skills include using mindfulness techniques during parent-child interactions. Upon successful completion parents will know the importance of mindful parenting and its role in helping both parent and child. Parents will learn skills such as child sovereignty, cultivating kindness, and using compassion, as well as when to engage in using the skills. After completion of this skill it is the hoped that parents will leave with an attitude of acceptance and kindness towards themselves and their children. In doing so, Gouveia and colleagues (2016) found that parents begin to accept both themselves and their children and in turn experience less parenting stress.

Week Three will target a skill that was found to be of importance, limit setting. Upon successful completion parents will know how and when to set appropriate limits with their children/adolescents without the fear of causing emotional backlash. Parents will also learn limits that fall in line with their cultural and moral standards, and that limit setting is important and will not be the sole cause of an emotional outburst.

Week Four will further focus on developing proper boundaries. This skill will be taught within the context of the Circumplex Model and will be geared toward teaching parents how to remain connected but separated. Upon successful completion of this week's skill, parents will know how to establish expectations, consequences, and rewards. Parents will learn the skill of setting boundaries in accordance with their values and stand up for themselves appropriately. Parents are hoped to finish this skill believing

that clear boundaries are important for healthy communication, and to feel more confident in their ability to set clear boundaries.

Week Five will focus on teaching proactive parenting. This skill requires parents to anticipate problem behaviors and create an environment that alleviates potential problems, reducing conduct issues with children (Gardner et al. 2003). Upon successful completion of this week's group meeting parents will know situations in which problems may arise. Parents will learn the skillset of using preventative measures in order to avoid issues altogether, or diffuse them in a timely manner. Following this week, parents will have confidence in their ability to analyze situations and act accordingly.

Week Six's group skill will be learning the concept of flexibility. The group will learn that flexibility is the amount of change in family leadership roles, role relationships, and relationship rules (Olson 2000). Upon successful completion of this skill, parents will know about change in family leadership roles and balancing stability in the family versus change. This could be regarding roles, authority, or expectations. The attitude for this week will be geared towards valuing leadership roles and commitments, while also involving other members of the family.

Week Seven's group will focus on listening speaking skills.  Upon successful completion parents will be able to distinguish between empathetic speaking and attentive listening. The skills include being fully involved in conversations, offering supportive statements, and refraining from imposing parent view on the child. Parents will value their personal ideas but will also be able to value the ideas and thoughts of their children.

Week Eight will be a continuation of the skills learned in weeks 3 and on, and will focus on respect while utilizing these skills. Respect can be shown through of the

Circumplex Model, such as autonomy, boundaries, and limit setting. Upon successful completion parents will be aware of child autonomy in boundary and limit setting, choosing appropriate limits of autonomy while respecting the child's wishes. Parents will value the idea of respect as a two way street between them and their children.

Week Nine will involve emotional bonding between parents and their adolescents. During this group parents will explore and learn about their parental bonding tendencies, which Stein and colleagues (2000) define as the emotional ties between them and their adolescents. Upon successful completion parents will know their personal parental bonding tendencies and how to identify emotional ties between family members. Parents will better understand their relationships with their children, as well as gain confidence to change these attachments if not sustainable.

Week Ten is the final week of the program, and will focus on high support and low control parenting. Rollins and Thomas (1979) explain parenting in terms of these two dimensions. Support is the parent's warmth, acceptance and understanding of the child, while control is the parent's urge to influence their child and their behaviors. Research conducted by Baetens ands colleagues (2014), found that high parental support and low control produce better outcomes in adolescents. Parents will distinguish between high/low support and control, identify their own tendencies, and be able to establish high support and low control interactions with their children and be committed to maintaining them during times of distress.

Following the completion of the ten-week module, parents will be given a certificate of completion, and will graduate from the program.

Parents will graduate from the program once their adolescents graduate from their respective programs (RISE/SOAR). Upon completion of their respective programs, both parents and adolescents will attend family therapy sessions, and will be discharged from the program as a whole once able to demonstrate understanding and application of the skills learned in respective groups. The family group sessions are out of the scope of this manual, and criteria will be addressed in its respective manual. The outline of the treatment manual is found in Table 2.

