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Parental Bonding in Non-Suicidal Self-Injuring (NSSI), Suicidal, and Normal Young Adults

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ABSTRACT

A combination of good and bad events is called a balanced life. But a balanced life depends on how the individual perceives and deals with the situation. The present exploratory study was conducted with the aim, firstly, to study the level of perceived parenting in NSSI, suicidal, and normal young adults, and secondly, to compare the level of perceived parenting in NSSI, suicidal, and normal young adults. For the purpose Personal Data Schedule, Parental Bonding Inventory, Beck Depression Inventory, and Structured interview (Life style modification factor) was employed on 200 (100 males + 100 females) young adults out of which 22 (13 males + 9 females) reported NSSI, 17 (12 males + 5 females) reported suicidal ideation and 30 (15 males + 15 females) normal young adults were selected randomly. Results revealed that Mother Care, Mother Overprotection, and overall Parental Care have significant differences between NSSI and normal young adults, NSSI and Suicidal ideation young adults, and Suicidal ideation and normal young adults. Further studies with a larger sample size, age diversity, gender studies, and sophisticated statistical techniques are required.

Keywords: Non-suicidal Self Injury, Suicidal Ideation, Young Adults, Parental Bonding.

INTRODUCTION

Life is good when it is full of joy, happiness, good physical and mental health, and a completely balanced environment. On the other hand, if there is any imbalance of these things, life becomes worse and ruins itself. Balanced and unbalanced situations or environments are two sides of the same coin. A maladjusted person and a well-adjusted person may approach these situations differently. Some people cope with these situations, but most of the individuals do self-harm and other unacceptable social activities. The DSM-5 has added nonsuicidal self-injury (NSSI) as a new diagnostic category [1]. Nonsuicidal self-injury is when the individual repeatedly inflicts shallow, yet painful injuries to the surface of his or her body. The individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his/her body of a sort likely to induce bleeding, bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent) [1]. Family environment or parental involvement in an individual's life plays an essential role. NSSI is linked to strong psychological control, high reactive control, and low parental support [2].

Lack of adequate research studies in the past decade on NSSI in India is reported in previous studies [3, 4]. This revelation

indicates ignorance towards the severity of the problem and also a lack of understanding of the intricacies of overlap between NSSI and suicidal ideation. Further, the lack of information about the varied psychic peels functioning under the exhibition of NSSI behaviour creates a huge gap in knowledge about NSSI.

The information regarding NSSI behaviour in adolescents is, though not adequate, but in young adults, it becomes rarer. In adolescents, any maladaptive exhibition of behaviour seems to be generally explainable due to several psycho-physiological changes encountered in this developmental period, but in young adulthood, the assumption of normality. Paucity of research on young adults exhibiting NSSI behaviour makes the present research a vital research initiative in the area.

The following objectives guided the conduct of the current study:

To study the level of perceived parenting in NSSI, suicidal, and normal young adults.

To compare the level of perceived parenting in NSSI, suicidal, and normal young adults.

MATERIALS AND METHODS

For the present research, a mixed-methods research approach with an exploratory sequential design was employed. In the present study, a simple randomization was employed to select the sample. This study focuses on young adults of Nagar Palika Parisad, Pithoragarh. The randomly selected sample of the present study consisted of 69 (22 = NSSI, 17 = Suicidal, 30 = normal) young adults aged 18–29 years old.

The sampling process was completed in two phases. The phases are as follows:

Phase-I:

In phase one, Personal Data Schedule (PDS) and Beck Depression Inventory-II (BDI-II) were administered on randomly selected 200 (100 boys + 100 girls) young adults from various institutions located in Nagar Palika area of Pithoragarh. 17 incomplete forms were initially removed. 74 young adults who were pregnant, lactating, reported a history of drug and substance abuse, and intake of medication for any diagnosed psycho-physiological problems were also excluded from the sample. Then, 109 samples were explored for the symptoms of NSSI and suicide intentions. 23 NSSI, 19 suicidal, and 67 normal young adults were identified. Then the tools were administered on the sample selected.

