

RECOVERY FROM DELIBERATE SELF-HARM:
PERSPECTIVES FROM THOSE WHO HAVE SURVIVED
AND FROM THOSE WHO HAVE HELPED

A Thesis

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Bethany Lee Gelinias, candidate for the degree of Doctor of Philosophy in Clinical Psychology, has presented a thesis titled, ***Recovery from Deliberate Self-Harm Perspectives from Those Who Have Survived and From Those Who Have Helped***, in an oral examination held on November 27, 2015. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

Interventions for adolescents who engage in deliberate self-harm are notoriously challenging and negligibly effective. Self-harming adolescents often keep their behaviours a secret, do not see their self-harm as a problem, and rely heavily on parents and friends for support and assistance in help-seeking. In fact, social support, particularly via friends and family members, has been identified as one of the most crucial components to self-harm recovery. Although parents and friends are vital to help-seeking and recovery, little is known about the lived experience of parents and friends in supporting someone who self-harms. What little is known indicates that parents and friends struggle with self-harm, as they feel uninformed, unsupported, and often overwhelmed. Mental health professionals and programs would do well to capitalize on the existing primary sources of social support; however, a better understanding of their experiences, perceptions, and struggles are required first. The current study transpired through three stages, involving in-depth interviews with: (1) 10 individuals who have recovered from adolescent self-harm, (2) 10 friends of recovered individuals, and (3) 10 parents of recovered individuals. The current study addressed three main objectives: (1) elucidating the perspective and experience of individuals who have recovered from self-harm, particularly in terms of help-seeking, recovery, and their support needs, (2) elucidating the perspective and experience of friend-caregivers, and (3) elucidating the perspective and experience of parent-caregivers. By examining the retrospective perceptions of recovered individuals, we have gained insight into the wants and needs of a sub-population that is often secretive and uncommunicative. The current study reports on recovered individuals' experiences with parental involvement, friend involvement,

help-seeking, recovery, and support needs. In turn, by examining the perspectives of caregivers, we can gain insight into the wants and needs of the social support system that is in the best position to aid and support self-harming individuals. The current study reports on caregivers' experiences in the caregiving role, actions in the caregiving role, and perceived support needs. The following key messages were reported across participant groups and were derived from recovered individuals', friend-caregivers', and parent-caregivers' lived experiences. First, direct communication about self-harm is essential to the recovery process. Second, viewing self-harm as an attention-seeking behavior is disadvantageous. Third, self-harm has a widespread and longstanding influence for self-harming individuals as well as caregivers. Fourth, supports are desperately needed for both adolescents and their caregivers throughout the recovery process. Fifth, school systems are integral to improving education and awareness about self-harm. Sixth, psychoeducational support groups are believed to hold widespread treatment potential for adolescents as well as caregivers. The knowledge gained can be used to better inform and implement prevention and treatment strategies for self-harming individuals, as well as for caregivers. Gaining a multidimensional perspective on the self-harm dilemma provides a more comprehensive overview of support opportunities and potential clinical innovations. The corroboration and consensus provided across recovered individuals, friend-caregivers, and parent-caregivers helps focus future directions. In sum, by learning from the experiences of individuals who have lived through the process of recovery from self-harm, the current study augments our understanding of the process, and directs future research and clinical interventions.

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Dedication

To Jordan.

Perhaps I'll write something else of worth in the future and dedicate that to the others,
but for now, this one is for you.

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1.0 Introduction

1.1. Adolescent Self-harm

The occurrence of deliberate self-harm (referred to as self-harm herein) is commonly defined as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur (Chapman & Dixon-Gordon, 2007; Deliberto & Nock, 2008; Favazza, 1998; Gratz, 2001). The word deliberate distinguishes these behaviours from harmful consequences that are unintended (e.g., lung cancer from smoking), and the word direct makes a distinction from indirect methods of affecting body tissues such as chronic alcohol ingestion or overdose. Other terms used throughout the literature to reference this behaviour include non-suicidal self-injury (Klonsky, 2007), parasuicide (Colman, Newman, Schopflocher, Bland, & Dyck, 2004), and self-mutilation (Brain, Haines, & Williams, 2002).

1.1.1 Adolescent self-harm course and prevalence. Self-harm typically has an onset in adolescence (Gollust, Eisenberg, & Golberstein, 2008; Klonsky, & Muehlenkamp, 2007). Furthermore, if self-harm behaviours are continued into adulthood, these behaviours tend to peak in adolescence (Klonsky & Muehlenkamp, 2007; Nock, 2009). The estimated rate of self-harm among community adolescents is reportedly between 7% and 17% (Briere & Gil, 1998; Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Klonsky, Oltmanns, & Turkheimer, 2003). Ross and Heath (2002) conducted a study with a community sample of 440 adolescents (mean age unavailable; Grades 8 to 11) from urban and suburban schools in Canada. They found that 14% of the students reported having self-injured; of these self-harming adolescents, 64% were

female and 34% were male. A Canadian population-based longitudinal study conducted by Nixon, Cloutier, and Jansson (2009) indicated that 17% of youth (mean age unavailable; 14–18 years of age) had engaged in self-harm. A study involving a younger pre- to early-adolescent sample of sixth, seventh, and eighth graders indicated a lower prevalence rate (8%) of self-harm (Hilt, et al., 2008).

The frequency with which adolescents engage in self-harm behaviours can vary dramatically. For example, among the Canadian studies, Ross and Heath (2002) found that 13% of the self-harming adolescents reported engaging in self-harm at least once a day, while 18% of the self-harming adolescents had engaged in only a single self-harm incident. Nixon and colleagues (2009) reported that 29% of their self-harming sample had engaged in one solitary self-harm incident, and of those adolescents who had ceased self-harm behaviours, the mean duration for self-harm engagement was 1.8 years.

1.1.2 Adolescent self-harm behaviours and experience. The number of different types of self-harm behaviours in which adolescents engage can also vary. The most frequently reported self-harm behaviour is skin cutting (Briere & Gil, 1998; Gratz, Conrad, & Roemer, 2002), followed by self-hitting and scratching (Laye-Gindhu & Schonert-Reichl, 2005); however, other behaviours such as self-burning, biting, or skin-carving are also common (Briere & Gil, 1998; Klonsky & Muehlenkamp, 2007). Rare and more extreme types of self-harm behaviour include genital mutilation, bone-breaking, rubbing glass into one's skin, or self-castration (Briere & Gil, 1998; Gratz, 2001). Lloyd-Richardson, Perrine, Dierker, and Kelley (2007) found that the mean number of self-harm methods used among self-harming adolescents was 2.4 ($SD = 1.7$). Moreover, the majority of self-harming adolescents (52%) reported engaging in more

than one type of self-harm behaviour in the past year, while a minority (6%) reported engaging in six or more different types of self-harm behaviour. In contrast, Ross and Heath (2002) found that only 16% of the self-harming adolescents in their sample reported using more than one self-harm method.

Other qualitative elements of the adolescents' experience can also vary. For example, many adolescents report first getting the idea to self-harm on their own, approximately one third of adolescents report getting the idea from friends or peers, and a minority report other influences such as the media, family members, or reading about self-harm (Deliberto & Nock, 2009; Nixon et al., 2008). Some adolescents engage in self-harm alone, while others engage in the presence of friends and peers (Klonsky & Olino, 2008). The majority of self-harming adolescents report little forethought prior to engaging in self-harm; however, there are some indications that between 11% and 33% of adolescents will pre-contemplate the behaviour (Klonsky & Olino, 2008; Lloyd-Richardson et al., 2007). Other elements of the experience, such as the sensation of pain or using alcohol or drugs during the act, can also vary (Klonsky & Olino, 2008; Lloyd-Richardson et al., 2007).

1.1.3 Adolescent self-harm reasons. An exploration of the underlying motives of self-harm in adolescence reveals a wide variety of potential reasons for this behaviour. Several studies have used motive checklists or directly asked individuals who self-harm for their reasons or motives. Based on those studies, the leading motivation for self-harm is an attempt to control or regulate affect (Briere & Gil, 1998; Laye-Gindhu & Schonert-Reichl, 2005; Polk & Liss, 2009). An online survey of 37 individuals (*M* age = 23 years) inquiring about self-harm motivations revealed that 31% of respondents indicated that

they used self-harm both in response to overwhelming emotions and in order to feel something (Horne & Csipke, 2005). Accordingly, some individuals who engage in self-harm may use it to either contain excessive affect or to express diminished affect.

Polk and Liss (2009) asked 154 young adults (M age = 22.7 years) to describe, in their own words, their reasons for engaging in self-harm. The responses were then coded for similarities and six themes emerged. The two most frequently cited themes (endorsed by the majority of the sample) were 1) to release emotions and 2) to feel alive – by creating emotions, both of which involve affect regulation. The other four themes included: to feel in control, to self-punish, to prevent suicide, and to avoid or distract from internal pain. Similar themes or factors, derived from individuals' self-reports, are reported throughout the literature (Gelinias & Wright, 2013; Klonsky, 2009; Scoliers et al., 2009; Warm, Murray, & Fox, 2003). Similar reasons have also emerged from studies in adolescent-specific populations. For example, Lloyd-Richardson and colleagues (2007) queried 640 adolescents on the underlying motives of their self-harm, and overall the self-harming adolescents endorsed an average of 4.8 ($SD = 5.6$) motives. Self-harm motives that served an intra-personal (automatically reinforcing) purpose were endorsed by 22-28% of the self-harming adolescents. Examples of these intra-personal motives include: to relieve feeling numb or empty, to punish oneself, or to feel relaxed. Inter-personal (socially-reinforcing) motives were endorsed by 19-31% of self-harming adolescents, examples of which include: to get attention, to avoid punishment, or to get help. Thus, a community sample of adolescents reported engaging in self-harm in order to influence others as well as to regulate their own emotional states. The most common

reasons for self-harm included ‘to try to get a reaction from someone’, ‘to stop bad feelings’, and ‘to get control of a situation’.

A cross-sectional survey of adolescents ($n = 30,477$) in seven different countries revealed a bi-dimensional conceptualization of the reasons for adolescent self-harm (Scoliers et al., 2009). Adolescents endorsed several different reasons that fell on two dimensions: A Cry of Pain (i.e., comprises affect regulation and expressing internal pain) and A Cry for Help (i.e., involves attention- and help-seeking motives). The most commonly cited reason for self-harm was the adolescent ‘wanted to get relief from a terrible state of mind’. The majority of adolescents reported at least one motive from each dimension, demonstrating that most self-harming adolescents will have several reasons for engaging in self-harm, and these reasons will involve intra- and inter-personal motives.

1.2 Help-seeking for Adolescent Self-harm

Intentionally engaging in self-harming or self-mutilating behaviours is a perplexing and counter-intuitive clinical phenomenon. More perplexing still is that self-harm behaviours are becoming increasingly prevalent across the world (Kimball, 2009; Scoliers et al., 2009). Adolescent self-harm especially, has seen a dramatic increase in prevalence rates (Corcoran, Keeley, O’Sullivan, & Perry, 2003; Hawton, Rodham, Evans, & Weatherall, 2002). The increased prevalence of self-harm behaviours among adolescents necessitates evidence-based interventions. Unfortunately, there are several indications that the implementation of effective self-harm interventions is challenging.

First, adolescents tend to keep their self-harm behaviours a secret. A study completed by Whitlock, Eckenrode, and Silverman (2006) indicated that nearly 40% of

self-harming participants (mean age unavailable, age range 18 – 24) reported that no one was aware of their self-harm. Steps and safeguards are often put in place to keep this behaviour unknown to others (e.g., wearing long-sleeves to hide scars, engaging in self-harm in secluded locations). Individuals who self-harm justify their secrecy with reference to fear of negative responses from others and stigmatization (Klineberg, Kelly, Stansfeld, & Bhui, 2013).

Second, if self-harming individuals reveal their self-harm to anyone, it is unlikely to be someone able to provide mental health assistance. In the Whitlock et al. study (1996) only 21% of their self-harming participants disclosed their behavior to a mental health professional. Evans, Hawton, and Rodham (2005) asked self-harming adolescents whom they feel able to talk to about their self-harm, from whom they seek help, and from whom they have received help. Less than 10% of self-harming adolescents seek or receive help from general practitioners, psychologists, social workers, or psychiatrists. Adolescents are most likely to tell friends about their self-harm behaviours, and are most likely to seek and receive help from friends as well (Evans et al., 2005). Peer help-seeking is problematic because few peers are equipped to handle the responsibility. Less than a quarter of young people who have supported a self-harming peer told an adult or encouraged their friend to seek adult help (Curtis, 2010; Michelmore & Hindley, 2012). A systematic review of help-seeking among self-harming adolescents reported rates of less than 40% for formal help-seeking in this population (Nada Raja, Morrison, & Skegg, 2003).

Third, adolescents do not seek help, as they often do not perceive that they have a problem (e.g., difficulty coping, depression, poor stress management). For example, a

study of self-harming adolescents indicated that only about half of the adolescents with thoughts of self-harm recognized that they had a need for help (Saunders, Resnick, Hoberman, & Blum, 1994). In the study conducted by Evans and colleagues (2005), approximately 56% of the self-harming adolescents believed they did not have a serious problem and did not need help. Only 26% of the self-harming adolescents sought help. In a school-based study, fewer adolescents who had thoughts of self-harm said they would seek professional help than did their peers who were not experiencing such thoughts, but who were asked what they would do if they had thoughts of self-harm (Carlton & Deane, 2000). In fact, the perceptions that self-harming behaviour is not serious and that help would not be beneficial have both been cited specifically as barriers to help-seeking in this population (Culp, 1995; Nada Raja et al., 2003). If the self-harming adolescents do not believe they have a problem, forced treatment is unlikely to be successful. Many young people who present for services for self-harm disengage in treatment (Michelmore & Hindley, 2012). Furthermore, engaging adolescents in treatment, even if they are connected to services, is challenging (Oldershaw, Richards, Simic, & Schmidt, 2008).

Fourth, adolescents can be reliant on others, such as parents or caregivers, for several treatment-associated factors; moreover, parents have a pivotal role in ensuring provision of treatment, as mental health assessment and treatment often requires their permission (Oldershaw et al., 2008). Adolescents may also rely on parents for the practicalities (e.g., transportation, finances) involved in seeking treatment, and parental attitude and involvement can influence an adolescent's treatment adherence (Oldershaw et al., 2008). Parental detection of self-harm has been shown to increase professional

involvement; therefore, adolescents may also be more reliant on others to detect their distress and recognize their behaviours as problematic (Michelmore & Hindley, 2012).

Adolescents who engage in self-harm are a notoriously difficult population in which to intervene. The aforementioned barriers to treatments for self-harming adolescents make novel methods for influencing adolescents' behavior all the more necessary. Indirect approaches, such as parent-focused or peer-focused interventions may be critically important to influencing change among self-harming adolescents.

1.3 Recovery of Adolescents who Self-Harm

Although overshadowed by the research exploring the onset and continued engagement in self-harm, there has been some research completed self-harm cessation. Consequently, some information is available on the journey to recovery from self-harm. This body of research provides insight into three main areas: the reasons for self-harm cessation, barriers to recovery, and strategies for recovery.

1.3.1 Reasons for self-harm cessation. Four studies have examined reasons for self-harm cessation using different methods and populations. Deliberto and Nock (2008) asked 94 adolescents why they may or may not like to stop engaging in self-harm, and determined that the primary reason for wanting to stop self-harm behavior was that it is an unhealthy behavior. Other reasons for wanting to stop self-harm include: it attracts unwanted attention, causes scarring, causes shame, and upsets family members and friends.

Young, van Beinum, Sweeting, and West (2007) used a population-based survey of 1,258 young adults to query a number of self-harm factors, including reasons for ceasing self-harm. The most frequently reported cessation theme was that the young adult

realized harm to self and family, or “stupidity”. The second most frequent theme was that the self-harm behavior was only part of a temporary phase, followed closely by the theme of coping, feeling better, or finding a purpose in life. The least common theme involved gaining professional or informal help.

Through in-depth interviews with six young women Shaw (2006) determined 10 factors involved in the cessation of self-harm. Similar to the two aforementioned studies, Shaw (2006) determined that coming to view self-harm as problematic or unhealthy, receiving professional treatment, developing insight or coping strategies, and experiencing unwanted attention or interference in goals or social activities because of self-harm were factors involved in cessation. Other factors unique to Shaw’s (2006) findings include: reducing psychological catalysts to self-harm, eliminating deterrents (e.g., fear that others will think she is “crazy”), and the notion of momentum (i.e., once on the path, it is easier to refrain from self-harm).

Finally, Gelinas and Wright (2013) asked 54 university students about certain factors involved in the recovery from self-harm. Six themes for reasons for self-harm cessation emerged from the participants’ responses: (1) realization of self-harm stupidity/futility, (2) distress regarding scarring and negative attention, (3) change for interpersonal reasons, (4) receipt of help/support, (5) desire for wellness, and (6) development of alternate coping strategies. References to family and friends were made throughout several themes (i.e., distress regarding negative attention, change for interpersonal reasons, and receipt of help/support), and feelings of social support or alienation were demonstrated to be important in the reasons and motivations predating self-harm cessation.

1.3.2 Barriers to self-harm recovery. Fortune, Sinclair, and Hawton (2008) used self-report questionnaires to survey 2,054 adolescents, and asked: “what do you think could be done to help prevent young people from feeling that they would want to harm themselves?” Through the adolescents’ indication of what requires prevention, potential barriers to self-harm cessation were revealed. The adolescents suggested communication and support as a primary way to help prevent self-harm, and particularly emphasized the importance of family. Adolescents reported extracurricular activities and friendship/peer-interaction as also being important to prevention. More tertiary suggestions to help prevent self-harm included: less school-related stress, access to school counselors and self-harm-educated teachers, public education about self-harm, treatment for mental illness, and the involvement of formal organizations. Barriers to help seeking because of confidentiality and stigma concerns, substance abuse, and the media were mentioned infrequently.

Gelinas and Wright (2013) asked University students whether or not they had encountered any barriers to recovering from self-harm. From the 32 responses garnered, four themes emerged: (1) mental illness or distress, (2) interpersonal issues (3) ease, addictive properties, and functionality of self-harm, and (4) stress. The themes of interpersonal issues and stress both specifically referenced poor relationships and support from family and friends.

1.3.3 Strategies for self-harm recovery. Sinclair and Green (2005) conducted a qualitative interview study with 20 adults two years after a hospital admission for deliberate self-poisoning, and derived three key narratives of resolution. The first narrative was entitled resolution of adolescent chaos. The individuals who contributed to

this narrative reported that becoming an independent adult and gaining autonomy from a chaotic, abusive, or invalidating family structure was imperative to their self-harm cessation. The second narrative was entitled recognition of alcohol as a factor, and involved the treatment for addiction, and subsequent abstinence as essential to self-harm cessation. The third narrative was entitled seeing self-harm as a consequence of illness. These individuals considered their self-harm as a symptom of illness and a cry for help; therefore, their recovery from self-harm was a result of having mental illness addressed.

In the study conducted by Gelinas and Wright (2013), university students indicated five themes of strategies for recovering from self-harm. These themes included: (1) positive coping behaviors, (2) seeking professional help, (3) negative coping behaviors, (4) seeking social support, and (5) rationalization/self-talk. The theme of seeking social support emphasized the importance of having someone to talk to, and the key role that family and friends can play in the cessation of self-harm.

1.4 The Role and Importance of Parents/Caregivers

1.4.1 Parents' role and influence in self-harm. As discussed, parents are imperative in terms of recognizing the need for help and seeking treatment for their adolescent child. Parents can also play a vital role in the development, maintenance, and prognosis of their child's self-harm behaviour (Byrne et al., 2008). The extant literature has repeatedly identified parents as having the potential to act as a motivator and strategy to self-harm recovery, as well as a barrier to recovery (Gelinas & Wright, 2013). A number of components, such as perceived quality of parent-child relationship, family cohesion, and communication style can all affect self-harm trajectories in adolescence and will be discussed below.

Parent-child relationship. Several studies have determined that adolescents engaging in self-harm often perceive their relationship with parents to be of lower quality than adolescents not engaging in self-harm. By way of example, McLaughlin, Miller, and Warwick (1996) found that self-harming adolescents perceived their parents to understand them less than did a community control group. Similarly, a longitudinal study conducted by Hilt and colleagues (2008) indicated that self-harming adolescents ($n = 508$, Grades 6 to 8) perceived lower quality relationships with their parents than adolescents not engaging in self-harm. Martin, Rozanes, Pearce, and Allison (1995) found that certain familial relationship features (i.e., poor quality of boundaries, ill-defined roles, and inappropriate affective responsiveness) contributed to higher rates of self-harm among adolescents. Unsupportive parental relationships have been related to the onset of adolescent self-harm (Andrews, Martin, Hasking & Page, 2013; Wichstrom, 2009). Finally, adolescent satisfaction with familial support appears to protect against later recurring incidents of self-harm (Wichstrom, 2009).

Family cohesion. Parental importance can also be seen through the influence of family cohesion on self-harm. Family cohesiveness has been shown to play a significant role in protecting against self-harm (Rubenstein, Halton, Kasten, Rubin, & Stechler, 1998). Tulloch, Blizzart, and Pinkus (1997) also found family cohesion (influenced by open-communication styles) to be highly inversely related to self-harm. A systematic review of the psychological and psychosocial factors related to self-harm (Webb, 2002) suggested that rather than family problems or dysfunction contributing to risk factors to self-harm, the absence of protective factors (e.g., family confidant, family intactness) within the family may distinguish a self-harming adolescent from an otherwise distressed

adolescent.

Parent-child communication. There are also several indications that self-harming adolescents have poor communication with their parents. The communication hypothesis of self-harm is based on the interactional model of family functioning in which disturbance of family communication is thought to be responsible for the development of dysfunction (Tulloch et al., 1997). This communication hypothesis has found recurring support in the literature.

