The role of parents in adolescent mental health: They matter more than we thought.

The Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults (CRPSIB)

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Reflection question

How is growing up now different than it was when you were young? What is similar and what has changed?
How I came to be here

“I think my greatest fear is to be forgotten. A teacher I had last year doesn’t even remember my name -- it makes me think that no one remembers me. How do I know I exist? At least I know I exist when I cut”

-- Self-Injury Message Board Post
It’s tough to be a teen anytime, but particularly in the contemporary era..

THE ADOLESCENT MENTAL HEALTH LANDSCAPE
The health paradox of adolescence

- Adolescence is (physically) the healthiest period of the lifespan: prior to adult declines; beyond the frailties of infancy and childhood:

- Yet: overall morbidity and mortality rates increase 200% from childhood to late adolescence

- Individuals are at greater risk of mental health challenges during adolescence than any other time

- Primary sources of death/disability are related to problems with control of behavior and emotion
Kids are also at high risk for mental health issues

- Rates of mental health challenges high and appear to be increasing

- Age of onset for most mental disorders is 18-24 but symptoms often begin earlier (most common are depression and anxiety)

- On any given day in the U.S., an estimated 6-8 million children (8%-10% of the 0-18 population) take medications for what are classified as mental health problems.

- The proportion of U.S. office visits that resulted in the prescription of a psychotropic medication among adolescents increased 250% from 1994 to 2001: The largest increase was for SSRIs and stimulants

- 13.9% of students have been diagnosed with a DSM IV classifiable disorder (29.3% believe they have struggled with a DSMIV disorder)

Changes in depression scores in college students by year (Twenge, et.al, 2010)
Global comparisons of rates of mental illness: The World Health Organization Study

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### Results

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Although disorder severity was correlated with probability of treatment in almost all countries, 35.5% to 50.3% of serious cases in developed countries and 76.3% to 85.4% in less-developed countries received no treatment in the 12 months before the interview. Due to the high prevalence of mild and subthreshold cases, the number of those who received treatment far exceeds the number of untreated serious cases in every country.
Even some of our most privileged youth are struggling.

(average = 5.88)
And growing up is increasingly complicated

- Reaching adulthood takes longer ("maturity gap")
- Lines between adolescence and adulthood blurry
- Acquiring all skills required to be an adult is more difficult than ever
- We are living in exponential times: [Living in Exponential times](#)
- Net result: The process of navigating the many developmental tasks associated with moving into adulthood is increasingly complicated
Where do parents fit in?
We all instinctively know that parents matter.
Particularly in childhood
But a teenager’s job is to begin moving out into the world, so how much do parents matter then?

Especially when we consider the myriad other influences that affect youth functioning, growth, and wellbeing...

Social and economic trends and pressures

Targeted marketing

Neuro/biology

Peers

Technology
We did not set out to study parents: Study of Self-Injurious Behaviors in Adolescents and Young Adults

Establishing Baseline Epidemiology
- Basic characteristics, risk and protective factors, comorbidity, disclosure & help-seeking, identification of sources of contagion

Recovery and trajectories
- Factors contributing to recovery, evolution of using NSSI over time, contribution of NSSI to wellbeing perspectives

Effective outreach and prevention
- Development of strength-based, participatory approaches to NSSI assessment, intervention, and prevention
But that changed over time…
A few key findings
Objectives:
To assess student mental health and wellbeing with particular focus on non-suicidal self-injury, suicide, wellbeing, risk and protective factors, and help seeking in a community population of young adults

Methods:
• Cross-sectional survey administered in 8 universities (Cornell, Princeton, Harvard, Columbia, U. North Dakota, Youngstown State, MIT, U of Rochester) (total n=14,372)

• Simple random sample of 10,655 Cornell graduate and undergraduate students; 4,150 participated (RR= 38.9%)

• Administered via web-based survey in 2006-2007 academic year

• Representative of all known population parameters, with the exception of more female than male respondents.

• All analysis conducted controlling for design effects
We found that parents were present even when not present..
That parents are primary sources for advice and comfort when students are sad, depressed, or anxious.
That parents are the most helpful people to talk to about serious mental health issues, such as self-injury (n=833):
That most teens from whom self-injury is silent want to talk to their parents.
Parents emerged as so important from this study that we concluded:

- Education and outreach is warranted for social network gatekeepers, namely parents and peers. Focus should include enhancing links with institutional gatekeepers.
Study 2: Longitudinal study in 5 colleges (SSWH 2006 – 2009)

Objectives:
To longitudinally investigate the relationship between NSSI and suicidality in a young adult sample

To longitudinally assess psychological distress trajectories over time and to identify key contributors to the onset of distress in a young adult sample

Methods:
• Simple random sample of undergraduate and graduate students drawn from 8 universities (n=14,372; overall response rate of 38.9%) using measures from the Survey of Student Wellbeing administered via web-based survey in 2006-2007 academic year.