**Table 2**. Outline of Treatment Manual

| Activity | Time Allocated |
|---|---|
| Check In | 10 minutes |
| Parenting Practice Skill (Ex: Emotional Support, Limit Setting, & Proactive Parenting) | 10 minutes |
| Application of Parent Skill/ Learn RISE DBT Skill | 35 minutes |
| Break | 10 minutes |
| Role Play/Interactive/Discussion | 45 minutes |
| Break/Dismissal | 10 minutes |

Parents will check in during the first ten minutes of the allotted group time. The next portion of the group will consist of an educational skill component, in which the

group leader (clinical graduate student) will teach the parents the adaptive parenting skills that foster a supportive relationship with children who are engaging in self-harmful behaviors. This portion of group will last about 10 minutes, and will be followed by the application of the skill for another 25 minutes. Here the graduate student will walk the group through a practical application of the skill, such as modeling the skill for the parents, or discussing appropriate times to implement the skill. During this time, the therapist will also discuss the DBT-A skill that will be taught in the RISE group for that week, as depicted in Table 3.

**Table 3**. DBT-A Skills

| Week | Skill |
|---|---|
| Week 1: | Mindfulness: What Now Skill |
| Week 2: | Mindfulness: How Skill |
| Week 3: | Distress Tolerance: TIPP Skill |
| Week 4: | Distress Tolerance: IMPROVE the Moment Skill |
| Week 5: | Emotion Regulation: Emotion Identification, and what are Good Emotions |
| Week 6: | Emotion Regulation: PLEASE MASTER |
| Week 7: | Interpersonal Effectiveness: DEAR MAN |
| Week 8: | Interpersonal Effectiveness: Cheerleading Statements |
| Week 9: | Walking the Middle Path: Dialectics |
| Week 10: | Walking the Middle Path: Validation |

The goal of this discussion will be to familiarize the parents with the DBT-A skills in order to facilitate use of the skill in the home as well as open discussion regarding the skills. The DBT-A skills that will be taught will be outlined below. Following the application of the skill there will be a ten-minute break.

After the break, the floor will be open for about 55 minutes in order to offer parents the opportunity to ask questions, share their struggles, role play the application of the skill themselves, and experience social support from the group and group leaders. Following this time, parents will be offered one last break and then will dismiss for the week. Due the anticipated barriers to involvement in the group, a student clinician will provide childcare for children who are unable to be left unattended. Travel vouchers will also be available for parents who may struggle with transportation. Snacks will be provided for parents during group, as well as for the children in childcare.

# CHAPTER FIVE

## THERAPIST GUIDE

The therapists will begin each group by checking in the parents for the group, which will be on a sign in sheet. After the parents have arrived and checked in, the therapist will teach the weekly practice skill. The therapist will describe the skill, as well as explain its importance in helping the family dynamics. The therapist should take about ten minutes to teach the skill and use the next twenty-five minutes of the group to practice the application of the skill with the parents. The therapist will engage the parents in practicing the newly learned skill with one another. It should be noted that it is not the therapist's job to display the skill for the parents, but rather to facilitate and correct the application of the skill if needed. Following the skill practice, the parents will be offered a ten-minute break to use the bathroom or stretch if needed.

After the break, the group will engage in a discussion or role-play for the week. Discussions will be parent-led and will focus on the how this week's skill may be beneficial in their homes, or how skills may be difficult to implement for various personal reasons. Role-plays will be structured and will begin by the therapist breaking the group into dyads or triads and facilitating the role-play for the group. This portion of the group will require the parents to act out a situation in the home where the skill may be used.

For example, parents may practice listening and speaking skills with another parent in role-play, listening in a non-judgmental matter, and responding with learned speaking skills. As the therapist monitors the practiced skills, they will gain a deeper understanding of the problems the parents face in the home. This will better aid future

skills and sessions.

The therapist will close the group by discussing thoughts and feelings the parents may have on the group, and answer any questions or concerns.

Given the geographic location of the current groups, it is anticipated that some individuals may be monolingual (Spanish), or that therapy would be more effective for parents in their primary language. Therefore, a bilingual student clinician will be available to assist in teaching the parent group in order to assure patients are comfortable with the material provided.