Communication is considered essential for strong family functioning; therefore, poor communication could lead to isolation of the adolescent from the rest of the family, and could cause the adolescent's problems to seem insoluble (Tulloch et al., 1997). Multiple studies have indicated that certain types of poor communication (particularly characterized by criticism and hostility) are positively related to both self-harm and suicidality (Allison, Pearce, Martin, Miller, & Long, 1995; Santos, Saraiva, & DeSousa, 2009; Wedig & Nock, 2007). Furthermore, parental communication characterized by high emotion, hostility, and criticism have been related to the continued repetition of self-harm (Santos et al., 2009). The influence of parental communication appears to be important over-and-above other potential factors. Tulloch and colleagues (1997) found that the absence of a family confidant was very strongly associated with adolescent self-harm, and this was the case after controlling for a wide range of possible causal factors, such as family transitions, substance use, and locus of control.

In the absence of familial communication, self-harm may become the only perceived solution. Evans and colleagues (2005) demonstrated that significantly fewer self-harming adolescents (approximately 25%) felt able to talk to their parents than did

adolescents who did not engage in self-harm (approximately 49%). Furthermore, fewer adolescents (approximately 21%) with multiple episodes of self-harm felt able to talk to their parents than those adolescents with only a single episode of self-harm (approximately 29%).

1.4.2 Parents' struggle and experience with self-harm. Parents have the potential to exert a strong positive influence over their self-harming adolescents; however, recent literature indicates that these parents are often struggling (e.g., emotionally, mentally, and socially) themselves. In fact, parents' struggle with a self-harming adolescent is akin to caregiver burden, and these parents are at risk of caregiver-burn out (Ohaeri, 2003). There are three qualitative studies that have delineated parents' perspective on their child's self-harm, and provide further insight into parents' experience of their adolescents' self-harm.

Typical parental experience. Oldershaw and colleagues (2008) conducted semi-structured interviews with 12 parents of adolescents receiving treatment for self-harm in community mental health services. Interpretative phenomenological analysis was applied to the interviews, and four key themes emerged from the parents' accounts. The first theme, the process of discovery, indicated that parental discovery of their child's self-harm was gradual. Parents reported waxing and waning levels of concern and suspicion leading up to full disclosure of the self-harm. Many parents reported noticing injuries, but encountering denial or excuses from their adolescents when questioned. Furthermore, parents took a "wait and see" approach, as they would tentatively hope the situation would resolve itself. Both parents and adolescents appeared ambivalent about seeking treatment, and often would not initiate help-seeking until an outside agency (e.g., school,

general practitioner) expressed concern. Parents were unlikely to seek help for their child until the situation with the outside agency deteriorated, or the self-harm behaviours worsened.

The second theme, making sense of self-harm, was described as an instinctive response of the parents to question motives behind self-harm. Parents reported significant difficulties in coming to terms with, and understanding, their child's self-harm. Any understanding or acceptance that was found came about through a gradual process. Parents reported coming to an intellectual understanding of the behaviour, rather than a true understanding. Although parents reported that their adolescents offered little to no explanation for their behaviours, almost all parents could identify problems or stressors that their child was facing. Parents perceived three causal factors to the self-harm: emotional difficulties (e.g., worry), situational difficulties (e.g., bullying), and personality factors (e.g., low self esteem, perfectionism). Within the context of these causal factors, parents recognized that self-harm may serve the purpose of coping with negative emotions, providing emotional expression, or providing a sense of control.

The third theme involved the psychological impact of self-harm on the parents themselves. Strong and lasting emotional reactions to their child's behaviour were reported. These reactions were varied and included shock, disappointment, guilt, fear, sadness, bereavement, and a sense of loss. Parents described feeling helpless and lost in the situation, so much so that they found themselves regretting that their children had not opted for other 'typical' teenage behaviours such as drug or alcohol misuse.

Finally, the fourth theme involved the effect of self-harm on parenting and the family as a whole. Parents felt that their child's self-harm had influenced their behaviour

as a parent as well as their experience of family life. Nervousness about triggering further self-harm incidents affected their parenting style, ability to set limits, and consistency in maintaining boundaries. Some parents reported feeling additionally pressured to be constantly aware of their child's action, and in doing so providing increased overt attention and caregiving.

Parental support needs. Byrne and colleagues (2008) conducted focus groups with 25 parents of self-harming adolescents with the intent of describing parents' experiences with adolescent self-harm in order to identify their specific support needs. Several overarching themes were identified. Support, psychoeducation, emotional reactions, parenting, and family were of major concern to the parents.

The first theme, support, emerged as the most central theme of the study. Parents reported the need for support in order to help them cope with the impact of self-harm on their lives and their families. Parents also indicated feeling unsupported by services and the healthcare system. Novel to the other qualitative investigations of parents' experiences with self-harm, Byrne and colleagues (2008) uncovered parents' desire for peer support. The opportunity to share and commune with others in similar circumstances was believed to be extremely important to self-harm management and parents' own well-being.

A second theme involved psychoeducation and a desire for informational support. Education on self-harm statistics, etiology, trends, motivations, and treatment services were specifically cited as of interest to parents. Advice on how to prevent or manage future self-harm incidents was also viewed as a priority by parents.

The third theme involved parents' emotional reactions. Similar to the other qualitative investigations (Oldershaw et al., 2008; Raphael, Clarke, & Kumar, 2006), parents expressed intense emotions such as guilt, isolation, fear, frustration, and decreased confidence following their child's self-harm. Parents blamed themselves for failing to recognize or prevent their child's actions. Self-harm episodes reportedly elicited intense panic, fear, and apprehension of future incidents. Anger and frustration with their child for the disruption and distress caused were also expressed.

The fourth theme identified by parents centered on issues concerning their parenting abilities. In particular, issues in the parent-child relationship, parent-child communication, and issues related to discipline were identified. As before, parents developed concern about their ability to parent and discipline effectively without causing future incidents. These parents also discussed a desire to help their children express their feelings more appropriately and develop better communication coping strategies.

The fifth theme involved familial disruption. Parents reported a major disruption in family dynamics as the self-harm had become the focal point of family life. These parents also spoke of the shift in power relationships, and the perception that the self-harming adolescent now held a position of power. The impact on siblings was described as devastating.

Parental attitudes toward health care involvement. Raphael and colleagues (2006) conducted in-depth interviews with six parents and a variety of health care professionals (i.e., nurses, emergency room doctors, psychiatrists, counselors, and youth workers) directly involved in the management of self-harm patients. Two separate interviews were conducted with the parents: the first within 24 hours of the child being

seen as an in-patient and the second approximately three to eight months later. The two separate interviews allowed for an examination of the ways in which parents' emotional attitude changed over time. There were three main themes identified: emotional responses, where to find information and support, and health professionals.

The first theme, emotional responses, revealed how traumatic and distressing the experience was for parents. All of the interviewed parents reported devastating feelings of confusion, rejection, hurt, shock, and grief. The severity of these reactions is substantiated by the many somatic and psychological symptoms reported, such as sleeplessness, depression, and inability to work. Parents began to question their bond with their child as well as their skills and competence as parents. Another common emotional reaction was of anger. Some parents reported anger at the self, the situation, their child, or the health care professionals involved. Other parents reported self-blame and fear that something inherent in their own behaviour would precipitate future self-harm incidents. Parents recognized a shift in family dynamics and reported that the shift seemed as though their child had moved into a position of power. Difficulties maintaining normal discipline and normal family life were expressed.

The second theme involved the next steps after hospital admission. The general sense from parents was one of helplessness due to perceived lack of information and supports. Parents reported difficulties in finding informational resources about self-harm, as well as difficulty in obtaining information from the healthcare professional with whom they were in contact.

The third theme involved the parents' perspectives on the healthcare professionals' involvement. Parents expressed a need for support and reassurance from the healthcare

professionals, either through advice, kind words, information, or follow-up appointments. At the first interview parents reported being too emotionally overwrought to accept or understand the help and support being offered by the healthcare professionals, but by the time of the second interview, this help and support was no longer being offered. Parents asserted the importance of continued provision and accessibility of help. Parents believed that their initial poor response to the help offered led to a misunderstanding with the healthcare professionals.

When considered together, these three studies (Byrne et al. 2008; Oldershaw et al., 2008; Raphael et al., 2006) paint a picture of the parental experience of adolescent self-harm, and serve to identify their specific support, emotional, and informational needs. In sum, parents of self-harming adolescents would benefit from emotional support, informational support about self-harm basics, parenting support and strategies, and strategies to limit family disruption and maintain parental control. Support and information from both healthcare services and peers would be ideal.

Parental caregiver burden. Caregiver burden is an all-encompassing term that has been adopted to identify the objective and subjective difficulties experienced by relatives of people with mental disorders (Ohaeri, 2003; Shah, Wadoo, & Latoo, 2010). Objective burden involves the practical problems experienced by caregivers, such as disruption of family relationships, constraints on social and leisure activities, financial difficulties, impairment in work efficiency, and negative impact on their own physical health. Subjective burden involves the psychological reactions which relatives experience, such as feelings of grief, loss, anxiety, sadness, stress of coping with disturbing behaviors, and

frustration with their changing role. Secondary emotions can also develop, such as hostility and anger in response to the original feelings of grief (Shah et al., 2010).

Parents of self-harming adolescents have yet to be considered caregivers in the usual sense and their experience has yet to be considered as one in which caregiver burden is likely. The experience of parents with self-harming adolescents shares many commonalities with that of caregiving relatives in more typical mental illness caregiving situations (Ohaeri, 2003). Caregivers of self-harming adolescents and caregivers of other mentally ill adolescents report comparable emotional, familial, and practical aspects of burden.

Emotionally distressing attitudes and circumstances are cited as a major component of caregiver burden. Caregivers report feelings of grief, guilt, anger, powerlessness, and loss (Ohaeri, 2003) that can result in a need for their own care and difficulties understanding the care-receiver's actions. Emotional and distress reactions are fundamentally the same as those reported by parents of self-harming adolescents (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Furthermore, parents of self-harming adolescents may feel out of control of the situation, and have inadequate coping resources themselves (Trepal, Wester, & MacDonald; 2006). Feeling in over one's head, with no one to turn to, is a common component of caregiver burden (Ohaeri, 2003). Similarly, parents of self-harming adolescents request the same types of professional assistance and information as do parents who are caregiving for different mental health concerns (Ohaeri, 2003; Raphael et al., 2006). Due to the high level of stress and responsibility, caregivers often experience poorer self-reported health, engage in fewer health-promoting actions, and report overall lower life satisfaction (Shah et al., 2010).

Given the similarities, parents of self-harming adolescents experience the same risks to their emotional and physical well-being.

1.5 The Role and Importance of Friends/Peers

1.5.1 Friends' role and influence in self-harm. Given adolescents' developmental stage, peer influence on beliefs and behaviour is immensely important. Extant literature has demonstrated a potential for both negative and positive peer influence on the development and maintenance of adolescent self-harm. Similarly, friends and peers seem to play a key role in the recovery from self-harm as well.

Negative influence of peers. One of the most robust predictors of adolescents' engagement in self-harm is their exposure to self-harm in peers, and their perception of peers' own self-harm behaviours. In a population-based Canadian study ($n = 568$) 29% of a sample of self-harming adolescents (mean age unavailable, ages 14–21) reported first getting the idea to self-harm from a friend (Nixon et al., 2008). Similarly, 38% of self-harming adolescents in the United States reported that they first got the idea to engage in self-harm from peers (Deliberto & Nock, 2008). DeLeo and Heller (2004) found among high school students ($n = 3757$) that participants' exposure to self-harm in friends or family members increased their own self-harm engagement more than three times. From a large sample of university students ($n = 3069$; mean age unavailable, ages 18–24), Whitlock and colleagues (2010) organized the self-harming students into three groups depending on severity and frequency of self-harm behaviours. Few (9.8%) individuals in the low severity group had any friends who also engaged in self-harm, followed by 17.6% of individuals in the moderate severity group, and 42.1% of individuals in the high severity group reported having self-harming friends. The more frequent or severe the

self-harm, the more likely it was that that individual had self-harming peers. Therefore, there is evidence that (actual or perceived) self-harm behaviour in peers contribute to the initial idea to self-harm, the likelihood of engaging in such behaviour, as well as the escalation of self-harm behaviour in terms of frequency and severity (Heilbron & Prinstein, 2008; Nixon et al., 2008; Whitlock et al., 2010).

Furthermore, a few recent studies have demonstrated that friend and peer self-harm can longitudinally predict both the engagement in self-harm, and frequency of self-harm (Heilbron & Prinstein, 2008; Prinstein et al., 2010; You, Lin, Fu, & Leung, 2013). These longitudinal studies also support the presence of both socialization and selection effects among self-harming adolescents. Socialization effects refer to the processes that occur between peers that make conformity to social norms and group behaviour more likely, whereas selection effects refer to the tendency for adolescents to befriend peers who share similar interests and activity preferences. Regarding socialization effects, You and colleagues (2013) determined that even after controlling for the effects of depressive symptoms and maladaptive impulsive behaviours, a best friend's engagement in self-harm can significantly predict adolescents' self-harm engagement six months later. Regarding selection effects, You and colleagues (2013) also determined that over a six month period, adolescents who self-harm tend to join new peer groups with other members who also self-harm. Similarly, adolescents who frequently engage in self-harm join peer groups with other members who also engage frequently in self-harm behaviours. Prinstein and colleagues (2010) also demonstrated socialization effects, as perceptions of friends' self-harm were associated longitudinally with female adolescents' own engagement in self-harm at 18 months post-baseline. Prinstein and colleagues (2010)

found similar evidence of selection effects, in that female adolescents' self-harm was associated longitudinally with higher levels of perceptions of friends' self-harm nine months later.

Among those individuals who are contemplating the cessation of self-harm, peers can also have a potential negative influence. In retrospect, young adults who have recovered from self-harm cite negative peer relationships (i.e., friend group that continued to participate in self-harm, peer pressure from friends to keep self-harming) as barriers to cessation (Gelinas & Wright, 2013). Peers can have a negative effect on self-harm cessation by reacting to a self-harm disclosure in a rejecting or alienating way (Mahdy, 2013). In fact, approximately 48% of self-harming members from an online self-injury support group report that face-to-face peers' reactions to their self-harm caused them to distance themselves (Boekmann, 2008). Peers may also react in a dismissive way that minimizes the severity of self-harm, and in doing so further deter individuals from seeking professional help (Pietrusza, Rothenberg, & Whitlock, 2011).

Positive influence of peers. Fortunately, peers have also proven to be capable of exerting a positive influence over their self-harming friends. The disclosure of self-harm to a friend may facilitate professional help-seeking (Hinson & Swanson, 1993; Mahdy & Lewis, 2013). In response to a self-harm disclosure, friends may react non-judgmentally and compassionately, and in doing so challenge the notion that disclosing self-harm behaviours will result in negative reactions and outcomes.

A relationship has been demonstrated between the quality of social support and social network and a higher likelihood to seek informal help for self-harm (Wu, Stewart Huang, Prince, & Liu, 2011). Social support has been proposed to act as a buffering

factor for the severity of self-harm, as those with high quality social supports tend to help-seek prior to engaging in self-harm (Wu et al., 2011). Individuals who have recovered from self-harm often mention the support of friends as being a facilitator to recovery (Gelinas & Wright, 2013). Therefore, positive friendship/peer-interaction has been suggested to be important for both self-harm prevention and recovery (Gelinas & Wright, 2013; Fortune et al., 2008).

1.5.2 Friends' struggle and experience with self-harm. Compared to parents, the experience of friends of self-harming individuals is largely unknown. How friends are affected and how they feel about their peer's self-harm remains relatively unexplored. Understanding how self-harm is viewed by friends/peers could have important implications for limiting self-harm severity and hastening recovery. For example, misinformation or negative perceptions of self-harm could evoke a negative response to a self-harm disclosure, and in turn, inadvertently exacerbate the frequency and severity of self-harm.

As previously mentioned, adolescents are more likely to disclose their self-harm behaviours to their friends and peers than to anyone else (Evans et al., 2005; Whitlock et al., 1996). In fact, the majority of individuals who self-harm speak to their friends about their behaviour (Heath, Toste, Nedecheva, & Charlebois, 2008). Friends become proverbial front-line workers, whether or not they are equipped to handle the problem. Being the first to know, friends are placed in a crucial role in terms of self-harm recovery, as well as a challenging role in terms of stress and high responsibility.

Typical friend experience. Boeckmann (2008) conducted a study examining self-harm knowledge and peer perceptions among online self-injury support group members

($n = 101$). Although the participants were the self-harming individuals themselves, this study sheds some light on the typical friend experience. Participants reported that their friends' primary reactions to learning about their self-harm behaviours included: offering support, wanting the participant to stop their self-harm behaviour, or not thinking of the participant any differently. Self-harming participants reported that their friends perceive self-harm to have either no impact or high impact on several different areas of their life. Participants largely perceived their friends to hold negative beliefs and attitudes about self-harm. For example, many participants perceived their friends to think less of those who self-harm (39%), pity those who self-harm (31%), and feel that self-harm is too distressing for them to talk about (46%). Encouragingly, participants reported that their friends would endorse seeking mental health services for self-harm.

Friends of individuals who engage in self-harm have certain attitudes about self-harm, as well as certain reactions to this behaviour among their friends. Extant research demonstrates that typically, friends have negative attitudes about self-harm, but try to be helpful and supportive towards their self-harming friends. Bresin, Sand, and Gordon (2013) investigated peers' perceptions of self-harm through a vignette study. Participants ($n = 262$) read a series of 12 vignettes depicting a friend engaging in self-harm behaviours that varied in severity. Half the vignettes depicted the participant directly observing the self-harm act, and the other half depicted the participant being told about the incident after the fact. For vignettes depicting severe forms of self-harm that occurred in front of the participant, "getting help" was the most common response, while for less severe forms of self-harm, "telling them to stop" was the most common. In contrast, for

vignettes where self-harm was disclosed afterwards, offering some form of support (e.g., talking to the individual about their feelings) was the most common response.

Typical friend struggles. In general, adolescents report uncertainty about how to respond to their self-harming friends, and high levels of discomfort and avoidance when discussing their friends' self-harm (Muehlenkamp, Walsh, & McDade, 2010). Furthermore, adolescents who have never self-harmed report having difficulty understanding self-harm behaviours and experience challenges when helping peers who self-harm (Klineberg, Kelly, Stansfeld, & Bhui, 2013). Bresin and colleagues (2013) had participants read vignettes depicting various types of self-harm, then indicate why they thought the person engaged in the self-harm behaviour. Participants inferred multiple functions of the self-harm, some of which were inaccurate, thus corroborating the idea that people have a difficult time understanding why others engage in self-harm.

In Boekmann's (2008) study among online self-injury support group members, it was discovered that friends believe that self-harm negatively impacts their relationship with the individual who self-harms. Individuals who self-harm perceive over 60% of their friends to feel that the relationship had been negatively impacted because of the self-harm behaviours. Similarly, these self-harming individuals perceive that 75% of their friends are very concerned about their self-harm.

Despite the scarcity of research on friends' experiences with self-harm, it appears that friends typically struggle with: a lack of understanding, discomfort with the topic, concern for their peer, and feeling as though the relationship has been negatively impacted. A better understanding of friends' specific struggles and challenges could assist in better preparing them for their difficult role.

1.6 The Current Dilemma in Adolescent Self-harm

Rates of self-harm are disconcertingly high among adolescents and appear to be rising. Unfortunately, individuals who self-harm tend not to seek formal help. Extant research has demonstrated that adolescent self-harm can be greatly impacted by social support, particularly of friends and family members, and this extends to the help-seeking and recovery processes. Despite their crucial roles, little is known about the experience of parents and friends supporting someone who self-harms, or their role in recovery from self-harm. What little is known indicates that both parents and friends struggle with self-harm, as they feel uninformed, unsupported, and often overwhelmed. Mental health professionals and programs would do well to capitalize on these primary sources of social support; however, a better understanding of their experiences, perceptions, and struggles are required first.

1.7 Research Questions and Objectives

The extant literature gives every indication that both parents and friends are essential to the prognosis, help-seeking, and recovery of those who engage in self-harm; however, very little is known about the parents' and friends' perspectives on their roles and experiences. The current study endeavored to fill this gap and expand our understanding of the role and experience of these crucial social support people. More specifically, the current study sought to address the following research questions: (1) How do individuals who have recovered from adolescent self-harm view the roles of their parents and friends, particularly, in terms of their own help-seeking, recovery, and support needs? (2) How do parents of individuals who have recovered from adolescent self-harm view their own roles, particularly, in terms of their parenting and support

needs, and the help-seeking and recovery of their child? (3) How do friends of individuals who have recovered from adolescent self-harm view their own roles, particularly, in terms of their friendship and support needs, and the help-seeking and recovery of their friend? Knowledge of the struggles and successes experienced by the recovered individuals, parents, and friends are imperative to improving the self-harm situation for the affected parties.

2.0 Method

2.1 Epistemological Assumptions

The current study was approached from a social-constructivist vantage point. The social constructivist paradigm recognizes reality as subjective, in that different individuals can have different perspectives on what truth is (Rubin & Rubin, 2005). Thus, from this perspective reality is constructed by individuals and multiple realities can exist. Furthermore, when confronted with something difficult to understand, people invent concepts, models, and schemes, to make sense of their experience (Schwandt, 2007). In order to organize and summarize countless realities, the social constructivist researcher's goal is to construct an amalgamation of knowledge that is more coherent and cohesive than before (Guba & Lincoln, 1994), while seeking to explain how individuals construct some phenomena in specific social and historical contexts (Crotty, 1997).

In order to construct this amalgamation of knowledge, the researcher herself contributes in an active way. According to social constructivists, the act of knowing is not a passive process; rather, knowledge is something fluid that is co-created and co-interpreted, rather than something solid that is simply discovered (Crotty, 1997). As truth is simply "agreed knowledge", social constructivist research is not a pursuit of objective truth, but instead a journey of engagement with other people, in which a subjective truth is accepted (Parker, 1998). Given the qualitative design of the current study, I acknowledge that my involvement in the research process has contributed to the shaping of realities on which I report. Adopting the constructivist position necessitates the acknowledgement of both the research participants' and researchers' contributions to the final product and final interpretation.