• Longitudinal study in 5 of 8 original schools (3 private, 2 public). Wave I-III data on 1,466 individuals (2006-2009)
Key Measures

Suicide (Kessler et al., 2005)

Self injury (NSSI-AT; Whitlock & Purington, 2010)

Global psychological distress (K-6; Kessler, 2002)
  • Captures DSMIV classifiable anxiety and distress in past 30 days

Demographics
  • Sex
  • Sexual orientation
  • Ethnicity / race
  • SES

Psychological traits
  • Optimistic or pessimistic cog style
  • Emotion regulation
  • Sense of presence of meaning in life
  • Endorsement of aggression
  • Life satisfaction

History of trauma or abuse (emo, phys, sex)

History of mental illness
  • Subjective and diagnosed (self)
  • Parental diagnosed

Social connectedness
  • Number of confidants
  • Category of confidant
  • Perceived peer connectedness

Mental health treatment
  • History of MH treatment
  • Attitudes toward treatment (stigma)
Trajectories over time using NSSI, SI/SA, and K-6 (PD)

28.7% of all students at time 1 had a history of PD or experienced onset of PD over the subsequent 2 years.

10.5% students are adding some form of PD within a 2 year period.

When restricted to <20 yo at T1:

31.7% of all students at time 1 had a history of PD or experienced onset of PD over the subsequent 2 years.

12.4% students are adding some form of PD in a two year period.
What differentiates individuals with NSSI history who do and do not progress onto SI/SA? (adjusted logistic regression analysis)

- Mother history of MI
- History of MH treatment (2.2)
- Personal history of MI
- Psychological distress
- Confidant categories:
  - No one
  - Peers only (1.0)
  - Peers and adult professionals (1.0)
  - Peers, professionals, and informal adults (.7)
  - Parents (.3)
- NSSI lifetime frequency (>20, 3.9)
- Presence of meaning in life (.7)
- Pessimistic cognitive style
- Perceived social isolation
- Emotional regulation and processing

Progress to SI/SA from NSSI
When we asked a similar question to determine what predicts who is at risk for later psychological distress (as measure by NSSI, suicidality, and global psychological distress) parents *again* emerge as key factors.

![Diagram showing factors related to psychological distress]

- History of MH treatment
- History of physical abuse
- SES
- Number of traumas reported
- Pessimistic cognitive style (this alone correctly categorizes 70% of individuals in the risk condition)
- Emotional regulation and processing
- Perceptions of therapy
- Presence of meaning in life
- Endorsement of aggression
- Confidant categories:
  - No one
  - Peers only
  - Peers and adult professionals
  - Peers, professionals, and informal adults
  - Parents
- Model identified would correctly predict 84 of every 100 people at risk for conversion

Progress from no PD at time 1 to PD by T3 (ROC curve analysis classifying 58%-75% of individuals who convert)
Our current study: The role of parents in NSSI recovery
Why study parental roles in NSSI recovery?

Theoretical reasons:

- Parental contributions to etiology of maladaptive behaviors is well documented
  - Parental contributions to recovery less well understood and studied

- Parent-child interactions are important after disclosure/discovery:
  - Indirect modeling of communication styles and emotion regulation, expressivity, and cognitions
  - Directly through response to and regulation of child behavior
The Current Study

Objectives:

❖ To identify key processes and turning points in recovery from youth and parent perspectives

❖ To identify key dynamic processes in family and parent-child interaction patterns

Sample and procedure:

❖ Recruit 35 families (dyads or triads):
  ❖ Youth with NSSI experience and their parents

❖ On-line survey assessing family interaction style, emotion acceptance and regulation, communication styles, and family warmth

❖ Interviews: key events, turning points, processes, and exchange patterns

❖ 9 parent and 11 youth interviews complete; 7 family units (2 with 3 members)
Parents and children may identify very different events as key.

When an event is characterized as key by both parent and child, the meaning may vary dramatically.

Disclosure/discovery moment provides a window of opportunity for parental knowledge gain which may shut without vigilance.

There is low correspondence between parent and child in stage of the process (youth are in middle or end when parents are beginning).

Parents are often ill equipped to respond effectively and this is complicated by developmental issues also occurring.

Therapy plays a different role for youth and parents.
Our future work will focus on development of

- Deepening understanding of how parents contribute to recovery and later thriving

- Development of interventions for parents of youth who injure and young adults in general aimed at building their own capacity for emotion regulation, mindfulness and positive communication

- Development of trainings and curricula for parents and those who work with parents on use of mindfulness principles and practices in parenting to support “existential resilience” and connectedness in youth
Taking the long view: It is all downhill from here.

Except for the way it all feels

$N = 4,960$

MIDUS II
Since it is how we feel that really matters, life only gets better over time!
Reflection question

What do you take away from this? What should we be looking at that I have not mentioned?
Thank you!