Phase-II:

The structured interview was conducted to obtain more information about the lifestyle modification factors, cyber usage, and self-harming behavior. For this phase, one NSSI, two suicidal, and 37 young adults were unavailable for the interview. Hence, the sampling was completed on 69 (22= NSSI, 17 = suicidal, and 30= normal) young adults. For the present study, the following kinds of tools were used:

1. **Personal Data Schedule:** This Personal Data Schedule was created by the researcher. In this questionnaire, there are several questions relating to the personal lives of young adults, name, father's name, mother's name, age, height and weight, address, etc.
2. **Parental Bonding Instrument:** The parental bonding instrument (PBI) [5] has two scales termed ‘care’ and ‘overprotection’ or ‘control’, which measure fundamental parental styles as perceived by the child. The measure is ‘retrospective’, meaning that adults (over 16 years) complete the measure for how they remember their parents during their first 16 years. The measure is to be completed for both mothers and fathers separately. There are 25 item questions, including 12 ‘care’ items and 13 ‘overprotection’ items. Participants are asked to rate each parent on a 4-point liker scale, in which 0 is very like, 1 is moderately like, 2 is moderately unlike & 3 is unlike the parent in question.

   Reliability and Validity: In the original study, the PBI possessed good internal consistency and test-retest reliability. The PBI has been shown to have

satisfactory construct and convergent validity and to be independent of mood effects [5].

3. **Structured interview (Lifestyle modification factor):** This structured interview has been created by the researcher. In this questionnaire, the questions are based on the young adult's daily life routine, food habits, sleeping patterns, internet uses and, mobile content, drug and alcohol consumption, NSSI behaviour, etc.
4. **Beck Depression Inventory (BDI-II):** The Beck Depression Inventory-second edition is a 21-item self-report instrument for measuring the severity of depression in adults and adolescents aged 13 years and older. The version of the inventory (BDI-II) was developed for the assessment of symptoms corresponding to criteria for the diagnosis of depressive disorder listed in the APA Diagnostic and Statistical Manual of Mental Disorders. In BDI-II, 21 depressive symptoms and attitudes were chosen by Beck [6]. These items are: 1) Mood, 2) Pessimism, 3) Sense of failure, 4) Self-dissatisfaction, 5) Guilt, 6) Punishment, 7) Self-dislike, 8) Self-accusations, 9) Suicidal ideas, 10) Crying, 11) Irritability, 12) Social withdrawal, 13) Indecisiveness, 14) Body image change, 15) Work difficulty, 16) Insomnia, 17) Fatigability, 18) Loss of appetite, 19) Weight loss, 20) Somatic preoccupation & 21) Loss of libido. The BDI consists of 4 scales. The cut score guideline for these scales from total scores of patients diagnosed with major depression is 0-13 for minimal depression, 14-19 for mild depression, 20-28 for moderate, and 29-63 for severe depression [6].

The tools were administered in three phases, which are as follows:

Phase I: In phase one, the Personal Data Schedule (PDS) and Beck Depression Inventory-II (BDI-II) were administered to the young adults. Then, PDS and BDI-II were explored for NSSI and suicidal behaviours.

Phase II: The second phase was completed with the administration of the Parental Bonding Instrument (PBI). This tool was applied to the sample (the categorized groups) for obtaining the quantitative data.

Phase III: The third phase involved the structured interview conducted to obtain more information about the lifestyle modification factors, cyber usage, and self-harming behavior.

Statistical Methods

Descriptive Statistics: In descriptive statistics, the mean and standard deviation (SD) were computed to know the nature of the dependent variables.

Inferential Statistics: In inferential statistics, one-way ANOVA and least significant difference (LSD) as post hoc were calculated by SPSS-20.

RESULTS

The sample is divided into three groups; details related to the groups are in the following table (Table 1):

Table 1: Details of the sample

S. No.	Name Of Group	Male	Female	Sample Size
1.	NSSI	13	9	22
2.	Suicidal ideation	12	5	17
3.	Normal	15	15	30
Total		40	19	69

Table 2. Mean, SD of young adults NSSI group (N=22)

S. No.	Dependent Variables	Mean	SD
1.	Mother Care	24.73	5.119
2.	Mother Overprotection	19.55	6.69
3.	Father Care	25.39	6.34
4.	Father Overprotection	17.27	5.13