Henwood and Pidgeon (2003) assert that “knowledge” must be considered through individual, institutional, and sociocultural lenses, and in this way, researchers are able to formulate interpretations without compromising the data. Paying tribute to the “reality” of individual experiences while paying tribute to the researcher’s active involvement, is very much in line with the interpretative phenomenological approach being adopted for the current study. By being straightforward about the underlying epistemological assumptions, and disclosing the subjectivity involved, integrity in the proposed research can be maintained.

2.2 Study One (Recovered Individuals)

2.2.1 Study One design. Study One involved the investigation of the experience and perspective of individuals who have recovered from adolescent self-harm. Qualitative semi-structured interviews (see Appendix D) were used to gather information on five topics: 1) recovered individuals’ view on parents’ role (e.g., “How did you experience your parents’ involvement with your self-harm?”); 2) their view on friends’ role (e.g., “How did you interpret their reactions/responses to your self-harm?”); 3) the help-seeking process (e.g., “What was your experience with help-seeking for self-harm?”); 4) the recovery process (e.g., “Is there anything you would have done differently to aid in your recovery?”); and 5) their support needs while self-harming (e.g., “What information do you wish your social supports had known?”). Study One participants also completed a few brief questionnaires, including a demographic questionnaire and the Deliberate Self-Harm Inventory (DSHI; Gratz, 2001; see Measures section or Appendix C).

2.2.2 Study One participants. For Study One, participants included 10 individuals who have recovered from adolescent self-harm. Although the participants were young adults at the time of the study, they were reflecting largely upon their adolescent experiences. In order to be considered eligible, participants must have engaged in self-harm more than 10 times in their lives. In order to be considered “recovered”, potential participants must fulfill both an objective and subjective requirement. Objectively, they must have ceased self-harm behaviours for at least six months by the time of participation. Subjectively, they must believe that they are fully recovered, and not likely to relapse or resort to self-harm behaviours again in the future. In order to determine the type, frequency, duration, and cessation of self-harm behaviours, participants were screened using the Recovered Individual Screener questionnaire (see Appendix A).

Participants for Study One were recruited primarily through the University of Regina student body. Posters, listserv emails, and in-class presentations were used to recruit participants. Recruitment presentations that specifically solicited participation from individuals who had recovered from self-harm were conducted in Introductory Psychology courses. Potential participants contacted the primary investigator via email to be screened for eligibility. Once eligibility was determined, participants qualified to receive credit for participation through the Psychology Department participant pool.

2.3 Study Two (Friend-Caregivers)

2.3.1 Study Two design. Study Two involved the investigation of the experience and perspective of friends to someone who has recovered from self-harm. Qualitative semi-structured interviews were used to gather information on three topics: 1) their experiences as a friend-caregiver to someone who self-harmed; 2) the actions they took

while caregiving; and 3) the perceived support needs. Study Two participants also completed a brief demographic questionnaire (see Appendix B).

2.3.2 Study Two participants. For Study Two, participants included 10 individuals who played an active role in supporting a friend who had recovered from self-harm. In the event that participants had more than one self-harming friend, they were asked to reflect upon the friend with whom they had the most contact and had supported the most. Eligible participants' friends must have ceased their self-harm behaviours for at least six months by the time of participation. In order to determine the type, intensity, and duration of participants' caregiving and supporting, participants were screened using the Friend Screener questionnaire (see Appendix A).

Participants for Study Two were recruited primarily through the University of Regina student body. Posters, listserv emails, and in-class presentations were used to recruit participants. Recruitment presentations that specifically requested participation from individuals who had played an active role in supporting a friend who has recovered from self-harm were conducted in Introductory Psychology courses. Potential participants contacted the primary investigator via email to be screened for eligibility. Once eligibility was determined, participants could be offered credit for participation through the Psychology Department participant pool.

2.4 Study Three (Parent-Caregivers)

2.4.1 Study Three design. Study Three involved the investigation of the experience and perspective of individuals who have parented someone who has recovered from self-harm. Qualitative semi-structured interviews (see Appendix D) were used to gather information on three topics: 1) their experiences as a parent-caregiver to someone

who self-harmed; 2) the actions they took while caregiving; and 3) the perceived support needs. Additionally, participants of Study Three completed a brief demographic questionnaire (see Appendix B).

2.4.2 Study Three participants. For Study Three, participants included parents who had a child recover from self-harm. Eligible participants' children had ceased their self-harm behaviours for at least six months by the time of participation. In order to determine the type, intensity, and duration of participants' caregiving and supporting, participants were screened using the Parent Screener questionnaire (see Appendix A). Participants were recruited from the community using posters, online advertising, and emails targeting family and community groups.

2.5 Materials and Measures

2.5.1 Screener questionnaires (see Appendix A). A specific screener questionnaire was developed for each study (i.e., Recovered Screener Questionnaire, Friend Screener Questionnaire, Parent Screener Questionnaire). These questionnaires were used to determine eligibility for participation. The screener questionnaires were administered via telephone.

2.5.2 Demographic questionnaire (see Appendix B). A brief questionnaire was developed for each study, and solicits background information such as age, sex, relationship status, ethnicity, occupation, education, relationship to the recovered individual, duration of self-harm, duration of caregiving.

2.5.3 Deliberate Self-Harm Inventory (DSHI; Gratz, 2001) – adapted (see Appendix C). The DSHI is a 17-item, behaviorally based, self-report questionnaire that assesses the frequency, severity, duration, and type of self-harm behaviour. The DSHI is

based on the conceptual definitions of self-harm as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent. The measure queries whether the individual has engaged in 17 types of self-harm. If the individual responds affirmatively to behavioural engagement, the frequency, severity, and duration of the behaviour for that particular type of self-harm is then assessed. The DSHI demonstrated adequate internal consistency in the original study ($\alpha = .82$), as well as adequate test-retest reliability over a period of two to four weeks ($r = .68$; Gratz, 2001). The DSHI also demonstrated construct, convergent, and discriminant validity through comparisons with other self-harm measures, measures of related constructs, and measures of constructs hypothesized to be unrelated to self-harm (Gratz, 2001). Since the construction of the DSHI, there has been some debate as to whether or not certain behaviours should be classified as self-harm behaviours (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Mahdy et al., 2013; Yates, Tracy, & Luthar, 2008). As such, two items querying negligible self-harm behaviours (i.e., stuck sharp needles into one's skin, prevented wounds from healing) have been removed, leaving a total of 15 items. For the purposes of the current study, the total number of times that an individual engaged in self-harm behaviours, the duration of self-harming behaviours, and the amount of time since recovery, are important factors; therefore, these additional three questions were added to the DSHI.

2.5.4 Interview guides (see Appendix D). A specific interview guide (of approximately 15 to 20 questions) was developed for each study. As the interviews were semi-structured in nature, these questions were re-worded, re-ordered, or otherwise altered depending of the flow of conversation. Furthermore, follow-up questions were

added as needed to each interview in order to clarify, extend, or encourage the participants' responses.

2.6 Procedure

2.6.1 Screening. Potential participants who contacted the principal investigator and self-identified as interested in participating were subjected to a brief telephone pre-screen. The telephone screen involved the oral administration of the appropriate screener (either for parent, friend, or recovered individual) to determine eligibility to participate. Once eligibility was confirmed, the participant was scheduled for an in-person assessment, including a 75-minute interview and the completion of a few brief questionnaires.

2.6.2 Consent. At the outset of the assessment, participants were provided a consent form (see Appendix E) outlining: necessary information about the purposes of the study, its voluntary nature, withdrawal without penalty, anticipated risks and benefits, and a description of their involvement. The consent form also requested permission to audio-record the interview. Confidentiality of all documents and audio-records was explained and assured.

Generally, qualitative research uses an open-ended approach to questions, and as such, this method may result in spontaneous and unexpected conversational directions (Hadjistavropoulos & Smythe, 2001; Smythe & Murray, 2000). Consequently, consent during the qualitative interviews was an ongoing process, referred to as 'process consent' (Dewing, 2007; Hadjistavropoulos & Smythe, 2001; Smythe & Murray, 2000). In order to adhere to these recommendations in qualitative research, consent was not solely

limited to the initial signing of the consent form; rather, consent was considered continual and collaborative.

Following the interview, participants were asked if they had questions or concerns about the study, or their participation therein. Participants were reminded of their right to withdraw from the study at any time. A debriefing form (see Appendix F) was provided to all participants upon completion of the interview and questionnaires and all participants were invited to contact the primary investigator or supervisor at any time if they had further questions regarding the study.

2.6.3 Interview. Each participant took part in a flexible, semi-structured, face-to-face interview that was approximately 75 minutes in duration. The interview followed the appropriate guide for Studies One through Three with follow-up questions generated as needed. Although the same interview guides were used throughout, the individual interviews were unique, due to the open-ended nature of the questions, and the ensuing idiosyncratic follow-up questions that may arise. Each participant filled out a select few paper-and-pencil questionnaires at the same point in time as the interview. The interview was audio-recorded. The primary investigator administered all interviews and questionnaires.

2.6.4 Transcription. The audio-recorded interviews were transcribed verbatim. As a thematic content analysis approach was used to analyze the interviews, the focus was placed on accurately capturing the content of the interview. As such, the way in which content is communicated (e.g., nuances of language, accents, involuntary vocalizations, etc) was less of a focus (Oliver et al., 2005).

3.0 Qualitative Data Analysis

3.1 Theoretical Approach

To meet the objectives of the proposed study, all interview audio-recordings were transcribed, then examined using thematic content analysis (Patton, 2002; Sandelowski, 2000) within an interpretative phenomenological framework. Thematic content analysis allows for important themes and ideas from the semi-structured interviews to surface. Thematic content analysis aims to describe a phenomenon through the identification of important textual information and themes (Hsieh & Shannon, 2005). Interpretative phenomenological analysis (IPA) is used to discover how individuals perceive particular situations or experiences they are facing, and how they make sense of their world (Smith & Osborn, 2003). As such, applying this IPA framework will allow for a better understanding of the parents', friends' and recovered individuals' lived experiences with self-harm. The goal of IPA is to describe the meaning or "essence" of the lived experience of a phenomenon, and often involves describing core commonalities and structures of multiple participants' experiences (Starks & Trinidad, 2007).

3.2 Steps to Analysis

With IPA, the focal point is the experience of the research participant. Therefore, the aim is to adhere as closely as possible to the words and created meaning of the participant, while organizing themes. For Studies One through Three, the six phases of thematic analysis (Braun & Clarke, 2006) were applied. The first phase involved becoming familiar with the data by reading and re-reading the transcribed interviews while noting initial ideas. The second phase involved systematically coding the entire data set by breaking down participants' responses into topics of similar meaning (or

emergent themes) while collating data relevant to each topic. In the third phase, topics of similar meaning were further coded and collated into potential themes. In the fourth phase, all themes were reviewed in relation to the coded extracts and the entire data set. The fifth phase involved an ongoing analysis in order to refine the specifics of each theme and the overall story, as well as to generate clear definitions and names for each theme. Finally, the last step involved selecting poignant examples of each theme and relating the results to the original research questions. The computer software program NVivo was used to assist in data analysis (QSR International Ltd., 2006). The final goal of the qualitative analysis was to create categories and themes that accurately reflected the interviews, and thus the participants' experiences, as a collective. The categories and themes that emerged from the interviews assisted in answering the research questions, and achieving the study objectives.

3.3 Rigour and Trustworthiness

In qualitative research, several different procedures are routinely used to help ensure the rigour and trustworthiness of results (Creswell & Miller, 2000). Traditionally, four criteria are used to appraise rigour and trustworthiness, and include: credibility, transferability, dependability, and confirmability of the results (Guba, 1981; Van der Riet & Durrheim, 2006).

3.3.1 Credibility. The credibility of qualitative research refers to the degree to which the findings are believable, and congruent with reality (Guba, 1981; Van der Riet & Durrheim, 2006). Member-checking is a method of ensuring research credibility (Van der Riet & Durrheim, 2006). Member-checking involves presenting participants of a study with the final results in order for them to confirm and appraise the accuracy of the

interpretations (Creswell & Miller, 2000). In doing so, the participants are given an opportunity to validate the final product and ensure that it is true to the experiences and meanings on which they first reported (Ritchie & Lewis, 2003).

In the current study, all participants were contacted after the study's completion, and asked to review the final results and interpretation. At that time they were given the opportunity to clarify, qualify, or otherwise add to the final results. The participants' responses to member-checking were positive, in that several participants commented that participating in the study, and seeing the culmination of theirs and others' efforts was both informative and rewarding. Moreover, the participants confirmed the credibility of the results, as one participant nicely summarized:

I think the results fit my own experiences at least, and do reflect my voice.

Everything seems correct.

3.3.2 Transferability. The transferability of qualitative research refers to extent to which study findings are applicable or generalizable to other situations, contexts, or populations (Guba, 1981; Van der Riet & Durrheim, 2006). Transferability can be demonstrated by providing a comprehensive description of all aspects of the research study, particularly the participants and the research context. Within the limits of ethical considerations, I have described the participants, their stories, and the research context in as much rich detail as I was able. The participants' demographic information, experience with self-harm and/or caregiving, and other descriptors allow the reader to determine whether their stories are transferable to other situations.

3.3.3 Dependability. The dependability of qualitative research involves the reliability of findings; therefore, research is said to be dependable when the findings are

congruent with the original data (Guba, 1981; Van der Riet & Durrheim, 2006). In order to enhance the dependability of the current findings I utilized a well-established analytic method (Braun & Clarke, 2006), that mandates the reading and re-reading of data, and the comparison of findings with original data. Moreover, I presented all findings with examples and quotations from my original data (i.e., transcribed interviews).

A search for disconfirming or contradictory evidence can also serve to bolster the trustworthiness of qualitative findings. As researchers have a proclivity toward finding evidence to support their preliminary findings or themes, a deliberate search for disconfirming evidence serves to remediate this inherent cognitive and attentional bias (Creswell & Miller, 2000). Just as the act of searching for contradictory evidence can limit the potential for researcher's bias, the disclosure of contradictory evidence can also improve the transparency of the research for the reader. A search for both confirmatory and disconfirmatory evidence enhances the credibility of the final derived themes, as there is better assurance that these themes accurately and truthfully fit the original data. In the current study, after preliminary themes and categories were established, a purposeful search for contradictory evidence was conducted.

3.3.4 Confirmability. The confirmability of qualitative research describes the extent to which the researcher has considered and acknowledged her own beliefs and potential biases (Guba, 1981; Van der Riet & Durrheim, 2006). The social constructivist nature of IPA especially acknowledges the researcher's ongoing role and influence in the research process. To enhance confirmability I have openly and repeatedly acknowledged and included my own contributions to the research findings. Furthermore, I engaged in reflexivity, a process of critical self-reflection, whereby researchers acknowledge and

self-disclose their assumptions, beliefs, and biases that may influence their interpretation of data and their co-construction of knowledge (Creswell & Miller, 2000; Schwandt, 2007). An IPA researcher engages in reflexivity by reflecting, thinking critically, sensitively, sincerely, and candidly about the research experience and process (Willig, 2001). For the current study, a field journal was kept in order to keep an ongoing account and reflection of researcher assumptions, beliefs, and biases. This field journal was frequently consulted during the analyses in order to be considered when reporting study results. Furthermore, excerpts from the field journal are included throughout the Results section.

4.0 Study One (Recovered Individuals)

4.1 Introduction to Study One

The act of self-harm remains shrouded in secrecy and shame, and many – family, friends, and professionals, remain confused and ill-equipped. Despite the high prevalence rates among adolescents and young adults, and despite the devastating and dangerous impact that these behaviors can have on mental, physical, and social health, self-harm receives little attention in both research and clinical practice. Moreover, the programs and services currently targeting self-harm behaviors have limited effectiveness. The majority of individuals who self-harm seem to “age out” or otherwise recover on their own, or in response to social supports, rather than through formal supports. Although many individuals do recover, they often experience years of emotional distress before ceasing self-harm behaviors.

Limiting the duration of this distress through improved programs, services, social supports, or information should be a goal of the health care system. In order to best support those individuals who are engaging in self-harm we need to better understand the experience of self-harm. In particular, if we want to help someone recover from self-harm, we need to learn from those individuals who have successful experiences with the self-harm recovery process.

This chapter will explore individuals’ personal experiences in recovering from self-harm. In particular, experiences with parental involvement, friend involvement, help-seeking, support needs, and the general recovery process, will be examined. Though not all perspectives or experiences of these participants were identical or unanimous, certain commonalities and conclusions can be found throughout their stories.

4.2 Summary of Study One Participants

Ten individuals who had recovered from self-harm participated in Study One. Due to the sensitive nature of the subject, the fact that many of the participants' friends and family members remain unaware of their self-harm behaviors, and the participants' expressed desire to remain as anonymous as possible, I have chosen not to describe the story of each individual. Instead, I will provide collective descriptive information on their demographics, self-harm statistics, and experience engaging in self-harm. In order to introduce the participants in a more full and meaningful way I will include direct quotes that illustrate the descriptive information. In order to further maintain the participants' anonymity I have assigned each participant a pseudonym, and will refer to them by these assigned names.

The sample of recovered individuals included seven females, two males, and one individual who identified as non-binary. Participants ranged in age from 18 to 24 years old (mean age of 19 years). In terms of ethnicity, six participants self-identified as Caucasian, three as Aboriginal, and one as Hispanic. These participants had extensive contact with mental health professionals, some of whom had been involved with mental health care for many years (i.e., 20 years). The majority of participants reported having received a diagnosis from mental health professionals; the most common diagnosis being depression or anxiety. In fact, only three participants had not received a formal diagnosis.

The participants' self-harm history and experience was queried using the DSHI (Gratz, 2001). In responding to this questionnaire, participants indicated that they had used a variety of self-harm methods. All 10 participants reported cutting themselves. A majority of participants had also engaged in severe scratching, carving words or pictures

into their skin, and punching themselves until bruised. A minority of participants also reported other, rarer forms of self-harm (i.e., self-burning, biting themselves to the point of drawing blood, stabbing themselves with sharp objects, deliberately breaking bones, and head-banging). Of note, the participants in the current study are in line with extant research, indicating that it is common among self-injurers to engage in multiple forms of self-harm (Lloyd-Richardson et al., 2007).

The course of self-harm was also queried using the DSHI (Gratz, 2001). On average, participants began engaging in self-harm at the age of 13 (range: 10 years to 15 years old). On average, they engaged in self-harm over the course of 4 years (range: 6 months to 8 years). Past research (Nixon et al., 2009) has indicated that individuals typically engage in self-harm for several years. All 10 participants reported engaging in self-harm more than 10 times over the course of their life, and 8 participants reported engaging more than 100 times. In terms of severity, three participants reported requiring medical attention in response to their self-harm. Although all participants self-identified as “recovered”, the time since their last incident of self-harm varied from 6 months to 6 years ago. On average, participants had been recovered for 2.5 years.

Participants described different reasons, or paths, that led to self-harm. Depression, coupled with overwhelming situations or emotional pain was a frequently reported reason. For example, Emilee shared:

I have diagnosed depression, and so towards the start of 2009 I just remember feeling really, really sad all the time and I couldn't explain it and I didn't understand it. I remember my friend, she told me that she has started doing it [self-harm]. Then in the summer of 2009 I lost someone that was really close and

important to me, and so when I came back from his funeral, that was the first time I ever done it [self-harm] because there was so much grief and hard feelings and everything that I just couldn't contain it. And that's how it started. (Emilee)

For several other participants, the overwhelming situation and emotional pain which prompted self-harm stemmed from bullying. For example, Eve shared:

We have two big events in my life that caused self-harm and self-hate . . . I always seem to self-harm because of a different circumstantial thing affecting me, so the bullying and the assault were the reasons I did my self-harm. I think it would be different if nothing had happened to me. (Eve)

Others were less able to identify the cause of self-harm, and focused more on the result, or reinforcement they received from engaging in self-harm. Alana said it best:

Well, I don't really know why people start in the first place because I can't even say why I did. Once you start, you can forget about whatever emotional pain you're feeling, because you're focused on a physical pain like its real. Obviously, emotional pain is real and you can feel sad and you can feel happy. Those are actual feelings that people feel, but if you can't pinpoint it and you don't know how to release it, or you don't know how to share or explain, or you don't have people understanding the way you feel, when you do it in a physical way, you can see the pain leaving your body. You can see the emotion going away. You can physically feel the hurt that you have or the sadness that you have. There's just a wash up, like all these emotions are lifted and they're gone. (Alana)

4.3 Summary of Themes

The method of data analysis described in Chapter 3 was used to identify themes from the in-depth interviews. Five topic areas (i.e., parents' involvement, friends' involvement, help-seeking, support needs, and recovery) were queried, resulting in 15 superordinate themes, and various subthemes. The categories, superordinate themes, and subthemes are listed in Table 1, which as a whole, describe an individual's experience of recovery from self-harm.

Table 1.
Summary of Themes from Study One

TOPIC AREA	SUPERORDINATE THEMES	SUB THEMES
Parental Involvement	Parental reactions experienced as helpful	1. Assertively taking action 2. Arranging tangible support 3. Providing steadfast emotional support
	Parental reactions experienced as unhelpful	1. Inaction 2. Aggressive and resentful 3. Disconnected and distant 4. Misguided and misinformed
	Perception of parents' experience and emotion	-
Friend Involvement	Friend reactions experienced as helpful	1. Validation and positive affirmation 2. Mutual sharing and open discussion 3. Tough love
	Friend reactions experienced as unhelpful	1. Blame and condemnation 2. Trivialization 3. Stigmatization
	Perception of friends' experience and emotion	-
Help-Seeking	Formal help	-
	Informal help	1. Connection 2. Distraction 3. Contribution
	Obstacles to good help	1. Distrust and discomfort 2. Availability and accessibility of help 3. Help-seeking equated with attention-seeking
Support Needs	Emotional	-
	Informational	1. Self-harm is serious 2. Self-harm is not just for attention 3. Alternative coping strategies are needed
	Tangible	-
Recovery	Progression of recovery	1. Desiring wellness 2. Admitting self-harm is not aligned with wellness 3. Taking steps towards wellness
	Important factors to recovery	1. Embracing new perspectives and realizations 2. Offering honesty and accepting support 3. Engaging in positive activities and distractions
	Lingering effects after recovery	1. Negative effects 2. Positive effects

4.4 Parental Involvement

The participants of Study One had varying experiences with parental involvement. A few participants told their parents outright about their self-harm behaviors while others hid their self-harm for years before their parents became involved. Two participants said their parents still do not know, at least not for certain, that they had ever self-harmed. Despite the varying degrees of parental involvement, all participants were able to share about how they experienced their parents' role, how their parents may have influenced their self-harm, and reciprocally, how their self-harm may have impacted parents. Three superordinate themes emerged in this topic area: parental reactions experienced as helpful, parental reactions experienced as unhelpful, and perception of parents' experience and emotion.