## Common Problems/Issues

For parents who enroll after the start of the module (Week 1), it is imperative that they complete all ten skills before graduating the program. Since the program will have a rolling admission, this means after the first graduating class, there could potentially be graduations every week thereafter. It is important for the provider to note at the start of the program which parents have completed which skills. If a parent happens to be absent for a week (therefore misses a skill), they will not be given a certificate until they attend a group on the missed skill, however they do not need to re-attend learned skill groups. Once a parent graduates from the program, they are welcome to continue to sit in on the groups for as long as their children are enrolled in either SOAR or RISE.

For parents who are unable to attend every meeting due to scheduling conflicts or co-parenting, it is possible to switch off weeks between parents. A weekly journal will be required where parents will notate important skills and techniques taught during the group meeting in order to hand off to the next parent the following week. It will be

assumed it is the responsibility of the parent to catch up on the previous week's skills.

Cultural discrepancies may arise during the group meetings due to the anticipated demographic population. Although the program is structured from findings in Westernized literature, the group will maintain cultural sensitivity. It will be established during the beginning of the each group meeting that the focus will be to learn skills that require a collaborative effort between parents and their children, rather than Westernized child rearing techniques. During times of cultural differences, therapists will navigate the situations accordingly.

Due to the nature of the content discussed in the group, all discussions will remain confidential between group members, and all conversations regarding confidential information will be strictly prohibited outside of the group.

It is also anticipated that during times of distress, parents may feel the urge to discuss personal matters that they may be struggling with. Due to limited time the therapist will direct any personal questions, concerns, or conversations back to topics that will benefit the overall group. Parents will be encouraged to ask personal questions during the breaks or after the group dismisses.

Another potential issue that may arise regarding topics of discussion is the interaction between parents whose children who currently self-harm (RISE), and those who have not self-harmed in some time (RISE). It is hoped that the mixture of parents at different stages will help facilitate better group discussions and will help promote a sense of growth throughout the program. Moreover, parents who are currently navigating home situations with self-harming children may be able to find resources and comfort in the parents of children who are no longer self-harming.

It may be the case that some parents already practice or maybe have mastered some of the skills that are provided in the parent group, however it is important that parents attend each of the modules in order to graduate. Parents who already practice skills some of the skills being taught by the group may learn how to better refine their skills, or provide valuable input/support for other parents who may be struggling with these skills. Therefore, it is imperative that parents attend each week.

It is anticipated that the younger therapists may have a difficult time gaining initial respect from the parents enrolled in the group due to the assumption they do not have personal experience raising children. However, the therapist will be able to gain parent respect by highlighting their prior experiences in clinical work and also presenting skills, which are empirically supported. The therapists will also be put in a unique situation where they will be able to flex from teaching the skills from a clinical standpoint, as well as appeal to emotional struggles the adolescents may experience.

It is important for parents to understand the Circumplex Model of Marital and Family Systems. However, due to rolling admission it is anticipated that some parents may enter the program during later weeks; therefore a Welcome Packet is provided in the Index. The program overview is noted in Table 4.

**Table 4**. Program Overview

| Week | RISE DBT-A Skill | Parenting Skill | Goal of Parenting Skill | Example Discussion | Assessment Administered |
|---|---|---|---|---|---|
| 1 | What Skill | Parental Emotional Support | Provide a safe space for parents to share concerns and feel understood | "At home I feel as though I have to be strong for my children/partner, but I am having a difficult time adjusting to this, how do you feel?" | PARYC PSI |
| 2 | How Skill | Mindful Parenting | Teach parents to have an attitude of acceptance towards themselves and their children | Tell me a situation this week where you wished you were more accepting of yourself" | |
| 3 | TIPP | Limit Setting | Help parents set rules/limits without being too lenient or strict in fear of self-harmful behaviors | "Which limits would you like to set to help you regain control?" | |
| 4 | IMPROVE the Moment | Boundaries | Help parents to stay connected with their children without becoming too attached or too distant | "Which boundary do you feel will be beneficial to you, and why do you feel as though this boundary will be beneficial?" | |
| 5 | Emotion Identification | Proactive Parenting | Help parents understand and therefore avoid triggering environments | "Which situations have caused the most tensions in your home? How do you think you can avoid similar situations?" | |