5.	Parental Care	50.50	8.88
6.	Parental Overprotection	36.36	10.45
7.	PBI	86.82	11.64

Table 3. Mean, SD of young adults Suicidal Ideation group (N=17)

S. No.	Dependent Variables	Mean	SD
1.	Mother Care	24.412	5.95
2.	Mother Overprotection	15.82	3.45
3.	Father Care	24.18	5.102
4.	Father Overprotection	17.059	4.75
5.	Parental Care	48.589	10.22
6.	Parental Overprotection	32.88	7.38
7.	PBI	80.88	8.99

Table 4. Mean, SD of young adults Normal group (N=30)

S. No.	Dependent Variables	Mean	SD
1.	Mother Care	28.70	4.46
2.	Mother Overprotection	15.57	4.63
3.	Father Care	27.033	5.62
4.	Father Overprotection	14.53	5.75
5.	Parental Care	55.70	9.041
6.	Parental Overprotection	30.10	8.91
7.	PBI	85.47	9.51

Table 5: ANOVA on Mother care (MC)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	287.422	2	143.711	5.603	**SIG**
Within groups	1692.781	66	25.648		
Total	1980.203	68			

Table 5.1: Post hoc: Least Significant Difference (LSD) on Mother Care (MC)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	.31	1.63	NS
	Normal	-3.97	1.42	**SIG**
Suicidal	NSSI	-.31	1.63	NS
	Normal	-4.29	1.54	**SIG**
Normal	NSSI	3.97	1.42	**SIG**
	Suicidal	4.29	1.54	**SIG**

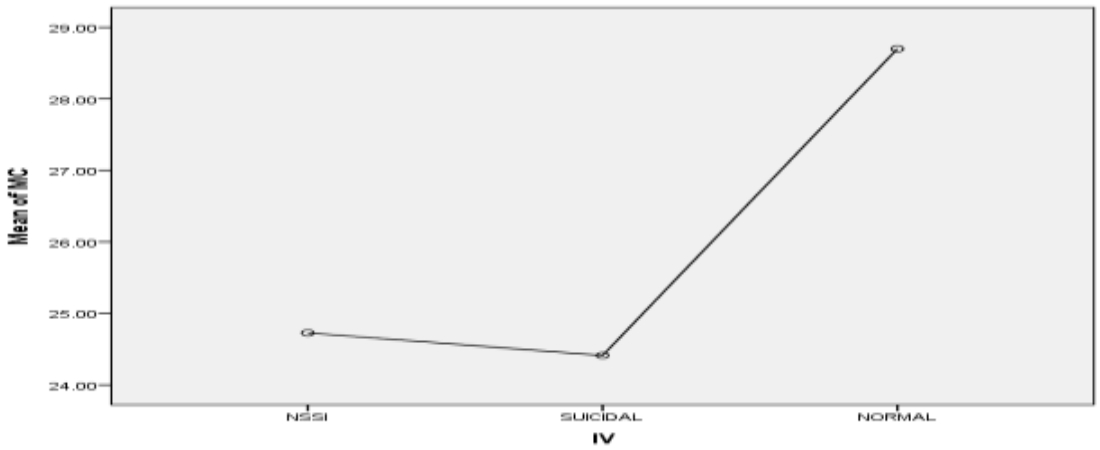

FIG.1: Plotting of the mean of Mother Care (MC)

On observing the results on MC in Table 5, it was revealed that there is a significant difference among the groups. Table 5.1 reflects significant differences between NSSI-normal and suicidal-normal young adults. It is found that there is no significant difference between NSSI-suicidal young adults. On observing the plot of means of the groups on MC given in FIG. 1, it is clear that the mean of normal young adults is higher than that of NSSI and suicidal young adults.