4.4.1 Parental reactions experienced as helpful. In speaking about their parents' reactions, participants identified three main reactions that were experienced as helpful: *assertively taking action, arranging tangible support, and providing steadfast emotional support*. Some of these parental reactions were immediately recognized as helpful, whereas other reactions were only retrospectively identified as helpful. Of note, "helpful" encompasses those reactions that were experienced as emotionally helpful, practically helpful, and relationally helpful.

Assertively taking action. In the first subtheme, assertively taking action, participants described parents who openly addressed their child's self-harm and became actively involved. In response to their parents' involvement, participants clearly distinguished between their emotional response at the time of their self-harm, and their emotional response at the time of the interview. Most participants shared that at the time,

they were highly irritated with their parents' involvement. Parents' actions were interpreted as prying, overbearing, or an overreaction. However, all participants who experienced active and assertive involvement from their parents believed these actions to have been exceedingly helpful. Though perceived as overbearing at the time, in retrospect participants described this involvement as "necessary", "essential", and "exactly what was needed". Parents' assertive action included directly discussing self-harm with their child, closely monitoring their child, and educating themselves about self-harm. Guinevere had been self-harming for a few years before her behaviours escalated to a suicide attempt. Guinevere's parents first discovered that she had been self-harming during her post-suicide attempt hospital stay. During this time Guinevere resented her parents' active and assertive attempts to better understand self-harm, but later, recognized this parental response as extremely helpful.

They really stepped up to understand what was going on. What cutting was or what self-harm was. . . They talked to a lot of people and I think my mom's brother – he is a therapist so they talked to him a lot. So he kind of – I think guided them into helping me. But they were very overbearing with their help and they kind of like refused to step back. (Guinevere)

Arranging tangible support. Several participants spoke about their parents arranging tangible support for them after discovering that they had been self-harming. Forms of tangible support included: financing therapy sessions with a private psychologist, liaising with the school in order to arrange extra supports, as well as arranging for hospital visits, appointments, or medication. Thus, parents provided tangible support by insisting on the involvement of mental health professionals,

monitoring the follow-through, and expending time, effort, finances, and encouragement to ensure participation. For example, Lynnzi shared that her parents were quick to respond to her self-harm disclosure as they arranged regular meetings with her school counselor despite her protestations.

My parents talked to me about it and told me why they thought I needed to and they told me that they're doing it to help. . . It wasn't really forcing me to go. But I mean once you've called the school it's kind of expected that you actually go. They pull you out of class and take you down there, so it wasn't exactly optional. (Lynnzi)

Additionally, several participants spoke about their parents removing sharp objects (e.g., knives, razor blades) from the home environment. For example, Emilee expressed initial frustration with her parents for hiding self-harm tools, but came to understand and appreciate her parents' actions.

Once you can't find a knife, suddenly once you're looking for it, the urge kind of goes away. Then you don't feel like you need to self-harm anymore. I really think that parents should take it away, because you have to be better enforceable parents. Because as a parent it is your job to protect your children. And maybe they will be mad, maybe they will be upset, but it is in their best interest. (Emilee)

Providing steadfast emotional support. The third subtheme, providing steadfast emotional support, was identified as an extremely helpful parental reaction. Participants spoke generally about parents being “always there for me when I needed to talk” or “providing moral support”. However, participants also spoke specifically about certain actions or comments that demonstrated emotional support, such as parents saying “I love you” or “thank you for telling me about your self-harm” as well as displaying physical

signs of affection. A key component in these stories was the emphasis on unwavering or steadfast emotional support. Participants needed the security of consistent love and support even when they reacted poorly to their parents. For example, Guinevere described being very reticent to speak to therapists or her parents about her problems, and admitted to being surly and unkind in response to her parents' help. Nevertheless she said:

For me, when they bombarded me with help and refused to stop – that helped me. That was like the best help for me, for them to just make me be healthy and they offered unconditional love and support. (Guinevere)

Parents who took steps to educate themselves about self-harm and engaged in discussions about self-harm with their child were also perceived to have helpful reactions. Participants appreciated when their parents took the time to inform themselves about self-harm, whether by talking to professionals, reading, or asking their children questions. Participants experienced positive emotions (e.g., feeling cared about) and outcomes (e.g., parents better able to problem solve) because of these parental reactions.

4.4.2 Parental reactions experienced as unhelpful. Participants also described four parental reactions that were experienced as unhelpful, including: inaction, aggressive/resentful, disconnected/distant, and misguided/misinformed reactions.

Inaction. The first subtheme, involving parents who suspected their child was self-harming but did not act, was noted in many participants' stories. Participants described how their parents tended not to take action, despite many clues to their self-harm (e.g., scars, blood-stained clothes, keeping knives and razor blades in their room). Some participants spoke about going to great lengths to keep their self-harming behaviors

hidden from their parents, while others described reaching a point where they did not bother to hide scars, bloodied tissues, or sharp objects because they knew their parents would not push the matter.

Parental inaction evoked significant emotion from the participants. In fact, in response to parental inaction, participants described intense emotions at the time of their self-harm, as well as at the time of the interview. Some participants were saddened, and felt uncared for. One participant, TJay, spoke about crying out for help with her self-harm in hopes that someone would notice how much pain she was in. Despite continual unexplained bruises, cuts, and scars, her parents never intervened.

It makes me a little upset to think that I'm their own child and they wouldn't even help me. It kind of makes me feel a little like, if my own parents won't even help me then why should I think that someone else who doesn't even know me would. It's very discouraging to think that my own parents probably knew, but they wouldn't help. (TJay)

Other participants spoke about feeling dismissed and alone because of their parents' inaction. For example, Emilee spoke about how the proverbial elephant in the room distanced her from her parents.

My mom, she knew but she pretended like she didn't know. She tried to push it under the rug kind of thing and I don't think she really knew how to deal with it at all . . . she kind of just like shoved them away and let other people deal with them. My dad never really talked about it - like we had one conversation about it and it was really awkward and uncomfortable for me so I kind of like took myself emotionally out of the situation. But we've never really discussed it. (Emilee)

Similarly, some participants noticed that their methods of self-harm (e.g., knives, razor blades) silently and suddenly disappeared, but their parents never openly voiced their suspicions or concerns. For example, Jess shared:

I kept it a secret from them for at least a year, for as long as I could, but when they found out I didn't ever really come to them when it happened. I pretty much stayed away from them. Their role was, I guess just try to take things away from me to stop me from doing it [self harm] but I don't think they ever really directly dealt with what was causing the problem at the time. They didn't really have any role other than they were just trying to control damage as best they could. I don't think they knew how to have direct involvement. (Jess)

In sum, parental inaction was met with negative (and long-standing) emotions and negative repercussions on the parent-child relationship.

Aggressive/resentful reactions. The second type of unhelpful reactions are those that are described as aggressive or resentful. Participants described both verbal and physical acts of aggression or resentment. For example, one participant recalled a particularly distressing incident when her mother said that the self-harm behavior “makes her want to jump in front of a train”. When parents reacted with these types of critical or resentful comments participants described feeling disparaged, unloved, and guilty. Some participants shared that their parents would physically check their arms, wrists, or other body parts for signs of self-harm. These participants perceived this type of scar-checking to be intrusive and aggressive, and described feeling ashamed and embarrassed in response. Being punished or reprimanded for self-harming was also experienced as an

aggressive act. Alana described how illogical and counter-productive these types of reactions are:

Do not yell. Do not threaten or put them down even more, because you self-harm when you get to a low, then you get lower and lower and lower and yelling is just going to put them underground. It's not a good idea. . . . Even if parents don't get it – their kids just need to know that they're loved and that they're supported in getting help, and that the self-harm, of course it's wrong and it's bad, but at the same time parents can't punish that either because kids are already punishing themselves. (Alana)

Other participants recalled less overtly aggressive incidents that were still experienced as harsh. For example, Jess described how reactions to cuts or scars can be detrimental:

Don't recoil or react very badly when you see scars on people, because generally it's not nice to be reminded of the fact that you've done something to scar yourself, especially when otherwise you're in a good mood and your mind isn't on it. Then suddenly someone else reminds you of the fact you have this going on, and now, all of a sudden all you can think about is the fact that you've hurt yourself and that other people are disgusted when they see it. (Jess)

Similarly, one participant felt disparaged when her mother would make comments about her not being able to wear a sleeveless grad dress or wedding dress because of her frightful scarring.

Disconnected/distant reactions. The third type of unhelpful reaction are those that are described as disconnected or distant. Participants described being treated

differently after their parents found out about their self-harm; some described being “treated like a stranger”. Emilee described these distant parental reactions as “the worst”.

When I asked Emilee what makes being treated like a stranger the worst, she shared:

It kind of makes you feel like if you tell this person and they react like that, maybe other people are also going to react like that and they're going to treat you with so much judgement. Then you can't really go to anyone about it and you can't talk about how you're feeling about it and why you're self-harming. (Emilee)

Many participants described a type of disconnect in which their parents would simply not acknowledge the situation. Jess spoke of her father's aloofness and her mother's silent treatment.

My dad never really had any reaction. I think he didn't really know how to deal with it so he just kind of kept his distance. My mom, her reaction would just always be that she was upset. Then we just didn't talk to each other a while after that. She would just be upset for the rest of the day and it sort of made things quietly awkward. (Jess)

Participants experienced this disconnected parental reaction as being held at arm's length, and felt their parents creating emotional distance between them. Consequently, they felt less able to express their thoughts and feeling and share in meaningful ways with their parents. By way of example, participants experienced parents giving mixed signals about emotional closeness. Out loud their parents would say “come talk to me”, but everything else their parents did, including their reactions to being told about self-harm seemed to impart the message, “but do not tell me anything that would upset me”.

Furthermore, some participants noted that parents would stay disconnected until

something potentially lethal would occur. Unfortunately, parental involvement would only last as long as the situation seemed dire. For example, Jess shared the story of how her self-harm and depression escalated to the point of attempting suicide. Following her suicide attempt she was in the hospital for several weeks, at which point her parents became (temporarily) more involved.

People don't really address the problem at hand unless it gets to the point where it's almost lethal and that's kind of how I felt in the hospital. I was getting a lot of support from everybody, but before that there were a lot of cries for help that I had given but nobody had listened to me. Now that I'm in the hospital everybody cares but once you go back and people say 'you're better now,' you stop getting that kind of attention and people don't really ask you how you are anymore. My parents were like this too. You're just waiting for it to get really critical before you directly address it. I really appreciated the attention I got in the hospital but I sort of wish that people would carry that attention on for me and for everybody else with self-harm problems. (Jess)

Misguided/misinformed reactions. Many participants' parents were uneducated about self-harm, or were acting from a place of misinformation. As a result of being misinformed, many parents would make comments that participants perceived as indelicate and judgmental. For example, one participant recalled her parents making comments suggesting that people with depression “brought it on themselves” due to poor life choices, or should just “snap out of it”. Another participant recalled how her family had described her self-harm as selfish and “the same as suicide”. Participants noted that indelicate and misguided comments acted as triggers for their self-harm, as these

comments served as reminders that they were misunderstood, alone, or judged. Another common misguided parental reaction was to focus on the consequences of self-harm (e.g., wounds, scars) rather than on the antecedents (e.g., triggers such as loneliness or bullying). Many participants expressed the desire for their parents to attend to what was going poorly in their lives and try to help them counteract their triggers to self-harm. Instead, parents often attended to their fresh wounds by applying first-aid, or expressed concern about their scars (“what if someone sees these?”). For example, Jess stated:

I don't think they [parents] ever really directly dealt with what was causing the problem at the time. They were just trying to control damage as best they could . . . I think if every time something happened she had focused on what was going on with me instead of the consequences, then maybe that would have helped. Because even now, when I'm depressed and I don't show up at school, she gets upset that I wasn't at school instead of addressing that I was depressed. (Jess)

Participants recommended that parents should focus on the *why* of self-harm and not on the *what* or *now what* of self-harm.

4.4.3 Perception of parents' experience and emotion. All of the participants whose parents were aware of their self-harm believed that their parents had experienced difficult and negative emotions. Parents were most often described as scared, worried, hurt, self-blaming, in pain, and uncomfortable. All the participants acknowledged that their self-harm resulted in a difficult ordeal for their parents. In fact, some participants believed that years later their parents were still affected and were still healing. Some participants had come to the realization that their parents' reactions likely stemmed from how scared they were of pushing too hard or demanding too much of their children.

Participants seemed to have one of two reactions to their parents' negative experience and emotion. Some participants described trying to conceal the severity of their own distress in order to hurt their parents less. Participants did not want their parents to blame themselves, experience guilt for not noticing sooner, or feel like bad parents. Eve spoke about wanting to shield her parents from the pain she was enduring, because she believed them to be unfamiliar with that type of pain:

I didn't want to share my self-harm or the feelings that I was having with my parents because they had never really gone through that. (Eve)

Other participants acknowledged that their parents were in pain, but at the time they were too sick themselves to care about how their actions were affecting their loved ones. For example, Maria shared:

I feel part of me was kind of in my own world. And I feel that I was going through so much and I had so much pain that maybe I didn't really even feel empathy, as bad as that sounds. I couldn't see the damage that it was doing really. Because I feel like there was just so much inside of me and all of this negative stuff and energy that it was blocking me from seeing what my self-harm was doing. (Maria)

4.5 Friend Involvement

The participants of Study One experienced a range of friend involvement during their recovery from self-harm. For some participants, their friend was the only person who knew about the self-harm and the most meaningful source of social support. Other participants reported hiding their self-harm from friends while it was occurring, and only sharing their struggle after recovery had begun. Despite the varying degrees of friend involvement, all participants were able to share how they experienced their friends' role,

how their friends may have influenced their self-harm, and reciprocally, how their self-harm may have impacted their friendships. Three superordinate themes emerged in this topic area: friend reactions experienced as helpful, friend reactions experienced as unhelpful, and perception of friends' experience and emotion.

4.5.1 Friend reactions experienced as helpful. In speaking about their friends' reactions, participants identified three main responses that were experienced as helpful: *validation and positive affirmation, mutual sharing and open discussion, and tough love*. Similar to their experience with parental reactions, some of the friend reactions were immediately recognized as helpful by participants, whereas other reactions were only identified as helpful in retrospect. Again, "helpful" is broadly defined and encompasses those reactions that were experienced as emotionally helpful, practically helpful, and relationally helpful.

Validation and positive affirmation. The first subtheme, validation and positive affirmation, refers to friends providing compassion and understanding to the participants' situation while also providing encouragement and support to overcome the situation. Although not condoning self-harm itself, these friends responded to self-harm with non-judgment. Validation and positive affirmation also included responses that asserted the person's worth and value. For example, one participant related that her boyfriend would often tell her:

I know you're strong enough to stop yourself. . . I don't want you to hurt yourself because you don't deserve that. (Lynnzi)

Many participants spoke about the importance of having their feelings validated, despite how they had chosen to deal with these feelings. Being validated as a worthwhile

person was a significant message to receive from a friend. When asked about the best response to give a friend who is self-harming, Jess shared:

Basically validation is the best thing that can happen. Validation and somebody genuinely telling me to they want me to take care of myself, and then giving suggestions on how to do so. Or, just talking with me or inviting me over, sort of taking me away from the act of self-harm and just focusing on me as a person instead of focusing on the thing that I did. (Jess)

Mutual sharing and open discussion. The second subtheme, mutual sharing and open discussion, involved friends being willing to connect emotionally through forthright conversations. Frequently, participants noted the importance of having friends who were willing to openly discuss the reasons behind their self-harm, as well as the act of self-harm itself. Simply having a friend who was not afraid, or judgmental, or uncomfortable with the truth of their experience was deemed to be exceedingly helpful to these participants. Some participants described helpful conversations in which their friends shared how the self-harm was affecting them. For example, Lynnzi recalls a common conversation with her boyfriend:

He'd tell me that the self-harm upset him and the different reasons why he didn't want me to do it. He'd talk me through it, talk about it, and get me to tell him what was going on. (Lynnzi)

For other participants, the helpful conversations involved their friends opening up about their own emotions and problems. This mutual sharing was experienced as non-judgmental, and resulted in participants feeling less alone and isolated. One participant

described “sitting as equals” during these conversations, and from mutual sharing and open discussions among her friends a formal student-led support group was created.

Tough love. The third subtheme, tough love, encompassed a variety of friend responses. The common factor among this subtheme involved friends taking a firm stance despite the potential friction it would cause in the friendship. Often this involved friends asserting the severity of the self-harm and asserting that it was “a big deal”. Sometimes a tough love approach resulted in friends insisting that formal help be sought, telling parents about the self-harm, or initiating pacts and ultimatums (e.g., “If you self-harm again we are telling your mother”). A tough love response occasionally involved friends checking for the availability/access to sharp objects or checking for fresh wounds. Participants did not unanimously agree on the utility and acceptability of their friends physically checking for wounds or scars. Although some participants found this reaction to be particularly helpful, there are some caveats. First, the friend had to be someone extremely close to the individual who was engaging in self-harm. Second, these actions were initially interpreted as intrusive and embarrassing, and were only accepted as helpful and supportive after quite some time. However, being physically checked for wounds and scars was eventually perceived as a response that created accountability and that demonstrated their friend was invested and involved in their recovery process. Eve described the experience of having a friend physically checking her arms for fresh cuts in the following way:

When she first started checking I was really pissed. Like, you can't just do that to somebody . . . But after a while it seemed like she was doing it to show that she cared and it wasn't really an invasion of privacy anymore. (Eve)

In sum, a tough love response was viewed as a necessary evil, in that participants experienced their friend as harsh or disciplinarian, but came to see the response as helpful and coming from a place of love and concern.

4.5.2 Friend reactions experienced as unhelpful. Participants described three main friend reactions that they experienced as highly unhelpful: *reacting with blame and condemnation, trivialization of self-harm, and stigmatization of self-harm.*

Blame and condemnation. Several participants encountered friends who blamed them for engaging in self-harm as well as not being able to stop self-harming. Emilee described why a reaction of anger and blame is unhelpful:

It makes you feel like nobody accepts it [self-harm], even though you're trying to stop and you don't want to do it, but you can't help it. So it makes you feel like people are blaming you for being the way that you are and for having something really wrong with you. (Emilee)

Other participants described “aggressive” and “authoritative” condemnation of their self-harming behaviours from their friends and peers. These participants expressed their frustration with friends feeling entitled to make critical or condemning comments about their self-harm behaviour because of visible scars. Jess shared:

As soon as an emotional problem becomes a physical problem, it becomes something that everybody feels like they can ask about. (Jess)

Participants recalled friends who would angrily demand that they “just stop” self-harming. A reaction of blame and condemnation was often experienced as condescending and demonstrating a lack of understanding. Ultimately, this type of reaction did more harm than good, as it would distance participants from their friends/peers.

People have tried to get confrontational with me before and it just makes me angry more than anything, and it makes me want to cut off contact with them completely because I don't like being talked down to and I don't like being told what to do when I'm doing something about my own emotions. It feels like people are telling me how to feel or how to deal with my feelings and that's very frustrating. (Jess)

In an effort to offer solutions rather than simply describe problems, participants were asked what type of reaction would be better than the reactions of aggressive disapproval. Jess offered a solution that was commonly voiced by the participants:

It's best for them to try and fix the situation rather than to fix the behaviour.

Because the person who is self-harming knows they're not supposed to be doing it. (Jess)

Trivialization. The second subtheme, trivialization of self-harm, involved reactions that dismissed, ridiculed, or minimized the seriousness of self-harm. Several participants recalled being told that self-harm was “stupid” or “ridiculous”. Moreover, these participants often felt dismissed as someone who was overly dramatic, or attention-seeking. Some participants in the current study had engaged in severe self-harm (e.g., deliberate bone-breaking, fainting due to blood loss) and some had escalated to the point of suicide attempts. Despite this intensity of emotional and self-inflicted physical pain, the participants' friends and peers still trivialized the act of self-harm. Hand in hand with the trivialization of self-harm comes the idea that it is easy to stop. Jordy summarized the struggle against trivialization:

Some people that I talked to said self-harm was just kind of like an immature way with coping. So I think the people that don't really understand why someone would do that to themselves, they kind of just think it's stupid, or like it shouldn't happen because you should just not do it because you can. As if you can just not do it. (Jordy)

The majority of participants mentioned “being labelled” as one of the most unhelpful responses they received from friends. Common labels trivialized self-harm, and included: “emo”, “being a 16 year old girl”, and “attention-seeker”. During the interviews, many participants experienced intense emotional reactions while discussing the notion that self-harm is a plea for attention. In general, participants adamantly denied wanting attention directed toward their self-harm. Comparatively, participants did admit that they wanted attention paid toward their problem. These participants shared that they were experiencing intense emotional pain and overwhelming life circumstances, and were desperate for compassion, understanding, and assistance with these issues. However, participants believed that their self-harm was a reflection of their pain rather than the call for that compassion. Jess presented an interesting argument to the debate. “Is it wrong to want attention? Are people not deserving of acknowledged suffering?”

Attention-seeking is an accusation that everyone who has self-harmed has had and I think it's a really ridiculous accusation because it's very obvious that we are all doing it for attention. We want attention. Our needs, our emotional needs, simply are not being addressed and whether it's for ourselves to acknowledge this or for other people to acknowledge this, it's the acknowledgement...we needed the acknowledgement that we are suffering and we need other people to realize that.