**Table 4**. (continued).

| 6 | PLEASE MASTER | Flexibility | Teach parents to roll with family dynamics, power roles, and authority | "Where do you feel as though you can become more flexible?" | |
|---|---|---|---|---|---|
| 7 | DEAR MAN | Listening and Speaking Skills | Teach parents empathetic and/or attentive listening speaking and skills to promote healthy discussion | "Do you recognize how you may be distracted during conversations?" | |
| 8 | Cheerleading Statements | Respect | Teach parents how to utilize previously learned skills to create respectful interactions between parent and adult interactions | "Do you feel as though there is a power dynamic between you and your children? Does this power dynamic stem from fear?" | |
| 9 | Dialectics | Emotional Bonding | Teach parents skills to build a healthy and strong relationship with their children | "What is one way you feel as though you and your child bond well? What is one way you wish you could bond with your child? But have not been able to?" | |
| 10 | Validation | High Support/Low Control | Teach parents how to be warm and accepting while also refraining from influencing their children regarding their own viewpoints | "Where, as a parent do you feel the need to control and is this control valid?" | PAYRC PSI |

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# APPENDIX A

## PARENTING YOUNG CHILDREN MEASURE

| Item | Strongly agree | Agree | Not sure | Disagree |
|---|---|---|---|---|
| **First: Distraction/hyperactivity** | | | | |
| 1 when my child asks for something, he usually continues in his attempts to get what he wants. | | | | |
| 2. My son (daughter) is active to the extent of overwhelming me. | | | | |
| 3. It seems my son (daughter) is easily to get distracted. | | | | |
| 4. If I compare my son (daughter) to most of the other kids, I find that he had difficulty focusing his attention. | | | | |
| 5. My son (daughter) remains mostly for more than ten minutes playing with a game. | | | | |
| 6. My son (daughter) spends a lot of time away from home more than I expected. | | | | |

| | | | | |
|---|---|---|---|---|
| **7**- **My son (daughter) activity is much greater than I expected.**<br><br>**8**- **My son (daughter) shows upset and excessive**<br><br>**resistance when wearing his clothes or taking a bath.**<br><br>**9**- **My son (daughter) is easily distractible away from thing he is doing.** | | | | |
| **Second: Reinforces parent (support of the child to his parents)**<br><br>**10. It is rare that my son (daughter) do things to**<br><br>**introduce pleasure or satisfaction for me.**<br><br>**11. I feel most of the time that my son (daughter)**<br><br>**loves me and wants to be close to me.**<br><br>**13. Smiling of my son (daughter) to me is much less than I expected.**<br><br>**14. When I do something for my son (daughter), I**<br><br>**feel that my efforts are not appreciated.** | | | | |
| **Third: Mood**<br><br>**15. My son (daughter)'s screaming and raves:**<br><br>**• much less than I expected** | | | | |
| **• Less than I expected**<br><br>**• much as I was expecting**<br><br>**• much more than I expected**<br><br>**• This seems to be mostly a case going on with him**<br><br>**16. Which of the following describes your child's best:**<br><br>**• mostly he/she likes to play with me**<br><br>**• In some cases, he/she likes to play with me**<br><br>**• usually does not like to play with me**<br><br>**• Mostly does not like to play with me**<br><br>**17. It's apparent that my child's screaming and**<br><br>**fussing is more often than most children**<br><br>**18. When playing, my child often do not cheer or laugh** | | | | |