Table 6: ANOVA on Mother Overprotection (MO)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	226.998	2	113.499	4.277	**SIG**
Within groups	1751.292	66	26.535		
Total	1978.290	68			

Table 6.1: Post hoc: Least Significant Difference (LSD) on Mother Overprotection (MO)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	3.72	1.66	**SIG**
	Normal	3.98	1.44	**SIG**
Suicidal	NSSI	-3.72	1.66	**SIG**
	Normal	.26	1.56	NS
Normal	NSSI	-3.98	1.44	**SIG**
	Suicidal	-.26	1.56	NS

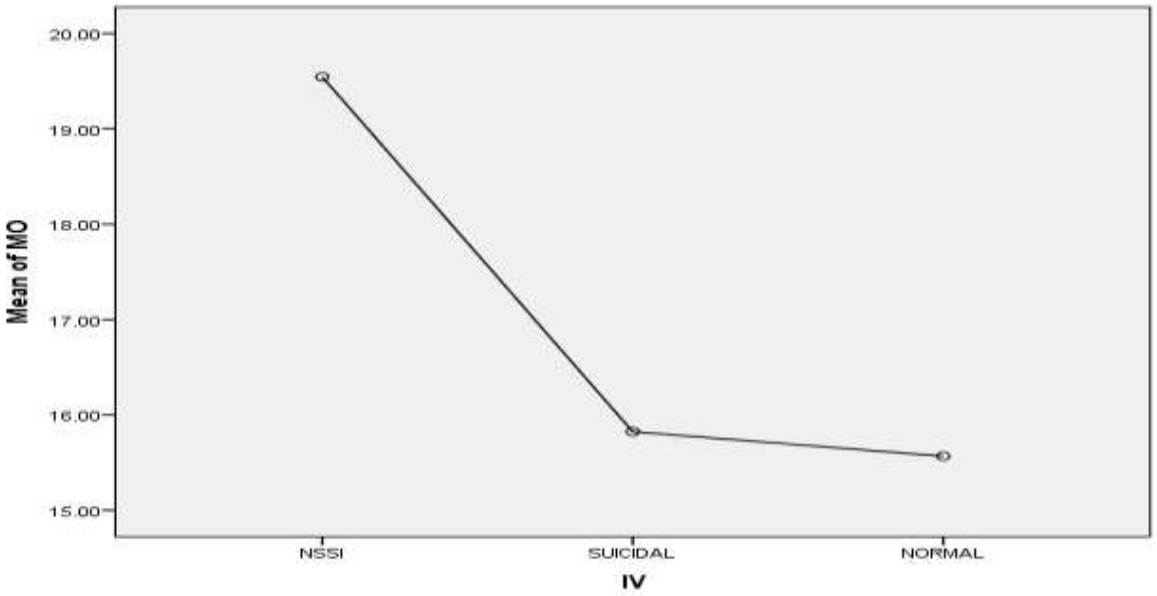

FIG.2: Plotting of the mean of Mother Overprotection (MO)

Table 6 reveals a significant difference among groups on the variable MO. The significant difference between NSSI-suicidal and NSSI-normal is observed in Table 6.1. On analysing the plot of means of groups on MO (FIG.2), it is revealed that in NSSI young adults, MO is found to be more than in suicidal and normal young adults.

Table 7: ANOVA on Father Care (FC)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	95.529	2	47.765	1.447	NS
Within groups	2178.210	66	33.003		
Total	2273.739	68			

Table 7.1: Post hoc: Least Significant Difference (LSD) on Father Care (FC)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	1.14	1.85	NS
	Normal	-1.71	1.61	NS
Suicidal	NSSI	-1.14	1.85	NS
	Normal	-2.86	1.74	NS
Normal	NSSI	1.71	1.61	NS
	Suicidal	2.86	1.74	NS

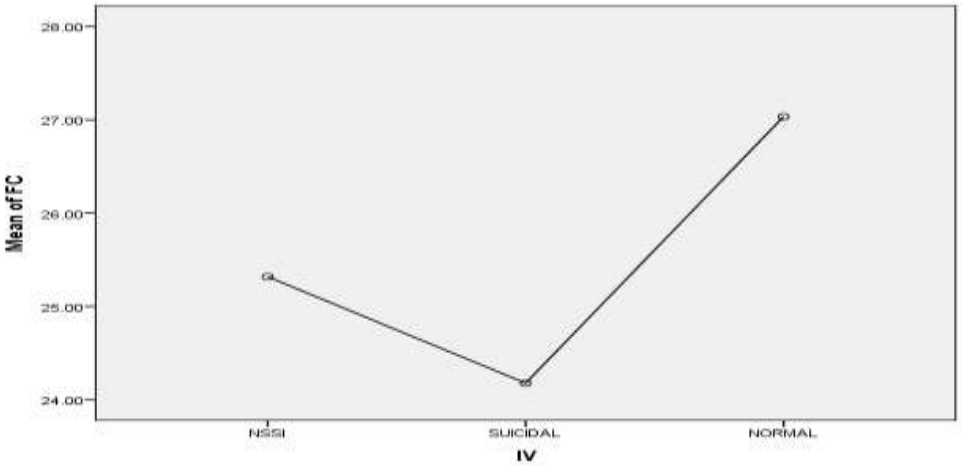

FIG.3: Plotting of the mean of Father Care (FC)