To be told in a vindictive way that I want attention; it's almost like an accusation that it's wrong of me to want somebody to recognize my own suffering. I think it's what makes it worse for all of us, that we don't want people to think we want attention, but we need attention. So we should be wanting attention. I think the wanting attention thing is the biggest hurdle for me and for a lot of people in terms of getting better because we need to learn to accept that we deserve attention and we've been told that we don't. (Jess)

Stigmatization. The third subtheme, stigmatization of self-harm, involves friend reactions characterized by discrimination, judgment, and negative stereotyping. Participants shared that they were fearful that their friends would think of them differently and fearful that they would be misunderstood. Oftentimes, participants found that they were treated differently after their friends became aware of the self-harm. Participants described being treated as “weak”, “weird”, and “defective”. Participants also experienced a loss of closeness or community among their friends and peers. Friends would distance themselves physically and emotionally. In some cases participants were ostracized to the point that they were told they were no longer welcome in the group, or that they needed to take their problems elsewhere. Whereas responses of trivialization send the message “you are too dramatic”, responses of stigmatization send the message “you are too broken”. In an effort to offer solutions rather than simply describe problems, participants were asked how friends could avoid sending this message. Jordy responded:

Make sure that your friend knows that you're worried about them because you care about them, and not because you think it [self-harm] is odd or you think it's like a defective characteristic or something like that. (Jordy)

4.5.3 Perceptions of friends' experience and emotion. Similar to their perception of the parental experience, the participants in the current study recognized that their friends had also experienced difficult and negative emotions. Friends were often described as “burdened”, “overwhelmed”, and “worried”. Emilee described the balance between relying on her friend’s care and her guilt for the stress she had caused:

I did feel really bad that I put that on her, because she was only 16. How can she deal with that? I couldn't even deal with it. But I was really blessed to have a friend like her that was really supportive. (Emilee)

In hindsight, the participants believed that their friends were too young to handle the problem of supporting someone who self-harms, as friends were often at a loss at how to help, and quite frightened by the situation. In fact, some friends had resorted to telling parents or other authority figures about the self-harm. The old adage “you’ll thank me later” applies, as participants were able to see in retrospect that their friends were unequipped to handle the situation and had made the difficult decision to involve better prepared adults.

Several participants asserted that they only told those friends who themselves had experience with self-harm, or who had also dealt with similar problems. Participants asserted that no one truly understands self-harm unless they had experienced it themselves. Among self-harming friends there were more open and frank discussions about self-harm behaviors, reasons, and consequences. Although the participants described feeling more supported and understood among self-harming peers, they also noted that it may not have been healthy to focus so much time and attention on this mutual problem.

4.6 Help-Seeking

4.6.1 Formal help. Several participants had not received any formal assistance because of how well they kept their self-harm hidden, and those participants who had professional involvement described vastly different experiences. Formal help-seeking was a positive experience for some, while negative or neutral for others. Similarly, some participants believed their formal support (whether a psychologist, school counselor, or family doctor) to have been integral to the recovery process, while others thought it was largely a waste of time. Whereas some participants cited practical and tangible forms of support (e.g., pamphlets for community resources, medication) as most helpful, others emphasized more emotional forms of support (e.g., being listened to, being shown compassion and understanding). Whether received or not, participants described wanting two things from their formal support people: practical support and emotional support.

Readiness to accept help is an important factor in determining the outcome of formal help-seeking. During a self-harm journey, there seems to come a time when things had to get better using any means possible, or things were going to get tragically worse. For these participants, that something worse often meant suicide. Emilee articulated the shift she experienced in a post-suicide attempt hospital stay which prepared her to finally accept help from the healthcare system, and eventually a psychologist.

That crossroads... I was either going to die or I was going to get help and get better. I kind of saw, like afterwards, that new perspective. I kind of saw life in a different way. . . I think after the hospital I saw the light, but before that it was always just dark. Everything was dark. (Emilee)

Maria had seen numerous counselors, psychologists, and other formal support

people all throughout adolescence. She described being guarded and aloof for years when forced to have interactions with formal supports. Maria “hit bottom” and also experienced a turning point in which she sought out formal supports herself. Maria shared that adopting a future-oriented outlook at that crossroads was key for her.

My therapist told me I still have so many other plans, and then he told me about my future and how I wanted to travel, and all this stuff. . . So I would tell people to envision their life for where they see themselves. Even if you are really depressed, there’s still something that you want, or you do see yourself doing. I would tell them to envision that and know that it’s possible and just not to – not to give up. (Maria)

Participants described being dragged to therapists’ offices by their parents, sitting in stony silence across from school counselors, and flushing medication down the toilet. At some point, a turning point, people experience a readiness to accept help. Before that point, formal help sources are unlikely to be met with success, regardless of the particular strategies used.

4.6.2 Informal help. Apart from friends and families, individuals who engage in self-harm often seek out other types of informal support. Informal support sources can include people (e.g., coaches, teachers), groups (e.g., community programs, religious affiliations), or activities (e.g., recreation, hobbies) and the like. When describing informal help-seeking, participants in the current study had different wants and needs than when they had described formal help-seeking. Informal support seeking was meant to fulfill the following wants and needs: connecting with others who understand, distracting oneself, and contributing in a positive way.

Connecting with others who understand. Oftentimes participants were not able to connect with friends or family members over their self-harm, because their loved ones did not share a common experience. Understanding stemming from firsthand experience with self-harm was important to individuals engaging in self-harm. The participants discussed seeking out peers who had firsthand experiencing with self-harm. Connections were often forged over the internet. Alana shared her experience using Tumblr (a social media forum for online communication and networking), and her reasons for seeking this type of informal support.

You can find a bunch of people on Tumblr that have the same problem. You'd go and you talk to them and then you see what their experience is like, and you can just openly discuss it that way because you actually have somebody who gets it. Then you feel better about it because you're like 'I'm not the only one and I'm not crazy because I'm not the only person doing this. They have the exact same feelings that I do.' . . . That instant feeling of aloneness kind of gets lifted because you know you're not the only human who does it. That your emotions are valid; that your emotions are what other people feel too. (Alana)

Distracting oneself. Informal support can take the form of activities and hobbies. When seeking informal support participants wanted to be distracted from their urges to self-harm. Although the most effective distractions were enjoyable activities that provided a sense of mastery or accomplishment, simply keeping busy through multiple extracurricular activities or commitments was also useful. Lynzzi expressed the utility of distraction:

I tried to distract myself a lot to deal with my anxiety. Find things to distract yourself, like do what you love. I had drama, go on stage. I joined the choir so I could sing. I was painting almost daily. Just finding things that you enjoy to try to deal with it. (Lynnzi)

Rather than a long-term solution, this type of informal support seeking was often accessed as a short-term solution.

Contributing in a positive way. Although many participants were depressed, anxious, suicidal, or simply at rock bottom, they would engage in informal support seeking in hopes of positively contributing to others. Activities such as mentoring, volunteer work, organizing support groups, or providing a listening ear to strangers struggling online were described by participants as a way in which they were themselves supported. In helping others heal many participants surprised themselves by also healing. Indeed, much of the self-hate, low self-esteem, guilt, and shame that fueled their self-harm behaviours were alleviated by contributing to a worthwhile cause. After gaining momentum in her own recovery process, Alana would visit Tumblr and connect with individuals who were still struggling with self-harm, specifically to help others and give back to the website which had provided her with support.

Sometimes I'd like to go in there and be like 'Hey, I get it, let me help you.' I do have one girl that I keep more contact with. I pay attention to what is going on in her life. If I think she's going to slip, I'll send her a message. I'll try and talk her down and out of it and stuff. (Alana)

4.6.3 Obstacles to receiving good help. While in the process of help-seeking participants met with several different obstacles to receiving good help and support.

Three main obstacles were described: *distrust and discomfort in seeking help, lack of availability and accessibility of help sources*, and the notion that *help-seeking is equivalent to attention-seeking* and should therefore be avoided.

Distrust and discomfort. Once ready to seek help, individuals struggling with self-harm still experienced apprehension about sharing their story with others. Seeking help requires communicating about self-harm, and this open disclosure is dreaded and avoided. Emilee described her thought process when debating whether or not to talk to a professional:

I was kind of scared because maybe they'd go tell my mom . . . and just opening up emotionally was just really hard and I kind of didn't want to dig into that.

(Emilee)

Guinevere shared how unsuccessful their early contact was with mental health professionals due to distrust and discomfort. Guinevere felt that the professionals with whom she was in contact simply could not relate to her situation, and thus, fully engaging in therapy with someone who did not understand was too uncomfortable a prospect.

At first I was very resistant. I was like 14 or 15 and I'm like 'no I'm fine, I don't need help.' I did not want therapy and they made me go to a counsellor and I lied to her the whole time. I think I saw her for a few weeks and at the end of it she told my mom I was fine. If she had some sort of relatable story or something to my situation that she could talk about, that would make me have my guard down a little bit. (Guinevere)

TJay had persistently sought out professional help, rejecting many mental health professionals along the way based on lack of connection or trust. She wanted to pass on the following advice:

You can't get discouraged after one or two therapists, you have to keep going until you find somebody you like . . . if you just give up after the first one, you'll never get better, but if you keep going until you find someone, it's rewarding.

(TJay)

Availability and accessibility of help. Given how young individuals are when they begin to self-harm, they are often unaware of how to where to access help. Also given their age, support was not always readily available to the participants without adult guidance. Trevor was 13 when he realized his self-harm had become a serious problem. However, his parents were neglectful in general and unaware about his self-harm specifically. Trevor expressed how unattainable help seemed to a young boy with little family support:

I didn't really have some kind of grownup. I didn't even know if there was a school counselor. I didn't even know there were family doctors back then to talk to about that kind of shit. Doctors, psychologists, counselors never crossed my mind because I didn't even know about them... I was too young. (Trevor)

Other participants described how they received formal help only because of how involved their parents were. The participants emphasized that their parents were crucial in providing transportation and finances, as well as practical knowledge about who to contact, how to make appointments, and how to get time off school. The practicalities of

formal help-seeking are overwhelming to adolescents, and few youth-friendly options seem available.

Although self-harm can be either an impulsive or pre-meditated act, most self-harming individuals agree that when you have the urge to self-harm an immediate intervention is better than an appointment scheduled for two months later. Jess described the impracticality of waitlists:

My experience has mostly been that it [formal help] is not very helpful because you can go to the emergency room if you've seriously injured yourself or if you're at risk for suicide but if you want someone on short notice to just talk to or to work through issues, like you can't get someone without waiting one or two months. By then you've forgotten what you wanted to talk about. So the waiting list is way too long and not realistic. I think that's the reason that a lot of people don't seek help is because it just takes way too long. It's a headache. You settle for friends because that's short notice and you can't wait long with something that's like an impulsive habit you have. You can't put that off. (Jess)

Help-seeking equated with attention-seeking. Another obstacle to the receipt of help involved the perception that help-seeking was akin to attention-seeking. As previously mentioned, participants were highly averse to having others believe that they were acting in a certain way in order to garner attention or pity. Indeed, participants opted not to seek help rather than have anyone believe that they were attempting to elicit sympathy. Although this is partially an internal struggle or obstacle that participants face, it was also discussed as a societal struggle. Society in general is quick to label those who are open or vocal about their struggle with self-harm. Participants discussed the double

standard that exists between reactions to depression. If someone is depressed, and drinks away their proverbial sorrows, no one labels them as attention-seeking when they speak openly about seeking help through Alcoholics Anonymous. Comparatively, if someone is depressed and engages in self-harm, they are often labelled as attention-seeking when they speak openly about seeking help for self-harm. Jess described an unspoken rule not to show scars to others; because it would somehow diminish the importance or severity of self-harm; however, was unable to put a name to the reason or rationale for this rule.

I find a lot of people who self-harm, there's sort of this code that you don't show your cuts to other people or you don't show them off because it makes it somehow less, I don't know. It's like if you really did self-harm then you wouldn't want anyone else to know about it. (Jess)

Jordy had never sought help during his experiences with self-harm, and even after recovery expressed ambivalence about whether or not help-seeking was indeed the same as attention-seeking.

When I thought about getting professional help, it's almost like I would think that I would be doing it for attention or something like that. Like if I actually went to a professional about self-harm, it would be more like, 'look at me,' rather than something that I was just doing because of the emotions that I had. (Jordy)

4.7 Support Needs

4.7.1 Emotional needs. During recovery, individuals need to be told, blatantly and directly, that they are loved and that someone is there to support them. Even when friends and family think that it is obvious that they are available to support their self-harming loved one, they need to be direct and unwavering in their offerings of support.

Several participants in the current study spoke about the importance of being told, and told repeatedly, that they have people to rely on. TJay discussed the mixed messages that she was sending to friends and family while self-harming. She recognized that on one level she did not want negative attention, but on another level she was desperately crying out for help. TJay recognized that at the time, she would likely respond poorly to someone offering help; however, that this offer of help was exactly the type of emotional support she needed at the time.

I voluntarily acted out – like I knew what I was doing and I kind of wanted someone to approach me. I would just wear a tank top or I would wear shorts and I would walk around and talk to people and kind of hope, ‘Dude, my legs are cut out, can you help me?!’ At the same time that I didn’t want help, I was asking for help. I was begging people. . . That kind of bothered me now that I look back, because I was bluntly asking for help. It’s minus 20 outside and I’m wearing a tank top and you can clearly see there’s scars on my arm. Why don’t you ask me if I’m okay, or why don’t you tell somebody? (TJay)

Another type of emotional support that participants identified as important was physical touch and physical presence. Just having someone nearby, someone to sit with them, or someone to hold them, was crucial. Because self-harming in the presence of other people is rare, the physical presence of another person plays a dual role, in that it provides emotional support and helps prevent acting upon the urge to self-harm. Eve described this double function of physical touch and physical presence:

I think the physicality of having somebody there with you is important, because there is no way that I was going to sit at the dinner table and take the knife and

just start going at it, because you can't do that. . . I think physical contact is also important, as strange as it might sound. Even like a touch of somebody's hand. My mom would just hold me and rock me until I calmed down. (Eve)

Sensitivity and kindness when dealing with or discussing self-harm was another important type of emotional support. Often times, friends and family have very negative beliefs about self-harm, and will refer to people who engage in self-harm as “freaks”, “attention-seekers”, or the like. Similarly, they may make comments asserting that people can just decide to stop self-harming and never do it again, thus implying it is easy to cease these behaviours. The participant in the current study found that handling the topic of self-harm and mental illness in an insensitive manner could easily act as a trigger for them to self-harm, while careful handling of the topic left participants feelings supported and cared for.

4.7.2 Informational needs. Participants identified several informational messages that they felt would have helped their recovery process. These information messages are meant for everyone – adolescents at risk of self-harming, parents, teachers, peers, and society in general.

Self-harm is serious. First, is the message that self-harm is a serious problem, and in fact, is a slippery slope. Prior to engaging in self-harm many participants were under the impression that self-harm is “no big deal”. They would have liked to have more information on the scars, shame, secrecy, and self-loathing that often result. Additionally, they would have liked to have been told that often mild forms of self-harm progress into more severe types of behaviours. For example, Trevor had experienced escalating severity of self-harm, and in retrospect, wished he had been told the following message:

It is serious. It can seriously, you know, affect your wellbeing. When I was doing it I didn't think it was that big a deal. Now that I think back on it, it was a bigger deal than I thought it was. (Trevor)

Relatedly, participants would have liked available information about the addictive properties of self-harm and how most people find it difficult to give up. Lynnzi wished that self-harm (particularly, how addictive it can become) was better addressed in school health classes.

In high school when you study mental illnesses you talk about depression. Self-harm is barely ever mentioned. You don't actually talk about the causes, and the fact that it's an addiction just like any other addiction. Like, it's not something that people just want to keep doing. (Lynnzi)

Self-harm is not just for attention. As previously discussed, many participants wanted to send the message that self-harm is not a shallow or ego-centric bid for attention. Instead, it is often a cry for help, a distress call, or even – a very private behaviour that should be dealt with whether or not the person wants help/attention. TJay summarized this message well:

People think it's just an attention call, like it's just an attention grab, but it's not. I'm cutting but it's not because I want attention, it's because I'm actually in pain. (TJay)

Alternative coping strategies are needed. People tend to engage in self-harm because they are dealing with intolerable emotions or situations. Consequently, information on what other strategies may be helpful in dealing with these emotions or situations would be helpful. Participants specifically wanted someone who has dealt with

self-harm to provide information on concrete alternatives to self-harm. Lynnzi's description of which information should be shared in a school setting summarizes all three of these types of information support:

We've had people coming and talk to school about different topics, and it actually gets through to some people. So I don't know if you had people who've dealt with self-harm actually go into a school and talk, what would happen. They should talk about their experiences and talk about how they dealt with self-harm, and the fact that it's not just a choice, it's not just for attention, that it's an actual problem. Just to know that it's not like, it's not like exactly choosing to do it. You can't just drop it and quit it. It is an addiction, and people should actually understand that.

(Lynnzi)

4.7.3 Tangible needs. Several participants discussed how frightening it was for the health care system, particularly emergency room visits, to seem solely focused on keeping them physically safe, with no attention paid to whether or not they were emotionally safe. As participants often felt alone and discarded by the health care system, they recommended improved contact with mental health professionals. The participants shared stories characterized by a lack of follow-up, dismissive attitudes about self-harm, and a complete absence of psychoeducation about self-harm. Maria became emotional when describing her experience with the healthcare system following an emergency room visit:

I think the psychologist should have arranged for me to be with someone, and just try to get more help, or see what can be done. Not just let me go and say 'okay, you won't die now.' Nothing was done. I didn't really feel like they cared. . . I think

maybe they have a lot of cases like mine and maybe they see it a lot so they're desensitized to it. I'm not really sure what it is, but I do feel like they did take it very lightly. (Maria)

Apart from these problems which they would like to see remedied, participants also wanted more information or advertising about where and how to seek help. Many participants discussed not knowing where to turn for tangible support.

4.8 Recovery

4.8.1 Progression of recovery. Recovery from self-harm is experienced as a process, not as a decision or a distinct event. In fact, this process appears to begin long before someone actually ceases their self-harm behaviours and continues long after cessation.

Desiring wellness. Participants described starting to prepare for recovery by first developing the desire to get better. Self-harming individuals frequently hear that they need to stop the behaviour and know that their loved ones want them to recover; however, the desire to get better must be a personal choice, something experienced internally. Emilee spoke about preparing herself to begin recovering:

The first step was probably wanting to get better. I think that was probably the first step . . . and because I had that desire to get better it kind of outputted into everything I did. (Emilee)

Admitting self-harm is not aligned with wellness. The second step involves admitting that self-harm is a problem. Individuals who self-harm often view their behaviours as a solution, rather than a problem, because it (albeit temporarily) helps them manage their overwhelming emotions. Recognizing that self-harm does not solve

anything, and that self-harm has no bearing on their difficult situations and experiences, represents an important perspective shift. In order to be ready for recovery, individuals must come to recognize self-harm as a problem in and of itself. Emilee described coming to this recognition:

Then gradually I was able to think ‘okay, this isn’t helping’. Because I remember every time I’d feel upset and I would cut afterwards, I was like ‘well this hasn’t really solved anything. I still feel upset and now I have to worry about cuts on my arm and stuff, and my scars’. Then I feel stupid and emotionally bad. (Emilee)

Taking steps toward wellness. The third step involves taking action. After developing the desire to get better and the realization that self-harm is a problem, tangible steps need to be taken in order to prepare for recovery.

Realizing you need to deal with it definitely a stage. You know, like actually acting on that and finding help, or dealing with it in some way. And then it still takes a while to actually be able to quit. (Lynnzi)

Once taking steps toward wellness, participants describe the actual recovery process as a “slowing down”, “long road”, and “self-healing”. Several participants likened it to an addiction, and again, discussed the double standard that people have for self-harm.

People don’t think about the same thing with self-harm. It’s like: ‘Good you stopped, because you shouldn’t have been doing it in the first place’. It’s like ‘Thanks, but it took a lot more to stop than you think’. They’re like: ‘No, it’s easy.’ No! It’s not easy. It’s like any other addiction. Alcohol, drugs, food, TV, anything, once you get into the habit it is incredibly hard to break. (Alana)

Often participants experienced relapses, and multiple attempts at recovery before they were successful. Emilee described her frustration with this long gradual process:

I think most people just probably say 'It gets better,' but you don't want to hear that. It could be tomorrow, a week from now, or five years from now. You can say that it gets better . . . but it's not going to get better right now, and it's not going to get better tomorrow, but you're going to have to work for it. You are going to have bumps in the road but it's worth it. (Emilee)

Given her experience with recovery, and her frustrations with others' unhelpful advice, Emilee wanted to pass on the following guidance:

If you do relapse, don't be so hard on yourself, because it happens. But learn from it. What made this relapse happen? Kind of like learning your emotional triggers and learn the barriers that you need to have, and kind of believe you're strong. That was a big part of it, I felt weak for getting help, but being able to be in recovery – well that makes you strong. (Emilee)

4.8.2 Important factors to recovery. Once on the road to recovery certain factors were particularly important to the participants.

Embracing new perspectives and realizations. Part and parcel to recovery from self-harm is beginning to think and believe differently than before. During recovery, individuals experience new realizations and come to embrace new and healthier perspectives. Many participants spoke about finding hope in the midst of their suffering. These participants adopted a new future-oriented perspective, in that rather than focus on their present pain they were able to focus on (and believe in) better things to come. Maria

found value in constructing and holding on to a vision of her future self. She wanted to pass on the following message to those currently struggling with self-harm:

I would tell them to envision their life for where they see themselves. Even if you are really depressed, there's still something that you want, or you do see yourself doing or becoming. And I would tell them to envision that and know it's possible and just not give up, and that they're going to get through it. And the experience is going to make them a lot stronger. (Maria)

Other participants spoke about realizing things about themselves, and that accepting these self-truths aided in resisting the urges to self-harm and keeping on the road to recovery. Self-truths were varied, and specific to individuals, but all carried the theme they were “more” than they thought. For example, for one participant the most helpful self-truth may be that she is stronger than she thought, whereas for another participant it may be that he is more than others’ judgments of him. For Jess, it involved being “more” deserving of wellness.