| | | | | |
|---|---|---|---|---|
| **19. My son (daughter) usually wake up from sleep in a bad mood** | | | | |
| **20. I feel that my son (my daughter) moody and it is easy to become anxious.** | | | | |
| **Fourth: Adaptability** | | | | |
| **21. It seems my son (daughter) is a little bit different from what I expected and this is something that bothers me sometimes** | | | | |
| **22. It seems that my son (daughter) to forget what they have learned in the past in some areas and bouncing back to do special things for children younger than their age.** | | | | |
| **23. I think that my son (daughter) doesn't learn quickly unlike most children** | | | | |
| **24 - I think that my son (daughter) is not smiling very much unlike most children** | | | | |
| **25. My son (daughter) does some things that bother me much** | | | | |
| **26. My son (daughter) does not have the ability to work as much as I had expected** | | | | |
| **Fifth: Acceptability** | | | | |
| **27. My son (daughter) faces many difficulties in adapting to the changes that occur around him/her more than most kids** | | | | |
| **28-When something my son (daughter) doesn't like happens, he/she has a very strong reaction.** | | | | |
| **29. The presence of my son (daughter) with other people is usually a big problem** | | | | |
| **30. My son (daughter) became annoyed for the simplest things** | | | | |
| **31. My son (daughter) easily notice high sounds and bright lights, and respond to them more than necessary** | | | | |

| | | | | |
|---|---|---|---|---|
| **32. To build a system in sleep or eating for my son (daughter) was much harder than I expected** | | | | |
| **33. My son (daughter) usually avoids playing with a new toy for some time before he/she starts to play with it.** | | | | |
| **34. It is difficult for my son (daughter) to get used to the new things and it takes him a long time.** | | | | |
| **35. My son (daughter) seems not satisfied when he meets with people** | | | | |
| **who are strangers** | | | | |
| **36. When my son (daughter) is in a state of tension or distress, it is:** | | | | |
| **1. Easy to calm him down** | | | | |
| **2 - difficult to calm him down more than I expected** | | | | |
| **3. It is very difficult to calm him down** | | | | |
| **4. does not help anything I'm doing in calm him down** | | | | |
| **37. I have found that when I ask my son (daughter) to do something or stop doing something, this demand is:** **1. more difficult than I expected** | | | | |
| **2-difficult somehow than I expected 3-difficult as I was expecting** **4-a little bit easier than I expected** | | | | |
| **5-much easier than I expected** | | | | |
| **Sixth: Demandingness (The frequent claim and urgency)** **38. Your son (daughter) does some things or behaviors that bother you.** | | | | |
| **Think carefully and count the number of these things or behaviors, such as that he wasted his time or hesitate to his duties, disobey orders or directions, compulsive activity, nuisance or interrupts others while talking or working, quarrel, moaning and sobbing, etc.** **You have to write the number of these stuff or behavior as follows:** **1. 1 to 3** **2. From 4 to 5** | | | | |

| | | | | |
|---|---|---|---|---|
| **3. From 6 to 7**<br><br>**4. From 8 to 9**<br><br>**5. More than 10**<br><br>**39. When my son (daughter) screams, it usually takes:**<br><br>**1. less than two minutes.**<br><br>**2. From 2 to less than 5 minutes.**<br><br>**3. From 5 to less than 10 minutes.**<br><br>**4. from 10 to less than 15 minutes.** | | | | |
| **5. more than 15 minutes.**<br><br>**40. My son (daughter) does some things or acts that cause a lot of distress and anxiety for me.**<br><br>**41. My son (daughter) is exposed tp more health problems than I expected.**<br><br>**42. The older my son (daughter) and the more he/she becomes dependent on him/herself, I find myself more concerned that he/she will be exposed to harm or fall in a problem.**<br><br>**43. My son (daughter) became a trouble for me more than I expected.**<br><br>**44. It seems that care of my son (daughter) is much more difficult than most children.**<br><br>**45. My son (daughter) is always attached to me.**<br><br>**46. My son (daughter) imposes demands on me more than most of other children.** | | | | |