Table 7 shows that there is no significant difference among groups on the variable FC. Table 7.1 reveals that all the groups have no significant difference between them. FIG. 3 indicates the means of the three groups on FC. FC is higher in normal young adults than in NSSI and suicidal young adults.

Table 8: ANOVA on Father Overprotection (FO)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	119.171	2	59.585	2.100	NS
Within groups	1872.771	66	28.375		
Total	1991.942	68			

Table 8.1: Post hoc: Least Significant Difference (LSD) on Father Overprotection (FO)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	.21	1.72	NS
	Normal	2.73	1.49	NS
Suicidal	NSSI	-.21	1.72	NS
	Normal	2.52	1.61	NS
Normal	NSSI	-2.74	1.49	NS
	Suicidal	-2.52	1.61	NS

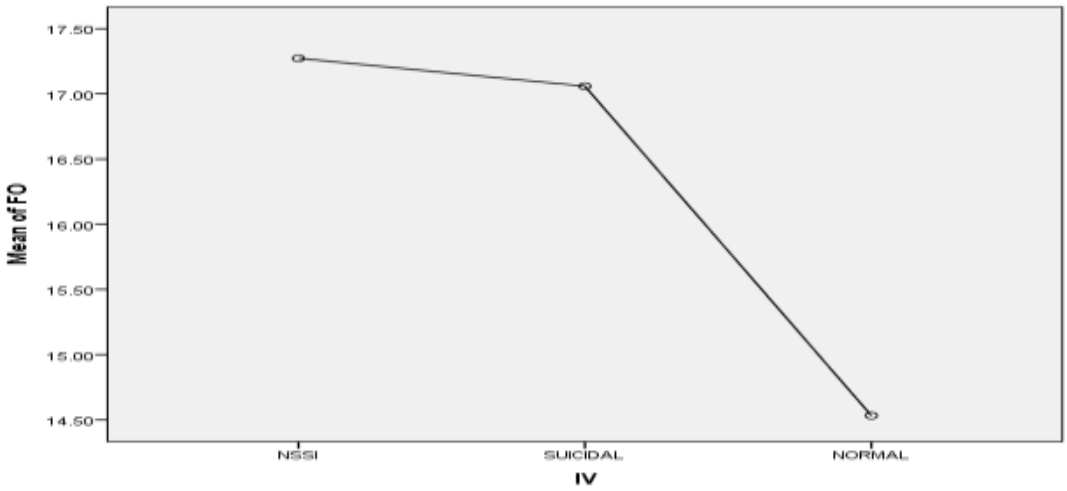

FIG.4: Plotting of the mean of Father Overprotection (FO)

Table 8 shows that there is no significant difference among groups on the variable FO. Table 8.1 reveals that all the groups have no significant difference between them. FIG. 4 indicates the means of the three groups on FO. FO is higher in NSSI and suicidal young adults than in normal young adults.

Table 9: ANOVA on Parental care (PC)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	652.285	2	326.143	3.778	**SIG**
Within groups	5697.918	66	86.332		
Total	6350.203	68			

Table 9.1: Post hoc: Least Significant Difference (LSD) on Parental care (PC)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	1.91	3.00	NS
	Normal	-5.20	2.60	**SIG**
Suicidal	NSSI	-1.91	3.00	NS
	Normal	-7.11	2.82	**SIG**
Normal	NSSI	5.20	2.60	**SIG**
	Suicidal	7.11	2.82	**SIG**