The most important thing to recovery – I think it was self-respect, or thinking or believing that I do deserve to actually get better. Because if you don't believe that you can be helped, or if you don't believe that you should be helped; especially if you believe that you deserve to be punished for something, you're not going to get better. . . . Eventually, I think I learned I deserve good things just because people deserve good things and I'm a person. Within that mindset there is no longer a very logical reason for me to self-harm anymore. (Jess)

For others, it was important to develop a different perspective on the act of self-harm itself. Rather than viewing it as a solution, as helpful, or as something that was only

affecting themselves, participants realized that it is something problematic, harmful, and something that hurts other people around them. For example, Alana and Emilee shared the following:

I really needed to stop. You would see it in people's eyes; that you don't just hurt yourself. You hurt everybody around you too. That emotional pain is so much worse than physical pain. It is not fair that that's what I was doing. It was really selfish of me. (Alana)

I think the biggest thing was taking off those metaphorical goggles and it was seeing that this [self-harm] isn't the way. If I keep going down this path it's only going to dig a deeper path and it's going to be harder to get out. So I'm like, why not stop here? Even as deep or as far as you're in, you don't want to get any deeper. Just knowing that this isn't going to help anything anymore. (Emilee)

Offering honesty and accepting support. During recovery, individuals begin to utilize their social supports, and in so doing, begin to speak openly and honestly about their self-harm. Upon reflection of their recovery process, several individuals shared regrets that they had not disclosed their struggles sooner. For example, Emilee believed that offering honesty about her self-harm may have limited her struggle with self-harm.

I really wish I would have told someone when I first started and not allowed myself to get as deep, as far in. I wish I would have maybe just reached out and sought help faster than I did. (Emilee)

Speaking openly and directly about self-harm was an important part of their healing process – whether to friends, family, or professionals. Relatedly, participants expressed

how important it was to realize that there were people willing to listen and wanting to offer support.

Engaging in positive activities and distractions. During the recovery process the urge to self-harm was still strong. Participants described it as a constant, sometimes daily, struggle to resist that urge and to choose healthy and positive ways of coping instead. Participants described both long-term and in-the-moment coping strategies. Long-term strategies included activities that one could engage in preventatively, as a way to generally improve emotions and well-being. Examples that participants shared included: regular yoga classes, committing to resolve interpersonal issues by talking them through, and gaining a sense of mastery by engaging in activities that you are good at. In the moment coping strategies involve activities that dissuade or distract from the urge to self-harm. Lynnzi and Emily provided the following examples:

Just find whatever works for you. Like, for me, it's watching my favorite TV shows, playing with my cats, or going and talking with my friends. But for you it could be a multitude of things, like reading a book, listening to some kind of music, dancing in your room, and just find something that could take place of this negative thing that you're doing. (Emilee)

Breathing exercises, or taking a long walk, especially if it's cold outside. That kind of helps you, especially when you feel so cold that you're completely distracted from any urges to do anything. Little tricks like snapping an elastic band on your wrist, it does help you. (Lynnzi)

4.8.3 Lingering effects after recovery. After recovery from self-harm there are still lingering or lasting effects of the behaviour that can still be identified. Despite having ceased the physical act of self-harm, participants noticed a lasting impression on their lives. Just as self-harm leaves individuals with physical marks – scars – it seems as though these experiences also leave them with emotional marks. Participants in the current study identified both positive and negative repercussions.

Lingering negative effects. No longer engaging in self-harm does not mean no longer having urges to self-harm. When experiencing emotions or situations that would have previously triggered self-harm, individuals often will still have the desire or urge to hurt themselves. These urges may be different in terms of frequency and intensity, but are still there. In the current study, some participants described having to make continual conscious choices not to engage in self-harm. Other participants described irritation at still feeling these urges, but that engaging in self-harm, “no longer felt like a real option”. To these participants, “recovery” did not mean having a complete absence of urges to self-harm, or being the same person they were prior to self-harm. Instead, “recovery” meant being stronger than these urges.

In the current study, participants described certain triggers as examples of lingering negative effects. Common triggers included: social media depicting self-harm, seeing others’ scars, hearing about others self-harming, and encountering objects such as knives or razor blades. Alana shared her internal experience when confronted with a trigger:

You see a razor on the table, the instinct before would have been to grab it and take it and hide it, to use later. You know when people say that they’re going to die and they see their life flash before their eyes? It’s kind of like that idea. You

see yourself taking and grabbing the razor and starting to self-harm all over again. And having the feeling of everything feeling better. But you have to not. You have to very consciously say: Okay, it's triggering all these ideas and memories but I'm going to throw the razor out or put it away, I'm not going to hide it for later. (Alana)

Other lingering effects included scars, bad memories about self-harm, and guilt about hurting loved ones. These physical and emotional reminders of self-harm take a toll on recovered individual's mental health. Although they are no longer physically self-harming, these recovered individuals often are left to manage emotionally self-harming acts. For example, self-loathing, regret, shame, distrust of oneself, and low self-esteem can result from self-harm, and do not necessarily disappear along with the self-harming behaviours. Consequently, participants shared that they must be very deliberate and purposeful about staying emotionally healthy, avoiding triggers, and knowing their own limits.

Lingering positive effects. Encouragingly, recovery from self-harm also results in lingering positive effects. Participants spoke about vast improvements in their knowledge about themselves, their social supports, and how to stay mentally well. These individuals learned who they could rely on and how to utilize their support system; consequently, they report being more likely to seek social support in the future. Because of their recovery experiences, participants identified improved understanding of their own emotions, limits, and the importance of responding preventatively to mental health concerns. For example, Guinevere learned how to be more assertive and proactive in regard to her emotional needs:

I think I'm way more vocal about asking for things from my mom or dad or brother. Talking about personal issues which I never did before. (Guinevere)

Relatedly, Jess learned about the necessity of prioritizing mental health:

I think its left me with a greater emphasis on the importance of resting and not over stressing yourself, because I know it can lead to very real physical consequences. It has led me to a much greater appreciation of the seriousness of mental illness, because a lot of people don't believe that it can kill, but I know it can. I prioritize emotional health and mental health a lot more than I think I would have otherwise. (Jess)

After their own taxing experience with self-harm, individuals feel better able to assist, support, and encourage others through difficult times. Participants shared that since their recovery they have both the desire and ability to help others. They attribute their ability to empathize and react with nonjudgment to their experiences with self-harm. Alana struggled with the idea that no one truly understood what she was going through while she was engaging in self-harm. Due to her experiences, she knows that she could provide genuine understanding to someone in a similar situation:

Because you get it and you understand and you know. Then that way, when someone is like 'Nobody gets it, nobody understands,' you can be like, 'I get it, I understand, let me tell you all the things that you're feeling.' Then you watch them light up and go, 'That is exactly right. That's exactly what I'm feeling.' Yeah, because I've been there before and I get it, and then maybe that helps someone too. (Alana)

Moreover, individuals with a recovery experience feel that the adversity they experienced made them a stronger person. Several participants spoke about new-found power in knowing that they can overcome difficult things - knowing that they can survive. Participants were able to find meaning in their self-harm through the personal strength and growth that resulted:

I think it just made me a lot stronger as a person. Just to know that I could go through so much pain and, I don't know, overcome it. (Maria)

I know that I can get through that, and I know how to get through it. I've been able to help a couple friends through it now. So I feel I am a bit stronger for it. (Lynnzi)

I really think that it was good that those bad things happened because it made me realize, 'So what if things suck right now, you can do this, nothing is going to hurt you more than that did. You can go, you can survive.' That was really big for me. If I could get through that I could get through anything. (Eve)

In sum, the experiences with self-harm and with recovery did not render these participants the same as they once were. Nor did these experiences render them either better or worse than the person they were prior to self-harm. Instead, they believed themselves to have simply been changed. By way of summary, I offer an excerpt from my field journal. These words were written after my final interview upon reflection of the recovery process as a whole.

If a person's inner fortitude, resolve, skills, and strength were not stored internally, but rather worn externally – what would it look like? I picture a heavy suit of armour – perhaps from medieval times. I imagine that my dear participants would be wearing suits of armour that are battered, beaten, and patched up. Although no longer shiny, new, or unworn, these people wear their armour proudly. They know that every time this armour has been patched and mended it has just gotten stronger. They know that this armour has proven itself time and time again and consequently their faith in its resilience is now unwavering. Their armour of inner qualities has seen quite the battlefield of life. I hope, I truly hope, that they see this armour, and little else, when they look upon their scars. (Field Journal)

4.9 Discussion of Study One

Study One expands our understanding of the lived experience of recovery from self-harm from the perspective of individuals who have themselves recovered. Study One contributes to the existing literature by providing a more rich and subjective account of what the experience of recovery looks and feels like. In this way, the current study compliments the existing objective research that quantifies various segments of this experience. Through in-depth interviews the experience of recovery from self-harm was examined in terms of parental involvement, friend involvement, help-seeking, support needs, and the process of recovery. In the following section I will: situate the results of Study One in the current literature, demonstrate how our new-found understanding of recovery extends and contributes to this literature, and provide implications regarding

parental involvement, friend involvement, help-seeking, support needs, and the process of recovery.

4.9.1 Parental involvement. As previously discussed, parents play integral roles during their children's recovery process, and have the potential to act as either a facilitator or barrier to recovery (Gelinis & Wright, 2013). Past research has examined the parental perspective and struggle with adolescent self-harm (Oldershaw et al., 2008; Raphael et al., 2006); however, the current study represents the sole investigation of adolescents' perspective on parental involvement. Through this multi-perspective lens we are better able to understand the various dimensions of self-harm recovery. Furthermore, the current study serves to improve lines of communications between parents and children managing self-harm. Past research has indicated that parents often feel disconnected from their self-harming children. They do not know how best to communicate about self-harm, and thus, are hindered in asking questions and receiving advice. Although not their own children, the participants in Study One can act as surrogate children, passing on advice and encouragement on behalf of other self-harming children.

Past research has described a "wait-and-see" parenting approach to self-harm (Oldershaw et al., 2008), in that parents tend to experience waxing and waning suspicion and concern about self-harm, but do not often directly voice their fears. Instead, they wait and see if there is significant improvement (in which case they need not intervene) or deterioration (in which case they have waited too long). The current study indicates that this wait-and-see approach is reviled by the children experiencing this type of parenting.

These children interpret the lack of direct communication or assistance as abandonment and apathy.

Extant research has indicated that parents report feeling stressed, hurt, and bereaved after learning about their child's self-harm (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Through the current study, we now know that adolescents are very aware of their parents' distress, and are able to identify that their parents were scared of pushing too hard, felt like bad parents, and lived with the constant worry that the self-harm would escalate to something worse. Despite their awareness of their parents' suffering, they felt unable to empathize or console because of their own emotional suffering. Similarly, despite difficulty understanding their child's self-harm, parents are often able to identify causal factors that have likely contributed to their child's self-harm (Oldershaw, et al., 2008). The participants in the current study voiced how important it is to address these causal factors. By adding the adolescents' perspective to this component of parental involvement we are able to identify a strength of parents, and as such, a good news story. Adolescents want parents to direct their attention and assistance to the reason for their self-harm (e.g., bullying, depression) and not to the outcome of their self-harm (e.g., scars); as such, parents can be encouraged that they, without in-depth knowledge of self-harm, can be an immense source of support to their child.

Implications for parents. Given how the participants experienced their parents' involvement, and given what they voiced in terms of their wants and needs during recovery, there are several pieces of advice and encouragement to be shared. In terms of advice, recovered individuals would like parents to know that they should: be informed about self-harm, be direct in communicating about self-harm, and be assertive and active

in supplying tangible and emotional support. In terms of encouragement, recovered individuals would like parents to know that the steadfast support they provide is invaluable, despite how poorly it may at first be received. Parents are encouraged not to give up on their offers of love and support, because one day, it will be recognized as key to recovery.

Implications for improved services. Mental health professionals can also benefit from an understanding of how parental involvement is experienced by self-harming individuals. Incorporating this information into psychoeducation could benefit parents, and indirectly benefit their children. Information sessions, support groups, or even psychoeducational brochures could emphasize the “how to” of parental involvement. For example, these informational sources could cover how to get informed about self-harm, how to directly communicate about self-harm, and how to actively provide tangible and emotional support to one’s child. Mental health professionals can also better discuss the benefits (e.g., child will come to see it as helpful) of these tactics, and the risks of alternative actions (e.g., child will feel dismissed and abandoned).

4.9.2 Friend involvement. As previously discussed, friends also play an integral role in the recovery process. Friends are often the people who are first apprised of the self-harm situation, and often are most aware of the details about the self-harm behaviours. Given the information that friends hold, it is often up to them to provide social support or encourage seeking formal support.

Extant research has indicated that friends often feel overwhelmed with the situation and ill-equipped to deal with their peer’s self-harm (Klineberg, et al., 2013; Muehlenkamp, et al., 2010). The current study adds the self-harming individual’s

perspective, in that we now know that self-harming individuals themselves often recognize that their friends are too young and unprepared to handle the situation on their own. Although getting a more capable adult involved may not be well-received at the time, it is often recognized later as an important factor to recovery. Friends often feel pressured to keep self-harm a secret and are afraid that involving adults or professionals will destroy their friendship. Therefore, friends should be encouraged by self-harming individuals' recognition that what they are asking is too serious and stressful a secret to be kept.

Although friends are often integral to the recovery process, past research has also indicated the detrimental effect that negative peer relationships and influence can have on self-harm behaviours. For example, peers can have a negative effect on self-harm cessation when they react to a self-harm disclosure in a rejecting or alienating way (Mahdy, 2013). From the current study we have a better understanding of how this happens. Often individuals who self-harm feel alone and misunderstood. Thus, when their peers misunderstand self-harm and react by avoiding or alienating, the self-harming individual has "proof" that they are in fact alone and misunderstood, which leads to increased self-harm in order to cope. Peers who are uncomfortable with the concept of self-harm may withdraw because they do not know how to react or respond. From the current study, we know that the self-harming individual can misconstrue their friend's discomfort with self-harm as rejection. As such, friends are counselled to directly discuss self-harm with their friend despite their discomfort. Indeed, expressing their worry and discomfort appears to be better received than ignoring or avoiding these open discussions.

Implications for friends. Given how the participants experienced their friends' involvement and what they voiced in terms of their wants and needs during recovery, there are several pieces of advice and words of encouragement to be shared. Friends are advised to view self-harm as a genuine cry for help, rather than a manipulative ploy. It is likely that their friend is in need of attention, but attention in the sense of caring concern. Consequently, treating them as someone who is hurting, but not someone who is morbid or defective is recommended. Comments and remarks related to the attention-seeking, or "twisted" quality of self-harm will not be well-received, and can be quite damaging. Rather than condemn or denounce a friend's self-harming behaviour, focus on how strong they are instead, how confident you are that they will be able to get through this, and how happy you would like them to become. For example, based on the current results, there seems to be an enormous difference between a statement telling someone to stop self-harming, and a statement telling them you would *like* them to stop self-harming, and why. Focusing on how you would like your friend to feel rather than what your friend must do, is a more helpful response. Friends who are feeling overwhelmed can be encouraged by the following message: one of the best things to do for a self-harming friend is also one of the easiest. Validate their feelings and experiences. Thankfully, providing validation does not necessitate taking a stand for or against the act of self-harm.

Implications for improved services. Given how important it is for peers to speak openly about self-harm, it would logically follow that someone needs to be speaking openly to adolescents about self-harm. In order to appropriately model good communication about a difficult subject, teachers, school counselors, and other mental

health professionals should be speaking frankly about self-harm. If the available adults in their lives are unable to directly address self-harm, why would adolescents and their friends who are struggling with self-harm be able to approach the problem any differently? Teachers and school counselors in particular should be trained on how to candidly discuss self-harm in a productive way. For example, these front line workers could be trained on explaining the benefits of formal help, knowing when adults need to be informed about someone's self-harm, and how to broach the topic with a self-harming friend.

4.9.3 Implications for help-seeking. Little is known about the help-seeking pathways of individuals who self-harm. The few extant studies that have examined help-seeking among self-harming individuals have indicated that formal help-seeking is rare (Nada-Raja et al., 2003). Some studies have indicated that adolescents do not seek help because they do not perceive their self-harm to be a problem (Evans et al., 2005; Saunders et al., 1994). The current study contributes to our understanding of the lack of help-seeking among this population, in that participants shared several other important deterrents to seeking help. Namely, participants disclosed that distrust and discomfort with formal help, lack of accessibility and availability of help sources, and the notion that help-seeking is the same as attention seeking were reasons for not seeking help. In contrast to past research, the current results demonstrate a greater diversity in reasons not to seek help. In the past, researchers have recommended educating adolescents on the dangers and pitfalls of self-harm in hopes of improving their help-seeking (Gelinias & Wright, 2014). The current study indicates that adolescents should also be educated about

where and how to access formal supports, and how help-seeking differs from attention-seeking.

Extant research has already concluded that engaging adolescents in treatment after they are connected to appropriate help sources is quite challenging (Oldershaw et al., 2008). One past study explored young adults' experiences with counsellors and clinicians after presenting to the emergency department for self-harm (Storey, Hurry, Jowitt, Owens, & House, 2005). These 38 young adults described a general theme of poor communication with mental health professionals. In particular, they felt that their counsellors and clinicians failed to establish trust and rapport in negotiating the aims of therapy. Instead, the goals of treatment seemed mandated, which served only to establish distance and misunderstanding between the young adults and the mental health professionals. Storey and colleagues (2005) concluded that the collaborative establishment of treatment goals is one of the most important factors to working successfully with individuals with a history of self-harm, and that working cooperatively is essential to improve treatment engagement.

The current study provides corroborating evidence in that several participants shared their reticence and refusal to participate with therapists, counselors, and emergency room staff; however, several suggestions for service improvement can also be gleaned from these participants' stories. Given the importance of treatment readiness, mental health professionals should consider assessing adolescents for readiness. One participant suggested asking new adolescent clients, "What are you prepared to do to get better?" in order to assist in this assessment. Those adolescents experiencing low-readiness to engage in treatment may respond better to motivational interviewing or

future-oriented approaches than to standard treatment. Whereas adolescents who are ready to seek and respond to treatment tend to ask for alternative coping strategies, adolescents with low readiness could benefit from discussing their future goals and aspirations, and brainstorming what might need to change or improve in order to help them achieve these future goals.

Similar to past research (Idenfors, Kullgren, & Renberg, 2015; Storey et al., 2005), the current participants also testified to the importance of shared-decision making in treatment planning and collaboratively setting treatment goals. When clinicians encounter self-harming adolescents (particularly those that have presented to the emergency room), they may presume the most pressing (and desired) treatment goal will relate to the self-harm behaviours and to depression. However, both current and past participants (Storey et al., 2005) have stated that often there are other issues (e.g., bullying, trauma, anxiety) that they see as more pressing, and would be more willing to pursue in treatment.

Participants in the current study also suggested improving follow-up services after an emergency room visit. Several participants had the experience in which they were taken to the emergency room after a self-harm incident, were quickly discharged, and then received either no or little follow-up services afterwards. Several participants said that they were still not ready to engage in services when they received a follow-up phone call or appointment a few days after the hospital visit. The participants felt that a second follow-up a few weeks or months later would have been far more helpful to them, as it was at that point when they were more likely to engage with formal support sources.

In terms of informal support, participants reported desiring three things: (1) connection to peers who understood what they were going through; (2) distraction from their self-harm and negative thoughts; and (3) the opportunity to make a positive contribution. These informal support needs could be provided through peer support groups. A group comprised of adolescents with similar self-harm experiences and tendencies would satisfy the desire for connection. As peer-support and encouragement are integral to such a group, participation would also satisfy the desire for contribution. By sharing in others' sorrows and successes, and by sharing helpful strategies to overcome self-harm adolescents could reap the benefits of investing in others' lives and wellness. If the peer-support group involved meaningful activities (e.g., art, volunteerism, theatre) it could similarly satisfy the desire for distraction. In the current study, participants predicted that their recovery process would have been far faster and easier if they had had informal support opportunities in which to connect, distract, and contribute. Programs and services could adopt these strategies in order to make their offerings more appealing as well as more as useful.

4.9.4 Implications for support needs. Although past research has suggested how best to support individuals in the process of recovery (Muehlenkamp et al., 2010; Rowe, French, Henderson, Ougrin, Slade, & Moran, 2014; Storey et al., 2005) these suggestions have not originated from individuals who have themselves recovered. The current study adds the perspective of individuals who successfully navigated the recovery process, and in so doing, adds a proverbial "expert" testimony. The current participants identified several important areas of support, including emotional, informational, and tangible support. When considering how to fill these support needs, we must ask ourselves "how"

and “where”. The widespread misconceptions and misinformation about self-harm should be addressed in a similarly widespread fashion. Indeed, a wide range of people require education on self-harm, including: adolescents, families, mental health professionals, and society in general. Information should be available to through several reputable means (e.g., brochures, health region websites, family doctors, school-based seminars and lectures).

In terms of informational support, participants shared three major types of information that they wished they themselves had known earlier, and their friends, family, and society knew now. First, participants wanted information regarding the seriousness of self-harm conveyed. Second, participants wanted information disputing the idea that self-harm is attention-seeking. Which begs the question – from where are the messages coming that self-harm is frivolous and attention-seeking in nature? Are these messages transmitted through the media, the schools, or through the health care system? It would seem that these widespread misconceptions should be addressed through widespread re-education. In order to prevent adolescents from starting self-harm, while educating others about the true nature of self-harm, the school system seems an intuitive starting point. Current participants suggested that someone who has recovered from self-harm should come into schools and do guest lectures on the seriousness, dangerousness, and alternatives to self-harm. This type of information session could provide credible information, as it is coming from someone who knows and understands self-harm from a personal and professional standpoint.

The school-system (e.g., school health classes) also seems like a good venue in which to instruct adolescents about the available alternatives to self-harm; particularly,

healthier forms of coping. To my knowledge, there are no studies comparing frequency of self-harm among adolescents with and without instruction on alternate coping strategies. Similarly, I am not aware of any studies comparing frequency of self-harm among adolescents with and without instruction on the seriousness and dangerousness of self-harm behaviours. Future research could examine the utility of in-school guest lectures about self-harm.