## PARENTAL DOMAINS

| Item | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| **First: Sense of Competence** 47. When my son (daughter) was diagnosed with this disease, I was in doubt about my ability to perform my duties and my obligations as a mother (or father) 48. When I became a father or (mother), this was more difficult than I thought. 49. I feel my competence when I take care of my son (daughter) 50. I can not make decisions without help 51.  I has lot of problems related to raising children more than I expected 52. I feel my success most of the time when I try to make my son do something or stop doing something | | | | | |
| **53. Since I got my last son, I found myself unable to give good care for him as I thought to do, I Need Help 54-mostly I feel I cannot treat things properly** **55. When given careful consideration to myself as a mother (or father), I think:** **1. I can tackle anything can happen** **2. I can tackle most things sound way to some extent** **3. Although in some cases, I have my doubts in my ability to tackle most things, but I find that I can tackle them without any problems** **4. I have some doubts about my ability to handle stuff** **5. I do not think at all that I treat things properly.** **56. I feel:** **1. A Very good mother (father)** **2. Better than most mothers (fathers) 3.Like** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **most mothers (fathers)** | | | | | |
| **4.I face some difficulties or problems related to my role as a mother (father)**<br>**5.I'm not that good in doing my role as a mother (father)**<br><br>**57. What is the highest level of education you and your spouse had reached:**<br>**For the mothers:**<br><br>**1. Primary Education**<br><br>**2. Elementary education**<br><br>**3. Secondary education or secondary technical or medium certificate**<br><br>**4. University education**<br><br>**5. After Graduate University**<br><br>**58. What is the highest level of education you and your spouse had reached:**<br>**For the fathers:**<br><br>**1. Primary Education** | | | | | |
| **2. Elementary education**<br><br>**3. Secondary education or secondary technical certificate**<br><br>**or medium certificate**<br><br>**4. University education**<br><br>**5. After Graduate University**<br><br>**59. I cannot make decisions without help**<br><br>**60. I have a lot of problems related to raising children**<br><br>**more than I expected.** | | | | | |
| **Second: Attachment: The emotional bond to the child**<br><br>**61. To what extent is it easy for you to understand what your child wants or needs**<br>**1. Very easy**<br><br>**2. Easy**<br><br>**3. Somewhat difficult**<br><br>**4. Very difficult** | | | | | |
| **5. I cannot usually understand or I identify what problem he is facing**<br>**62. It takes long time from parents to have the feelings of**<br><br>**warmth and tenderness towards their children** | | | | | |

43

| | | | | | |
|---|---|---|---|---|---|
| **63.** I expected to have feelings of warmth and tenderness towards my son more than I have and this is annoying me | | | | | |
| **64.** Sometimes my son do things bothering me because I feel as if I'm just a way or instrument for him | | | | | |
| **65 -** When I was young, I did not feel comfortable at all that I gave birth to a child with chronic disease or to take care of him | | | | | |
| **66.** My son wants and needs me more than what he wants or needs from other people. | | | | | |
| **67.** The number of what I now have from children is so much. | | | | | |
| **Third: (Role of Restricts): restrictions of parental role** **68.** I spend most of my life in that joyful work for my son. | | | | | |
| **69.** I find myself gave a lot of my life to meet the needs of my children more than I expected. | | | | | |
| **70.** I feel like I impasse because of my responsibilities as a mother (father). | | | | | |
| **71.** I often feel that he necessary needs for my son (daughter) controls my life. | | | | | |
| **72.** Since I gave birth to my son (daughter), I became unable to do new and diverse things. | | | | | |
| **73.** Since my child was diagnosed with this disease, I feel in most cases that I am unable to work on the things which I like to do. | | | | | |
| **74.** It is difficult to find a place in our house where I can be alone with myself. | | | | | |
| **Fourth: Depression** **75.** When I look at myself as a mother (father), I mostly have a sense of guilt or feeling bad about myself. | | | | | |
| **76.** I'm not happy by what I bought for myself from clothes in the recent period. | | | | | |