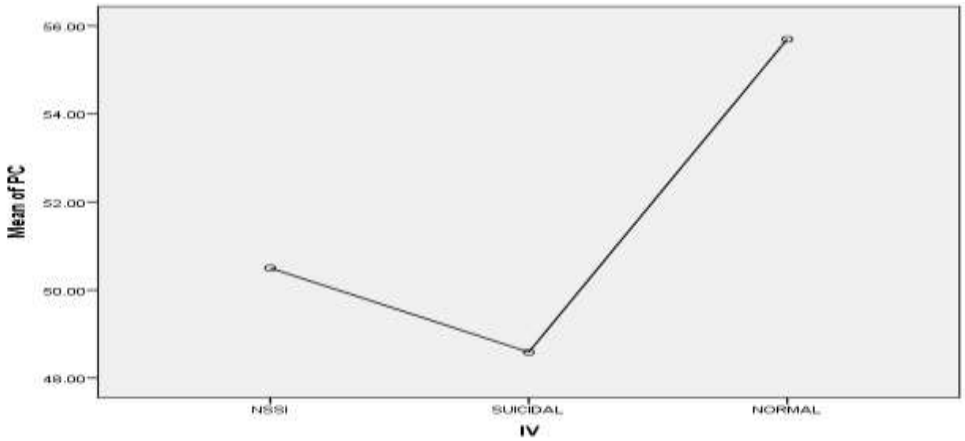

FIG.5: Plotting of mean of Parental care (PC)

Table 9 shows ANOVA on Parental care. It reveals a significant difference among the groups. The significant difference between NSSI-normal and suicidal-normal is observed in Table 9.1. The non-significant difference between NSSI-suicidal is revealed in this table. On analysing the plot of means of groups on PC (FIG.5), it is revealed that in normal young adults, PC is found to be more than in suicidal and NSSI young adults.

Table 10: ANOVA on Parental Overprotection (POP)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	498.184	2	249.092	2.007	NS
Within groups	5467.556	66	82.842		
Total	5965.739	68			

Table 10.1: Post hoc: Least Significant Difference (LSD) on Parental Overprotection (POP)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	3.48	2.94	NS
	Normal	6.26	2.55	**SIG**
Suicidal	NSSI	-3.48	2.94	NS
	Normal	2.78	2.76	NS
Normal	NSSI	-6.26	2.55	**SIG**
	Suicidal	-2.78	2.76	NS

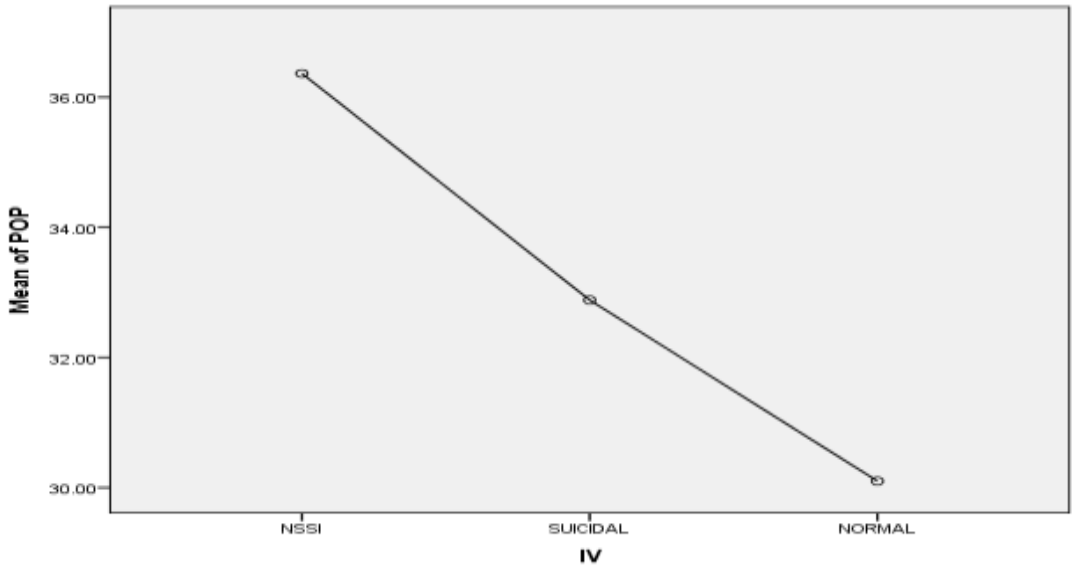

FIG.6: Plotting of the mean of Parental Overprotection (POP)

Table 10 shows the non-significant difference among groups on the variable POP. Table 10.1 reflects a significant difference in the NSSI-normal young adults and a non-significant difference in NSSI-suicidal, suicidal-normal young adults. FIG. 6 is the plot of the means of three groups on POP. The means of NSSI among young adults is higher than that of suicidal and normal young adults.