Although substance use is another common coping mechanism among adolescents and young adults (Khantzian, 1997; Swendsen et al., 2012), drug and alcohol use are widely addressed through the school system, through national campaigns, and through parenting practices. Alternatively, self-harm is rarely addressed as openly or publicly. Most individuals cannot remember how they began to self-harm. It seems as though internal, personal urges lead them to self-harm, and their knowledge of the behaviour remains quite internal and personal. If self-harm is never addressed candidly, the whole of these adolescents' knowledge remains narrow and biased. Substance abuse is indeed a problematic adolescent behaviour, and one that is often comorbid with mental health difficulties; however, this unhealthy coping strategy receives far more attention in our society than does self-harm. Moreover, substance abuse is not a topic considered taboo at the family dinner table, or considered freakish among school teachers and classmates. The shrouds of secrecy, and the veils of awkwardness surrounding the topic of self-harm needs to be dropped in order to provide needed widespread information and support.

4.9.5 Implications for the recovery process. Past, quantitative accounts of recovery from self-harm tend to focus on treatment outcomes and efficacy. That said, the

accounts do not provide the personal or human experience that accompanies those symptom reductions. For example, a recent meta-analysis investigating therapeutic interventions for self-harm concluded that the largest effect sizes lie with dialectical behaviour therapy, cognitive behavioural therapy, and mentalization-based therapy; however, precise mechanisms of action for therapeutic interventions remain unknown (Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015). The current study provides more insight into why some individuals who self-harm may have responded to treatment while others did not. The current participants emphasized the importance of treatment readiness, and described a recovery process in which they first had to desire wellness, then recognize that self-harm was incongruent with that wellness.

The current study also provides insight into the meaning of “recovered”. Extant research has defined treatment success by reduction in self-harm incidents (e.g., Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008; Winter, Sireling, Riley, Metcalfe, Quait, & Bhandari, 2007); however, based on the current results we know that even after self-harm has ceased, individuals continue to struggle with urges to self-harm, and are still susceptible to self-harm triggers. In this way, self-harm appears similar to addiction, as people with addictions talk about having to continually make healthy choices, and continually choose to say no to their drug of choice. Indeed, several of the current participants found it useful to describe self-harm as an addiction. Although self-harm does not have physiological mechanisms related to tolerance and withdrawal in the same way as drugs and alcohol, it does seem to have “addictive properties”. Given this additional information about the process of recovery, simple reductions in self-harm repetition over the course of therapy may be a misleading outcome measure. Moreover,

the continued struggle experienced by individuals in the recovery process indicates the importance of long-term follow-up in research and booster sessions in treatment.

Anecdotally, we know from the current participants that relapse is common, and continued support is essential in promoting long-lasting recovery from self-harm. In the same way that we counsel individuals with depression and anxiety to have a relapse prevention plan, and seek continued professional help in the case of recurrence, individuals with a history of self-harm would also benefit from long-term considerations.

5.0 Study Two (Friend-Caregivers)

5.1 Introduction to Study Two

Peer influence on adolescent and young adult behaviour is exceedingly important, and self-harm behaviours are no exception. Extant literature has emphasized the negative influence of peers on self-harm behaviours. For example, self-harm contagion (Deliberto & Nock, 2008), increased likelihood of engaging in self-harm based on peer group (DeLeo & Heller, 2004; Nixon et al., 2008), increased severity of self-harm based on peer identification (Whitlock et al., 2010; You et al., 2013), and impaired recovery from self-harm due to negative peer relationships (Boekmann, 2008; Gelinas & Wright, 2013) are all well documented. An emerging body of literature has focused on the potential positive influence that peers can wield in the area of self-harm. For example, there are indications that positive peer relationships can facilitate: professional help-seeking (Hinson & Swanson, 1993; Mahdy, 2013), informal help-seeking (Wu et al., 2011), and the recovery process for self-harm (Gelinas & Wright, 2013; Fortune et al., 2008).

Although peers can exert a considerable and constructive influence during the recovery process from self-harm, recent research has suggested that peer- and friend-caregivers feel uncomfortable and ill-prepared for this task (Muehlenkamp et al., 2010). In fact, peers report negative emotions, experiences, and outcomes associated with their caregiving attempts (Boekmann, 2008; Bresin et al., 2013; Klineberg et al., 2013). Given the influence these peers wield, it would be prudent for health care providers to utilize and support this resource. In order to best inform and support friend-caregivers, a better understanding of the friend-caregiver experience is necessary.

This chapter will explore individuals' personal experiences in supporting a friend's recovery from self-harm. In particular, how the friend-caregiver role was experienced, what action was taken as a friend-caregiver, and the support needs of all involved will be examined. Though not all perspectives or experiences of these participants were identical or unanimous, certain commonalities can be found, and certain conclusions can be drawn from their stories.

5.2 Summary of Study Two Participants

Ten individuals who supported a friend/peer in their recovery from self-harm participated in Study Two. Due to the sensitive nature of the subject and the participants' expressed desire to remain as anonymous as possible, I have chosen not to describe the story of each individual. Instead, I will provide collective descriptive information on their demographics and experience as a caregiver for self-harm. In order to introduce the participants in a more full and meaningful way I will include direct quotes that illustrate the descriptive information.

The sample of friend-caregivers consisted of eight females and two males. Participants ranged in age from 18 to 23 years of age (mean age of 20 years). In terms of ethnicity, seven participants identified as Caucasian, one participant identified as Asian, one participant identified as Hispanic, and another one participant identified as Aboriginal. Although all participants have self-identified as a "friend" to an individual whom they supported in recovering from self-harm, their exact relationship to that individual varied. During the interviews, four participants spoke about their sibling, four participants spoke about their friend, and two participants spoke about their romantic

partner. Throughout this chapter the participants will be referred to as “friend-caregivers” regardless of their exact relationship to the self-harming individual.

In terms of caregiving, participants reported acting as a friend-caregiver for an average of 3.6 years. The duration of caregiving ranged from one to seven years. On average, they undertook this caregiving role at the age of 14. The age at which they started caregiving ranged from 12 to 18 years old. When asked what type of self-harm their friends engaged in, the most common responses included cutting, burning, and suicide attempts. The majority of participants reported that their friends self-harmed at least 20 times. Two participants reported having friends who self-harmed more than 100 times. At the time of the study, the time since recovery for the participants’ friends ranged from six months to three years. As such, the participants were reporting on relatively recent experiences.

Participants described varied caregiving experiences. Some participants spoke about being the “only one” who knew about their friend’s self-harm, and as such, were the sole caregiver. Other participants identified as one of many caregivers for their particular friend and discussed their role as just one piece to the puzzle. For example, Gordon shared that he was the sole caregiver for his girlfriend, and the only one who was aware of her self-harm:

I was the only one there. But at the same time, maybe that’s all she needed. Just the one person to keep on reminding her to say ‘it’s not just me, I’m not just hurting myself. I’m loved so much that he’s willing to take over all these responsibilities and take on as much as he can’. (Gordon)

Some participants had themselves self-harmed during adolescence, and felt very familiar with the phenomenon, while others found their friend's self-harm disturbing and bizarre. Therefore, there was a wide range of knowledge about self-harm reasons, triggers, and methods. For example, Starlight shared that she had also self-harmed in adolescence, and her own experience allowed her to relate to and bond with her friend.

She would harm herself just because she hated herself and she wanted to make her arms look the way that she thought she looked. She thought she was so ugly, and she wanted to show that. But I also think she did it for attention sometimes. . . she would just roll up her sleeves when we were hanging out and she'd have cuts and cuts and cuts that are fresh all down her arm. And I'm like, that's a long way to go for attention. There had to be self-hatred behind it. So I was like 'yeah, she hates herself, I hate myself, so cool let's bond.' (Starlight)

In contrast, other participants expressed confusion and bewilderment. For example, Gabbana described being shocked when she first learned about her friend's self-harm and having difficulty coming to a comprehensive understanding of the behaviour.

When I first found out about the cutting – it was something that I could never do to myself. I just know that. That just seems so crazy to me. I didn't understand it. I was always trying to make sure that she didn't do that. I didn't really understand why she was doing it. I got that it was some kind of release of pain or something for her, but it still really didn't make sense to me. (Gabbana)

Wren shared that she struggled with how to help, until developing a better understanding of what self-harm was to her friend.

The one thing that really stuck is when the guidance counsellor said ‘cutting, it’s a solution. It’s just not a good one.’ I think that was pretty important for me to realize – that it [self-harm] is working. It’s a temporary and very quick release of emotion – it’s just a very negative way of doing it. So then I could help find other solutions for release. (Wren)

5.3 Summary of Themes

The method of data analysis described in Chapter 3 was used to identify themes from the interviews with friends. Three topic areas (experience of the caregiving role, actions in the caregiving role, and support needs) were queried, resulting in nine superordinate themes, and various subthemes. The categories, superordinate themes, and subthemes are listed in Table 2, which as a whole describe a friend’s experience in supporting recovery from self-harm.

Table 2.
Summary of Themes from Study Two

TOPIC AREA	SUPERORDINATE THEMES	SUB THEMES
Experience of the Caregiving Role	Caregiving role titles	<ol style="list-style-type: none"> 1. The Rock 2. The Parent 3. The Vault 4. The Protector 5. The Go-Between 6. The Everything
	Emotional experience of caregiving	<ol style="list-style-type: none"> 1. Initial emotional experiences 2. Enduring emotional experiences
	Impact and repercussions of caregiving	<ol style="list-style-type: none"> 1. Diminished physical, social, and emotional health 2. Altered approach to friendship 3. Altered view of oneself
	Challenges and struggles with caregiving role	<ol style="list-style-type: none"> 1. Lacking information required for caregiving 2. Managing the emotional toll of caregiving
Actions in the Caregiving Role	Helpful	<ol style="list-style-type: none"> 1. Openly addressing self-harm 2. Making support known and readily available 3. Interacting with non-judgement 4. Encouraging social and leisure activities
	Unhelpful	<ol style="list-style-type: none"> 1. Attempting to motivate with guilt 2. Engaging in emotional outbursts 3. Shouldering all the responsibility 4. Ignoring or minimizing the seriousness of self-harm
	Actions related to help-seeking	<ol style="list-style-type: none"> 1. Acting to prevent the necessity of professional involvement 2. Acting to assert the necessity of professional involvement
Support Needs	Support needs of friend-caregivers	<ol style="list-style-type: none"> 1. Informational support needs 2. Emotional support needs 3. Need to maintain a healthy life separate from the caregiving role
	Support needs of those who self-harm	<ol style="list-style-type: none"> 1. Improved understanding and follow-up for self-harm in the healthcare system 2. Opportunity to connect with others who understand the self-harm struggle 3. Improved awareness and education about self-harm in the school system

5.4 Experience of the Friend-Caregiving Role

The participants of Study Two varied in the objective details of their caregiving role; however, these same participants reported striking similarities in the subjective interpretations of their role. As previously stated, this group of friend-caregivers actually consisted of friends, siblings, and romantic partners. The participants also varied in the level of responsibility they assumed and level of support that they provided to their self-harming friend. For example, some participants described themselves as the “sole” caregiver, others as a “main” caregiver, and others still described themselves as “peripheral” or “secondary” caregivers. Regardless of the particulars of these caregiving experiences, the participants’ perceptions, feelings, and interpretations of caregiving were largely analogous. Four superordinate themes emerged in this topic area: perceptions of their caregiving role titles, the emotional experience of caregiving, the impact and repercussion of caregiving, and the challenges and struggles associated with the caregiving role.

5.4.1. Caregiving role titles. In discussing their experiences as friend-caregivers, the participants often shared titles, or names, for their role. These titles were reflective of how they perceived their roles. With a single word or a brief phrase they were able to paint a vivid picture of how caregiving *felt* to them. These role titles often became a central focus for their stories, with details and anecdotes being related back to their “title”. In fact, some participants described how their role title changed as their friend recovered from self-harm. I have chosen select role titles that I believe best represent the variety of friend-caregiver experiences that were shared with me.

The Rock. Often participants spoke about how crucial it was for them to be steadfastly available for their friends. They spoke about their friends needing permanency and dependability, and often how their own wants or needs were subjugated to the wants and needs of their self-harming friends. Wren experienced these feelings acutely, and identified her role as being her friend's "rock".

I guess I was kind of her rock, in a sense that she didn't have a lot for family. So I took it upon myself to become her rock and support. So I was the one she would talk to. I was the one when things got bad, would go and tell someone else. I was kind of her rock in the sense – I took in a lot of her stuff. (Wren)

Wren advanced the analogy of being a rock, by describing life as a river, and her friend's issues, all the dark emotions and experiences, as dark swirling and rushing water in that river. She, the rock, was the one safe sturdy place in the dangerous river of life.

The rock doesn't move. It's just there. When she needs to get her head above the water, she just stands on the rock. But, that means I was 'under' all the time. Under all her feelings and all the negative stuff she's dealing with. (Wren)

Wren aptly illustrated a problem common to many friend-caregivers: she kept her friend from drowning while risking drowning herself. Indeed, in reflecting on her role, Wren said she would not have assumed that particular role because in the end it was too emotionally draining and she was left feeling exhausted and worn.

The Parent. Despite being of comparable age, friend-caregivers often felt far older than their self-harming friend. They felt forced into a role of maturity and responsibility, and their role titles reflected this inequality. For example, Roxanne named her role "the mother figure", and described assuming an authoritative stance with her self-harming

brother. Roxanne assumed responsibility to arrange treatment for her brother, organized social activities, and regularly checked on his safety, mood, and medications.

I kind of like to think of myself as a little bit of a mother figure for him. Because my mom was always so busy and wasn't around all that much. And so me and him got really close. (Roxanne)

Roxanne noted that her role as “mother figure” shifted once her brother began to recover.

I didn't feel like I had to be so much the mother anymore. I could be a little bit more, you know, his sister or his friend rather than always watching over him. Kind of just an equal. (Roxanne)

Gordon had a similar experience, in that he also assumed an authoritative role in which he carefully monitored his girlfriend and assertively made rules for her safety.

I became almost controlling boyfriend, went into controlling boyfriend mode. It was to the point where I was, you know, checking her arms, her legs, anywhere that she might be cutting. I found her one razor blade that she had been using – I took the thing away. I kept everything away from her that was sharp or anything that could cut her, and pretty much just watched her like a baby bird. Like I was the mother bird. (Gordon)

At the time of the interview, Gordon's girlfriend had not been long recovered, and he shared that he occasionally still feels like a parent or authoritarian, rather than a romantic partner. Moreover, he described some lingering discomfort and displeasure with this inequality in their relationship.

The Vault. Other participants took a different approach to caregiving, and rather than assume a position of authority they assumed a role of ultimate ally. Their allegiance

often included vows of secrecy. Cerra described her role as a being the “bank vault” for her sister’s secrets, darkest thoughts, and fears. Cerra self-identified as being a confidant, and the one person who could be trusted to keep secrets and emotions safe.

I think I’m more of like a bank vault for her. Like a physical safe where I keep her secrets and we keep a lot from our parents that we tell each other emotionally. Like how we’re feeling and stuff. (Cerra)

Cerra described a role that most friend-caregivers are expected, and even pressured to assume. Consistently throughout their stories, these participants shared that their friends asked, begged, and demanded, that they keep the self-harm secret. Friend-caregivers often feel pressured to become that sole confidant, that bank vault of secrets, and are then left with the decision to either assume the sole responsibility for their friend’s well-being, or involve other people and abdicate their exclusive position.

The Protector. All participants described being protective, or taking protective actions at some point during their experience; however, some participants identified with this role more strongly than others. For Gabbana and Krissy, the caregiving role was experienced primarily as being a “protector”. Interestingly, they differed in how they played out their protective roles. Gabbana’s sister was described as volatile, often angry, and easily set off. Gabbana described her role as protecting her sister from herself. If there was anything Gabbana could do to soothe her sister’s anger or defuse a situation, she would do it. Gabbana shared example after example of how she would pacify her sister in hopes of preventing an incident of self-harm.

I guess I kind of feel like I was a protector because I based my behaviours on what I thought would prevent her from doing it. I changed a lot of things I wouldn't have normally done just in order to try and keep her from hurting herself. (Gabbana)

Krissy also named her role “protector”, but described protecting her friend from the outside world, keeping her sheltered, and leading her through difficult times and decisions.

I would say my role was a bit of a protector and problem solver. I'm constantly coming to help her. Like, to save her from everything. (Krissy)

Krissy also noted how her protective role began to change once her friend recovered from self-harm, and she was able to revert to an old role – simply that of friend.

She's less dependent on me than she was right at the beginning of everything. She still is, but now I'm more of a friend than a counsellor, like it used to be before everything happened. But we're closer because of it. (Krissy)

The Go-Between. The participants of Study Two shared many examples of instances in which they, rather than an adult or professional, were the ones told about their friend's self-harm, or their friend's safety risks. As such, friend-caregivers appear to be placed in the role of “go-between”, in that they are expected to act as a liaison, mediator, or middle-man. For Wendy, this was the part of caregiving with which she identified most. She shared that often her sister's friends would contact her to let her know that the self-harm had started again, or that her sister was unsafe. Frequently, her sister would also approach Wendy directly and ask for help in talking to their parents or going to the hospital emergency room.

Oftentimes the first thing that happens is people will find me on Facebook and they'll tell me and then I pass the information along. So I guess – I guess I'm a go-between. Someone they can trust to tell about it, and someone like an adult who can actually take action. . . I like it, because not all the responsibility is on me, but at the same time I know I can help. (Wendy)

Wendy posited that she was not as threatening as telling an authority figure, but she was also not as disempowered as her sister's peer group who also self-harmed. Although Wendy accepted and executed this role with grace, other participants found this role quite difficult. Often there is a mentality of "us versus them" when it comes to individuals who self-harm and mental health professionals. The "Go-between" role requires striking the correct balance between "us" and "them".

The Everything. Many participants shared that regardless of their role, there were times when they seemed to hit their limit. They felt they could not give enough, care enough, or love enough to help their friend. Everything they had to offer was still not enough. Some participants shared stories in which they described wholly devoting themselves to the care of their friend, and in fact, becoming their "Everything". Starlight shared that her role was called "Support Man Number One". To her, this meant she was her friend's right hand man, and during her years of caregiving her role evolved to that of everything and anything she needed to be.

I was her everything. I became almost a parent. And I also had to be the friend. And I was the call at two in the morning, and I was the person who got in a couple fights for her cause I had to protect her. I would pick her up anytime, or sit

with her in her room, or sleep there because she couldn't sleep. Yeah. I was a lot of things. . . I was on call 24/7. (Starlight)

Starlight described a role wrought with pressure, expectations, and the gut-churning sense that everything was still not enough.

5.4.2. Emotional experience of caregiving. Participants described a wide array of emotional experiences associated with their caregiving. In fact, each participant shared several significant emotions. Part of their emotional experience seemed to be an ever-fluctuating emotional state. Oftentimes they experienced intense emotions directed at themselves, at their friends, and at the situation in general. Regardless of length of caregiving, the intensity of the emotions stayed constant. Instead, the type of emotions varied as time wore on. For organizational purposes, I will describe the participants' initial (short-term) emotional experiences, followed by their developed, or enduring (long-term) emotional experiences.

Initial emotional experience. Confusion and shock featured chiefly in many of the participants' stories. When first finding out about their peer's self-harm, participants felt bewildered and disconcerted. Gordon related how shocked he was when he saw his girlfriend's fresh cut marks for the first time:

As soon as I saw, it just instantly floored me. It started off like 'what the fuck are you doing?' I did – I chewed her out right there. I just ripped her a new one. But it was still at the same time, you know, I was thinking like 'what do I do?! What do I do?! What do I do?!' (Gordon)

Other participants felt confused as to the purpose or rationale for self-harm.

When I first found out about the cutting – it was something that I could never do to myself. I just know that. That just seems so crazy to me. I didn't understand it. I was always trying to make sure that she didn't do that. I didn't really understand why she was doing it. I got that it was some kind of release of pain or something for her, but it still really didn't make sense to me. (Gabbana)

For others, the chief emotional experience was that of fear. For example, Gabbana described living in fear that her sister would go too far, and her self-harm would result in her death.

I really tried to do everything I could to make her happy. I feel like I did a lot of things I didn't want to do to keep her happy but – sometimes I just didn't. If I said 'no, I don't want that,' then she would say later she had cut herself because of it. . . Lots of fear and uncertainty. I was always scared that if I pushed her too far then maybe she would go further than just cutting herself. It just seemed easier to keep her happy than see what the consequences would be if I didn't. (Gabbana)

Others described the fear of “doing something wrong” in their caregiving.

I was scared to tell anyone, but scared about what would happen if I didn't. (Wren)

I was scared to tell my parents or get them involved. (Cerra)

It's stressful because you don't want to do something wrong. I mean – it's like you have a job of always trying to keep them happy or always being there for him and so scared to say the wrong thing sometimes. (Vollie)

For most, the emotions of confusion and fear went hand in hand. Those participants with the least amount of exposure to self-harm, and the least understanding of the phenomenon were the ones who found it to be the most frightening behaviour. In contrast, the participants who had themselves self-harmed, or who felt they had a better understanding of the behaviour were reportedly less panicked and afraid.

Enduring emotional experience. It is difficult (if not impossible) to remain in a state of panic for long periods of time; thus, over time, the shock and fear seemed to morph into other emotions. Participants seemed to distinguish between their initial emotional reactions and the emotional states in which they lived for the majority of their caregiving. Indeed, participants used language such as “gradually”, “eventually”, and “at some point” to indicate this emotional change.

Several participants described dulling or subverting their uncomfortable emotional experiences. For example, Starlight described “shutting off” her emotions, because the panic and fear caused by her friend’s volatile, severe, and frequent self-harm became too much.