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| **77. When my son acts improperly or overly induces a state of agitation or chaos, I feel my responsibility for that. As if I did not do anything properly.** | | | | | |
| **78.** I feel with every time my son does something wrong, that in fact it was my fault. | | | | | |
| **79.** I often feel guilty about the way I feel about my son. | | | | | |
| **80.** There are a few things that make me feel worried about my life. | | | | | |
| **81.** I felt sadness and depression more than I expected after knowing my son's disease. | | | | | |
| **82.** I feel guilty when I get angry of my son and that's what bothers me | | | | | |
| **83.** One month after my son was diagnosed with the disease, I noticed that I felt sad and depressed more than I expected. | | | | | |
| **Fifth: Relation of Spouse (the relationship between the spouses)** | | | | | |
| **84.** I've noticed that since my son was diagnosed with the disease, my husband (wife) does not give me help as much as I expected. | | | | | |
| **85.** As a sequel of my son's diseases problems happened in my relationship with my husband (wife) more than I expected | | | | | |
| **86.** Since my son was diagnosed with the disease, I and my husband (wife) became no longer share together in doing many things. | | | | | |
| **87.** Since my son was diagnosed with the disease, I and my husband (wife) became no longer spend a lot of time with each other in contrary to what I expected. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **88.** I lost my interest in sex since my son s was diagnosed with the disease. | | | | | |
| **89.** It seems that the problems with relatives have been rising after we got our diseased child. | | | | | |
| **90.** The presence of children had increased the cost of living more than I expected. | | | | | |
| **Sixth: Social Isolation** | | | | | |
| **91.** I feel lonely and without friends. | | | | | |
| **92.** When I go to a party, I usually expect that I will not rejoice. | | | | | |
| **93.** I no longer care of people as I used to do. | | | | | |
| **94.** I feel that people who are in my age do not like my company in particular. | | | | | |
| **95.** When I have problems with the care of my son I can resort to some people for help or advice. | | | | | |
| **96**-since I had children, the chance to see my friends and to make new friends declined. | | | | | |
| **Seventh: parent health (the health of the parents):** | | | | | |
| **97.** During the past six months, my health was more affected than usual or I had more aches and pains than I have under normal circumstances. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **98.** I feel that my health is good most of the time. | | | | | |
| **99.** The existence of a child I have, led to changes in my sleep system. | | | | | |
| **100.** I feel that my health is much better than before. | | | | | |
| **101.** Since my son was diagnosed with the disease: | | | | | |
| **1.** I became significantly ill. | | | | | |
| **2.** I never felt that my health is good. | | | | | |
| **3.** I didn't notice any changes in my health. | | | | | |

# APPENDIX B

# PARENTING STRESS INDEX

Supporting good behavior

1. Play with your child in a way that was fun for *both of you*?

2. Stand back and let your child work through problems s/he might be able to solve?

3. Invite your child to play a game with you or share an enjoyable activity?

4. Notice and praise your child's good behavior?

5. Teach your child new skills?

6. Involve your child in household chores?

7. Reward your child when s/he did something well or showed a new skill?

Setting limits

1. Stick to your rules and not change your mind?

2. Speak calmly with your child when you were upset with him or her?

3. Explain what you wanted your child to do in clear and simple ways?

4. Tell your child what you wanted him or her to do rather than tell him/her to stop doing something?

5. Tell your child how you expected him or her to behave?

6. Set rules on your child's problem behavior that you were willing/able to enforce?

7. Make sure your child followed the rules you set all or most of the time?

Proactive parenting

1. Avoid struggles with your child by giving clear choices?

2. Warn your child before a change of activity was required?

3. Plan ways to prevent problem behavior?

4. Give reasons for your requests?

_____

5. Make a game out of everyday tasks so your child followed through?

_____

6. Break a task into small steps?

_____

7. Prepare your child for a challenging situation?

_____

**Welcome Packet**

Welcome to the RISE/SOAR Parent Treatment Manual. This program is made to help you and your adolescent work together through treatment at your own schedules throughout the next ten weeks. The program will consist of an intake, an initial meeting with the clinician to learn more about the Circumplex Model of Marital and Family Systems, and a ten-week psychoeducational group of skills. It is important to understand where your tendencies lie as a family unit on the model in order to better focus on which skills may be the most beneficial to you throughout this module.

The Circumplex Model of Marital and Family Systems, as depicted in Figure 2, focuses on three dimensions of family systems: cohesion, flexibility, and communication. The green section of the model describes family systems that are balanced both cohesively and flexibly. The gray areas of the model are family systems that maybe functional in some aspects, but can be improved wither in terms of flexibility and cohesion.