Table 11: ANOVA on Perceived Parenting (PP)

S. No.	Sum of Square	Degree of freedom (df)	Mean Square	F value	Level of significance at 0.05
Between groups	363.786	2	181.893	1.775	NS
Within groups	6762.504	66	102.462		
Total	7126.290	68			

Table 11.1: Post hoc: Least Significant Difference (LSD) on Perceived Parenting (PP)

Groups (I)	Comparisons to groups (J)	Mean Difference (I-J)	Std. Error	Level of significance at 0.05
NSSI	Suicidal	5.93	3.27	NS
	Normal	1.35	2.84	NS
Suicidal	NSSI	-5.93	3.27	NS
	Normal	-4.58	3.07	NS
Normal	NSSI	-1.35	2.84	NS
	Suicidal	4.58	3.07	NS

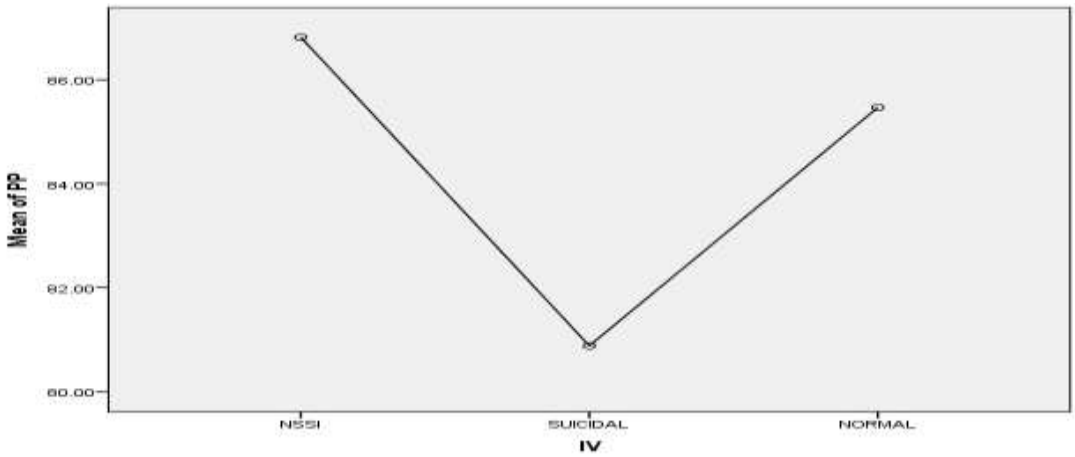

FIG.7: Plotting of the mean of Perceived Parenting (PP)

Table 11 shows there is no significant difference among groups on the variable PP. Analyzing Table 11.1 reveals that all the groups have no significant difference between them. FIG. 7 reveals that in NSSI and normal young adults, PP is found to be more than in suicidal young adults.

DISCUSSION

The aim of the present study was to compare the perceived parenting in NSSI, Suicidal, and Normal young adults. [7] revealed that the college-going students exhibiting self-injurious behavior have anxious attachments, are preoccupied with relationships, and require approval. Our findings are in tangential agreement as both NSSI and suicidal young adults report significantly lower mother care in comparison to their normal counterparts, which may be due to their anxious attachments to their mother, which can be understood by [8] revelation that a child becomes anxious if the parental affection is insufficient or unreliable.

Our findings are partially supported by the previous studies. The NSSI young adults reported maternal overprotection significantly higher than normal or suicidal which is also revealed by [9] in their study that young adults using NSSI behaviours characterize their parents as less caring, less trustful, difficult to communicate with and their early parent-child relationship as having feelings of failed protection, fear related to parent's abdication of their roles, more control exerted by parents and increased feelings of alienation from parents. This can be explained, in the Indian context, that an Indian child (referring to the male child) faced with the mother's unconscious intimations and demands, feels confused, helpless, and inadequate, frightened by his mother's overwhelming nearness and yet unable to get away, makes him fantasize her presence as the ominous visage of the 'bad mother' [8].