## Cohesion

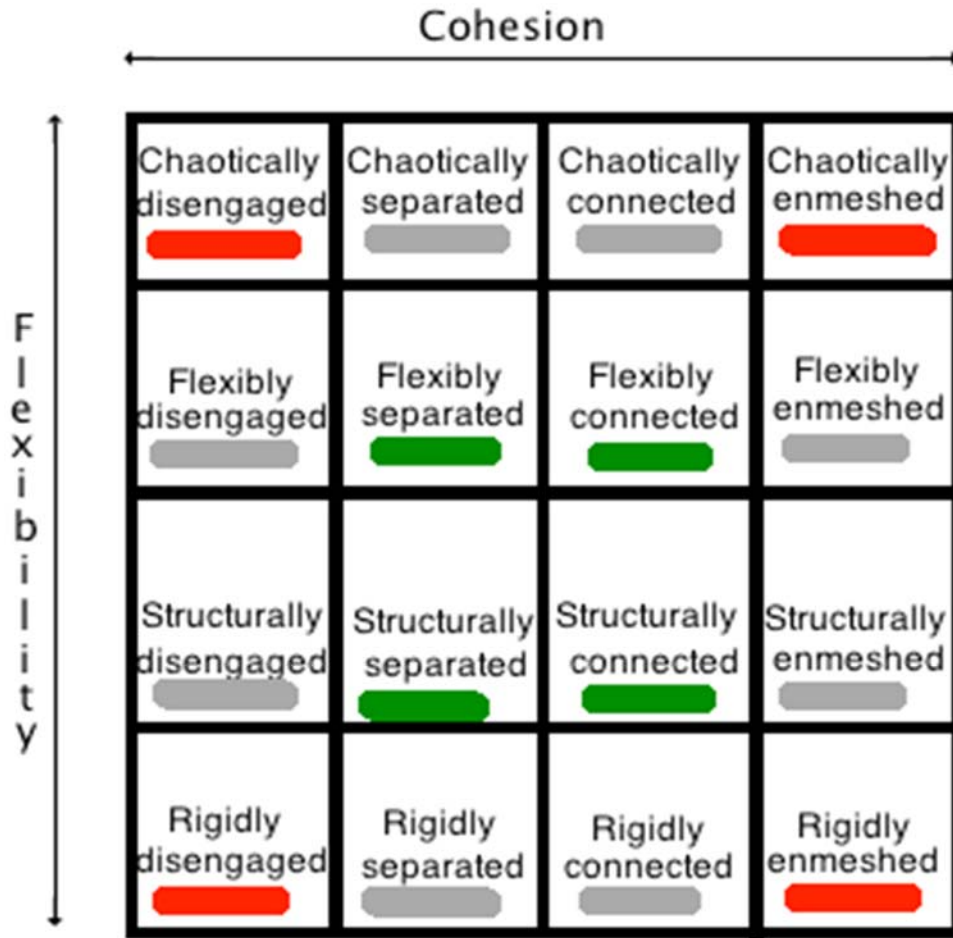| | | | |
|---|---|---|---|
| Chaotically disengaged | Chaotically separated | Chaotically connected | Chaotically enmeshed |
| Flexibly disengaged | Flexibly separated | Flexibly connected | Flexibly enmeshed |
| Structurally disengaged | Structurally separated | Structurally connected | Structurally enmeshed |
| Rigidly disengaged | Rigidly separated | Rigidly connected | Rigidly enmeshed |

*Figure 2*. Circumplex Model of Marital and Family Systems

The program will follow a ten-week rolling admission module, as depicted in Table 5, therefore it is important to see which skills the group has already learned, and which week's skills you are stepping into. Below is a schedule of the skills, and their corresponding weeks.

**Table 5.** *Weekly Parenting Skills*

| Week | Skill |
|---|---|
| Week 1: | Parental Emotional Support |
| Week 2: | Mindful Parenting |
| Week 3: | Limit Setting |
| Week 4: | Boundaries |
| Week 5: | Proactive Parenting |
| Week 6: | Flexibility |
| Week 7: | Listening/ Speaking Skills |
| Week 8: | Respect |
| Week 9: | Emotional Bonding |
| Week 10: | High Support/ Low control |

Attached are some notes you can take during the group sessions.

Week 1: _____

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Week 2: _____

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Week 3: _____

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Week 9: _____

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Week 10: _____

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