[10] observed that low parental care was more significantly associated with NSSI. The present study stated that parental care can affect the behavior of young adults. Thus, we can say the present study is consistent with the previous study.

[11] analysed that the protective effects of parents were negatively associated with

NSSI. The present study also observed that parental overprotection influences the behavior of young adults. Thus, the present study is consistent with previous studies.

[12] observed that adolescents who do not perceive autonomy support from their parents may turn to NSSI. The present study shows that NSSI young adults have higher perceived parenting than suicidal young adults. The present study observed that high and low levels of perceived parenting are associated with young adults' behavior.

CONCLUSION

Suicide and NSSI have a comorbid relationship. These two conditions share similar actions, yet they differ greatly in terms of suicidal intent and NSSI. In this present study, they both played a different but impactful role in perceived parenting. NSSI and Suicidal Ideation are not directly impacting the overall perceived parenting, but they are influencing the sub-categories or part of the perceived parenting, such as Mother Care (MC), Mother Overprotection (MOP), and Parental Care (PC). The study concludes that mother care and mother protection make more impact on the behavior of NSSI and suicidal ideation.

Declaration by Authors

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REFERENCE

1. American Psychiatric Association (2013). Diagnostic & Statistical Manual of Mental Disorders (5th ed.). United States of America: American Psychiatric Association Press, pp.155, 803-804.
2. Fong ZH, Loh WNC, Fong YJ, Neo HLM, Chee TT. Parenting behaviors, parenting styles, and non-suicidal self-injury in young people: a systematic review. Clin Child Psychol Psychiatry. 2022 Jan;27(1):61-81. doi: 10.1177/13591045211055071.
3. Aggarwal, S. & Berk, M. (2014). Evolution of adolescent mental health in a rapidly changing socioeconomic environment: a review of mental health studies in adolescents in India over last 10 years. *Asian J Psychiatr.*13, pp.3-12. DOI: 10.1016/j.ajp.2014.11.007.
4. Agrawal, V. & Tiwari, R. (2017). Nonsuicidal Self Injury in Children and Adolescents. *J. Indian Assoc. Child Adolesc. Ment. Health*. 13(2), pp.74-81.
5. Parker, G., Tupling, H., and Brown, L.B. (1979) A Parental Bonding Instrument. British Journal of Medical Psychology, 1979, 52, pp.1-10.
6. Beck, A.T., Steer, R.A. & Brown, G.K. (1996). BDI-II manual-2nd ed. USA: Person Group (Psychocorp), pp.1-11.
7. Kharsati, N. & Bhola, P. (2016). Self injurious behavior, emotion regulation, and attachment styles among college students in India. *Industrial Psychiatry Journal.* 25(1), DOI: 10.4103/0972-6748.196049.
8. Kakar, S. (1981). The Inner world: A psychoanalytic study of childhood and society in India. New Delhi: Oxford University Press.
9. Bureau, J-F., Martin, J., Freynet, N., Poirier, A.A., Lafontain, M-F. & Cloutier, P. (2010). Perceived dimension of parenting and non-suicidal self-injury in young adults. *Journal of Youth and Adolescence.* 39, pp.484-494; DOI: 10.1007/s10964-009-9470-4.
10. Saldias, A., Power, K., Gillanders, DT., Campbell, CW. &Blake, RA. (2013). The mediatory role of maladaptive schema between parental care and non-suicidal self-injury. *Cognitive Behaviour Therapy.* DOI: 10.1080/16506073.2013.781671.
11. Taliaferro, LA., Jung, S. T., Westers, NJ., Muehlenkamp, JJ., Whitlock, JL. & McMorris, BJ. (2019). Associations between connections to parents and friends and non-suicidal self-injury among adolescents: the mediating role of developmental assets. *Clinical Child Psychology and Psychiatry.* DOI: 10.1177/1359104519868493.
12. Emery, AA., Heath, NL. & Rogers, M. (2017). Parent's role in early adolescents self-injury: an application of self-determination theory. *School Psychology Quarterly.* 32(2), pp.199-211; DOI: 10.1037/spq0000204.

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