In the really bad times I felt almost nothing, like it was just pure trying to fix it right now, not letting myself feel it. Later, or when it wasn’t a panic situation it was really heavy heartedness. (Starlight)

Cerra felt the need to hide, conceal, or deny her own emotions and concerns so as not to add to her family’s burden. She described not feeling entitled to express negative emotions because there were too many negative emotions that had to be managed already.

Since we had to keep it hush hush I felt that I had to keep my emotions inside and bottled up. (Cerra)

All participants shared that their caregiving had resulted in significant stress. In particular, they described a prolonged stress resulting from their relentless worry about their friend's well-being and their ability to care effectively. Participants described it as "gnawing" and "constant", and some described continuing to feel stressed and worried even after their friend had recovered. Roxanne summarized the sentiment well:

Worried. It was mostly just being concerned if he's ever going to do anything or, you know, if he'll have a really bad day and something will set him off. . . and helplessness, wishing I could just do something to make it better. (Roxanne)

Anger and frustration were highlighted as important components to the enduring emotional experience of a friend-caregiver.

There were definitely times that I was angry at her. I felt like 'why are you doing this? Do you realize what you're putting everyone else through?' But there were other times that I thought, 'I don't know what she is going through, how can I think like that?' (Gabbana)

It made me so upset she was doing that to herself. It was hard not to get mad and just shake her, be like, why are you doing that? . . .I was mad. I was mad at her. And I was just confused. I was sad because I don't like seeing my friends get hurt in anyway. And she was doing it to herself which was so confusing to me. I had so many things going through my head. (Krissy)

Wren shared her complicated emotional experience, in which she became frustrated with her friend's inability to cease self-harming and her own inability to remedy the situation.

At first it made me angry cause I'm putting in all this effort and it is as if she didn't even notice. . . I was hurt by it too. I was like, well, I don't know what else I can do so you feel wanted and loved and all this stuff, but I didn't feel like I was good enough, or like I was helping. That kind of made me angry in a way. Why am I even trying if it's not going to do anything? It was really, really hard to get, and to accept that it's not because I'm not doing a good enough job or I'm not being a good enough friend. It was a lot more than that. Kind of like being defeated. (Wren)

For some participants, they found themselves in a state of hopelessness and helplessness. Self-harm seemed like too large a problem, and their own resources seemed too small in comparison.

It made me feel quite inadequate at times and really sad for her. . . I felt inadequate and heavy hearted and pitiful." (Starlight)

I felt like I was way over my head because I was like - 'you need a counsellor to talk to you about this. I'm an 18 year old girl. I don't know how to handle this stuff.' (Krissy)

Gabbana explained that her sister's situation seemed dire, and the mental health emergencies seemed endless. For years Gabbana described hopelessness as her primary emotional experience.

I would be upset because I didn't know what to do and I didn't know how to change it. It just felt like the situation was going to go on forever. That was going to be the

rest of our relationship for the rest of time. I honestly, for so long, thought it was going to lead to her killing herself. This is going to be the rest of the time we have together. It's always going to be like this. It was just depressing. (Gabbana)

5.4.3. Impact and repercussions of caregiving. Without exception, the participants in Study Two felt that the experience of caregiving had not left them untouched. Both their external and internal worlds had been altered, and participants shared numerous examples of the impact and repercussions of their experiences. Although some repercussions were relatively temporary (e.g., diminished sleep during the caregiving period), other repercussions were far more enduring (e.g., improved understanding of mental illness).

Diminished physical, social, and emotional health. Participants identified significant changes to their global well-being – including physical, social, and emotional health impediments. Reports of general physical malaise, poor sleep, and poor appetite was common. Several participants noted stopping healthy physical habits, such as regular exercise and involvement on sports teams, because of their caregiving responsibilities.

Participants also described how the prolonged stress of caregiving began to negatively impact their own mental well-being. For example, Gordon described how his mental space was consumed with questions about his girlfriend's self-harm:

It was definitely like I said no sleep, up all night thinking about it all night, trying to just - think of what's going to, how she's going to respond to something, whatever you say. And, you know, like how you're going to respond when you have to say it, you know, whatever the case may be. Like what happens if she's still doing it or what if there's something, what if she does something and I cannot stop it in time,

you know. What if she takes it too far, what if, you know, there's so many variables every night you just sit there awake. And your brain is just ticking and ticking and ticking. It's just, you dream about it, you don't ever get away from it. (Gordon)

Several participants shared that after caregiving they would have benefitted from therapy themselves, because the experience had left them emotionally exhausted or emotionally charged. For example, Vollie reported that she has become a “worrier”, and although her friend has recovered from self-harm, her thoughts are still consumed with concerns about other loved ones becoming self-harming or suicidal.

Other participants highlighted the impact on their social life. Interactions with family and friends were strained, tensions were high, and consequently these relationships suffered. Gordon relayed that he kept his girlfriend's self-harm a secret from his friends, and this subterfuge made it difficult to maintain his friendships. Starlight shared that her romantic partners would become frustrated with how much of her time was dedicated to caregiving for her self-harming friend. Roxanne felt her home life suffered because her brother's situation made everyone stressed and tense. Gabbana felt that her parents were so consumed with her sister's self-harm that they had little time or attention left for her.

Altered approach to friendship. Converting a relationship involving friends, siblings, or romantic partners into a relationship involving caregivers and care-receivers leaves a lasting impression. When discussing the impact of their experiences, participants often described how their relationship with the recipient of their care had been altered. For example, Cerra reported that she is now closer to her sister than before, and they are better able to communicate and connect. In contrast, Gordon shared how he still feels

more like a parent or guardian than a boyfriend because of the caregiving he had to provide. However, participants also described how their general approach to friendship has been altered based on their experiences. Starlight was the primary caregiver for her friend, and over several years dealt with many emergencies, prevented multiple suicide attempts, and sacrificed much to keep her friend safe. Due to these experiences, Starlight reflected on who she is as a friend:

Her self-harm forced me to think that that's what friendship was, that it was taking on people's crap all the time. Her suicide attempts trained me that if I don't respond to this text message she could be dead like in 20 minutes, and never be around again. So it made it that much more important, and I still have trouble unlearning that. (Starlight)

Due to her experiences, Wren also sees who she is as a friend in a different light:

I became a lot more observant of little things. I would pay attention a lot more if my friends were having a bad day. It's hard not to jump to the worst conclusions now that I've had these experiences. I've seen and I've been part of the worst of someone being so upset. So as a friend now I try to just be there all the time. . . I'm a lot more active of a friend that way and I pay attention to the little details. (Wren)

Altered view of oneself. Apart from affecting their external world, the caregiving experience also affected the participants' internal world – how they viewed themselves. Some participants believed the repercussions to be negative, while other participants were able to find positive outcomes. Starlight commented on the negative impact her caregiving experience had on who she is as a person, believing that she has become an “alarmist”.

I can't help but think that I'd be more balanced. If I didn't have those experiences with her, I feel like I might be a more patient person, and maybe even a better person if I didn't freak out all the time. (Starlight)

Some participants identified positive repercussions of their experiences, in that they now feel more prepared to handle difficult situations, they have more confidence in their abilities, and have a new-found knowledge that they can endure and overcome hardships. For example, Roxanne shared:

At the end I think it actually kind of made me a little bit stronger too, to have went through something like that. And now I have that knowledge, if I came through it, you know, in the future I feel like I can help somebody else and feel more informed than I did then. (Roxanne)

Gabbana, who spent years protecting and pacifying her sister, also identified an altered view of herself, and believed that her caregiving experience was one of the most momentous experiences of her life.

I feel like it shaped me as a person completely. I went through that for several years . . . I feel like just in general it's made me who I am. (Gabbana)

Gabbana went on to describe how her experiences with her sister's self-harm has changed the kind of person she is when relating to others, particularly those with mental health concerns.

I kind of assume that everyone could be going through something. I guess I'm always really conscious about things that I say to people or about people. Always on guard because you never know who might be going through something. . . I feel like people who have psychological issues of any kind – people assume they're

crazy or something. I know they're not. I don't judge things as much as I used to I guess. Just because they're going through something like that doesn't mean that they're crazy or a bad person or anything like that. (Gabbana)

5.4.4. Challenges and struggles of caregiving. Indirectly, participants shared many challenges and struggles that they had encountered during their experience of caregiving through stories and examples meant to answer other questions. When directly asked what was the biggest challenge or struggle that they encountered as a friend-caregiver, the participants' responses boiled down to two issues: lacking information to improve caregiving, and managing the emotional toll of caregiving.

Lacking information to improve caregiving. The most common challenge that was shared by the participants was simply not knowing how best to respond to their friend. These participants were not lacking in desire, motivation, or even resources. If they had the knowledge, they would have executed the best course of action.

Unfortunately, many participants described being plagued by a "not knowing".

*I think the most challenging was just not knowing what to do. Just never knowing what was going to make things better or if it was going to get better ever.
(Gabbana)*

The general dearth of knowledge included specific areas in which the participants felt they were lacking information. For example, Vollie described a lack of basic knowledge about why people engage in self-harm behaviours. She felt that her ability to provide optimum care was hampered because it was difficult for her to establish the empathy that comes with understanding.

Not understanding why they did this. And I came up with all these situations in my head as to why. I think that was the biggest thing, just not knowing why. Why would you do that to yourself? (Vollie)

Alternatively, Wendy described the constant struggle she experienced in not knowing the line between “pushing too hard” and “not pushing enough”. She shared often wishing she could say “Just stop. Just try a little harder” in regard to her friend’s recovery. Wendy was fearful of pushing too hard, resulting in her friend becoming upset and escalating the self-harm behaviours; however, she was also concerned that if nothing was expected of her friend, she would not start taking responsibility for her own actions. Wren’s struggle involved debating whether or not to get an adult involved, and wishing she knew which was the right course of help-seeking action.

Breaking that barrier of knowing the right thing to do is to tell somebody. But, she’s telling me ‘I will never talk to you again, you’ll be the worst friend ever. Don’t say anything to anyone.’ Being strong enough to say this is the right thing to do and just hoping that later on she’ll forgive you and understand you’re doing it for the best. I think that’s the hardest things because you put so much time and effort into making that person happy then to just do the one thing that they say not to do, is so hard. So, so challenging. (Wren)

Roxanne reported that she had researched self-harm, and how to be a support person, but still felt that she was coming up short in terms of having all the pertinent information. She described feeling at a loss as to what to say to her brother in order to best support him.

I think just not knowing what to say to benefit him. That's the biggest challenge.

When they say something and you don't know how to answer the question. And you don't even know where to go to get that answer. I think the biggest challenge was not knowing how to answer their questions. (Roxanne)

Managing the emotional toll of caregiving. Other participants in Study Two focused on the challenge of managing their own emotions during caregiving. Participants described caregiving as a sacrifice, in that their lives and emotions were subjugated to that of their friend. During this stressful time, managing both their own emotions, and that of their friend, was a significant burden. Starlight described her biggest struggle:

Being on call all the time. Yeah, it's a huge sacrifice to be that one person's everything when it comes to such a difficult trial. . . Being on call and sacrificing the rest of my life for that. (Starlight)

Several others described how emotionally difficult it was for them to see their friend's scars and be reminded of their dire situation.

Seeing the marks on her arms was hard . . . That was one of the hardest parts actually having a constant visual reminder of what was happening. (Gabbana)

Seeing the scars. It's like 'how did I not know this, how did I not see this?' It just hits you so hard at that moment that part of you shuts down. It was just such an overwhelming thing to see that, you know, someone you know so well or you think you know so well is doing this. . . Physically seeing it; it just tears the heart right out of you. (Gordon)

Cerra highlighted how constant and extreme her own stress and worry became during her caregiving experience. She shared that her concern for her sister turned her into an “emotional wreck”, and that her worries began to pervade even her sleep.

I'd have nightmares of walking in and finding her dead, and then I'd wake up and I'd be crying and in a fit. I've had that happen quite a few times. Or I'd be napping and I'd dream about it and I'd wake up and I'd freak out about where she is. So, just like dreaming and finding her dead is probably the worst thing. (Cerra)

Given that the major struggles reported by the participants involve lack of information and difficulty managing their emotions, it would appear that these caregivers would have benefited from information about self-harm and caregiving, as well as support in managing their own stress and emotions.

5.5 Actions in the Friend-Caregiving Role

5.5.1. Helpful caregiving actions. The participants of Study Two had a vast cumulative store of caregiving experience. These participants had been involved in supporting their friends in countless ways, and often reported trying numerous different tactics and approaches to caregiving. Despite their vast experience, at the time of the interview, none of the participants felt that they could definitively state what the ultimate and most effective approach to caregiving was for someone who self-harms. Many participants still felt at a loss as to what to do. Moreover, the participants noted that the best course of action may depend on the self-harming individual in question.

Nonetheless, every participant felt that they had learned a lot about caregiving due to their experiences and had useful information to share. In summarizing their advice and experiences with helpful caregiving actions, I have sought to include that which is

generalizable to many instances of self-harm, rather than focus on specific helpful caregiving actions for specific self-harm cases.

Openly addressing self-harm. The participants spoke about openly and frankly addressing self-harm with their friends as an extremely disconcerting, yet highly valuable caregiving tactic. Indeed, some participants relayed stories of suspecting that their friend was engaging in self-harm, and debating with themselves whether to broach the subject, or whether to ignore it in hopes it resolved on its own. Wren shared her thought process when trying to decide how to voice her concerns:

It was scary, so you didn't really want to find out more about it. It was kind of a mixture of: 'should I tell someone', or 'should I just pretend it didn't happen and see if it goes away.' (Wren)

Participants found that they could not be helpful, could not support in effective ways, and could not keep their friends safe if there were no open lines of communication about self-harm. Despite making for uncomfortable conversations, and occasionally emotionally turbulent confrontations, the participants shared story after story about the necessity of openly addressing self-harm.

Those conversations are incredibly uncomfortable to the person on the outside, but they're so important to the person who's self-harming, that you have to just put yourself out of that. It's not an easy thing, and you just need to realize that why they're talking to you about that stuff, that it is their most personal and most secretive thing, and they're opening it up to you, which means it's kind of a cry for help even if they don't know it. (Wren)

Openly addressing self-harm can take many forms. For some, it means confronting a friend about their behaviour. For others, it means calling self-harm what it is, and not using language that palliates or minimizes the behaviour. For others, it means maintaining an open and continual dialogue about the issue.

Keeping tabs on what she was doing that day. How did your day go? What are you feeling today? Where were your highs, where were your lows? So keeping as many tabs on her as I could throughout the day. Just update after update after update.

(Gordon)

Openly addressing self-harm can mean being clear about the consequences of this behaviour. For example, Gordon reported being straightforward with his girlfriend about how she could accidentally kill herself, how distraught her family would be if they knew, and how he would tell her parents and the police if he felt she was in danger. Furthermore, openly addressing self-harm can include sharing one's own perspective and feelings about it. Wren emphasized the importance of being open about her own emotional experience and sharing with her friend how the situation was impacting her as well.

I think you can't freak out about it [self-harm] but you need to make it known that it's not okay. And it's not exactly what the self-harmer wants to hear but for the whole path to recovery I think it's important that you show them it's important to you that it stops. . . It's okay to show them that is scares you and it's okay to show them that it makes you want to cry and stuff like that, because it should in a way. It's a very hard thing to accept and I think they need to know that it's something that isn't only affecting them. (Wren)

Wren also believed that asking direct questions about the self-harm is important in order to improve the caregiving and support.

You need to ask why they do it. Because you've kind of got to understand. It's very hard to help someone recover when you don't understand the why, or what they're feeling when it happens, that kind of thing. The worst things would be to ignore it and pretend it didn't happen. . . You just need to try to understand first, I guess.

(Wren)

Making support known and readily available. Additionally, the participants spoke about the importance of making their support both known to their friend, and readily available to their friend. Participants emphasized the importance of both components, in that there is value in *telling* their friend “I’m here for you”, and there is also value in *demonstrating* that help and support is easily accessible. For example, Vollie shared how she combined the telling and the demonstrating of her support for her boyfriend:

Just being there for him to talk about things. . . Just always being there for him. We have a dog who is very stressful so I'll do little things like take the dog out for a while and let him be by himself. Just making him supper and all these things and telling him I love him and just making him feel like he has a support system.

(Vollie)

Both Wendy and Starlight spoke about being responsive to take their friends to the hospital emergency room when told they were at risk of harming themselves as an important part of demonstrating that help is readily available. Both participants shared examples of when a trip to the emergency room (including the long wait and stress that

ensued) was a major inconvenience, but they were quick to demonstrate that they were more than willing to sacrifice their own time and plans in order to be supportive.

Starlight's story epitomized the adage *actions speak louder than words* in that she made every effort to prioritize her friend's health and well-being, and made herself available whenever her friend needed support, in whatever way she needed it.

Gordon shared his rationale as to why making support known and readily available was important to his girlfriend's recovery:

From what she told me anyways, the reasons that she was getting like this was because in a lot of ways she was feeling alone. So easiest way to come about resolving that is attention, attention, attention. So keeping as many tabs as I could.

(Gordon)

Although self-harm is often not about wanting attention, several of the friend-caregivers believed that attention is useful in remedying feelings of aloneness, self-hate, and emotional pain in general. In this way, "giving attention" is not a cursory or belittling caregiver solution. Instead, it is an attempt to assuage those negative emotions that are at the root of their friend's self-harm.

Roxanne also emphasized making her support known to her brother, while making tangible help readily available. In fact, she believed that the most helpful action she did as a caregiver was impressing on her brother how willing she was to offer whatever support she could.

I think mostly just being available for him to talk to me. And explaining to him that if he ever has problems he should talk to me, or I can help him with getting help.

(Roxanne)

From their stories, it appeared as though there were often times when the participants' friends were disinclined to the support offered. Indeed, Roxanne admitted that at times her brother would appear hostile and unreceptive to her offers of support; at which time she would opt to say:

I don't want to force you to talk to me about anything, but if you need to, I'm completely available and would love to listen. (Roxanne)

Encouraging social and leisure activities. Another caregiver action believed to be of particular utility, was the encouragement and facilitation of various social and leisure activities. Several participants related becoming involved in their friend's leisure activities and reinforcing their participation in hobbies and interests. Participants provided many examples, including: encouraging their friend to participate in an art show, attending their sporting events, assisting in the preparations for horseback riding competitions, and taking fitness classes together. Participants also encouraged their friends to maintain their social life. The general consensus was that their self-harming friends did better, and were healthier, when maintaining regular social and leisure activities. Participants noticed that withdrawal from social activities and disengagement from previously enjoyed activities often marked a decline in their friends' mental health. As such, participants described regularly attempting to keep their friends active, busy, and socially engaged.

I would always try and engage with him and that kind of stuff, try and have conversations with him. I would invite him out with my friends and try to help in that sense. (Roxanne)

I tried to keep her active outside of her house and like get her really doing things . . . Keeping her around healthy people. . . I would say find new friends for a while. Whether that takes going to a new class, taking a recreational dance class or art class or going and learning about motorcycles or something. Just make a couple new friends that have the same interests as you do, to have people to hang out with outside of that more toxic environment. (Starlight)

Interacting with non-judgement. Several participants stressed that the *how* was as important as the *what*, in terms of helpful actions. In particular, friend-caregivers believed that interacting with non-judgment was essential to helpful caregiving. All the other helpful actions – openly addressing self-harm, making support known and available, and encouraging healthy activities, would not be of benefit if there was underlying judgment and condemnation. For Wendy, this involved trying to be understanding of her sister’s limitations (i.e., inability to maintain her grades, difficulty working full-time, and requiring psychiatric medication). For Cerra, interacting with non-judgment meant being an emphatic listener. For Vollie, non-judgment involved accepting that the recovery process was going to be a long road for her boyfriend, and that a lot of support and sacrifices would be needed along the way. Gabbana expressed some regret that she was not able to better overcome her feelings of judgement, and believed that this had hampered her ability to provide support.

If I could have been there as someone for her to talk to, that she could go to with all her problems, and that she could try to explain what was going on without feeling like she was being judged for it. I think it would have helped her a lot more probably. (Gabbana)

Kent placed emphasis on avoiding the perspective that someone who self-harms is “broken” and “in need of fixing”.

I think their image of ‘broken because you self-harm’ is a really bad approach.

Trying to be confrontational, like: ‘Okay, how can we fix you? How can we make you better? What’s wrong with your life? What do you need from me?’ Instead, just be there as a support. The approach: ‘I’m listening. I’m understanding. I’m always here for you.’ I think that’s a lot better. (Kent)

Kent was insistent that a friend-caregiver’s emphasis should be on loving their friend, not fixing their friend. The notion that self-harm indicates something needs to be fixed, implies the person who self-harms is broken, and as such, is an extremely pejorative and demeaning perspective. Moreover, Kent relayed that other friends who had reacted from this judgmental perspective were not helpful to his friend, and their offers of support were not accepted.

5.5.2. Unhelpful caregiving actions. In retrospect, the participants of Study Two were able to identify several types of actions that they regretted as a friend-caregiver. At the time, these participants were operating with the best of intentions, and thus, their “unhelpful” actions can be attributed to lack of knowledge, overwhelming emotions, few alternate options, and simply doing the best they could with the few resources available to them. Some participants were able to share stories about actions they had witnessed and had deemed to be unhelpful based on their friends’ responses. In summarizing their advice and experiences, I have sought to include that which is generalizable to many instances of self-harm, by capturing the underlying intent and experience, rather than attempt to document each and every type of unhelpful action a caregiver could take.

Engaging in emotional outbursts. Several participants recalled instances of emotional outbursts directed at their self-harming friends. In retrospect, these participants believed their reactions to have been detrimental to their caregiving and to their relationship. Gordon shared that when his girlfriend first disclosed that she was self-harming he had an emotional outburst.

Well my initial reaction wasn't the best. Like I said I completely chewed her out in the sense like, you know, 'if you screw this up you could kill yourself'. . . I think the best way to probably cope with that, that I would change anyway, is I would take a far more calm approach. (Gordon)

Gordon explained that at the time he was completely taken aback, and extremely panicked. Although he wished he could have responded with a level head, he also noted that an emotional reaction is very difficult to avoid with no advance warning of the self-harm.

Similarly, Roxanne shared that she regretted an emotional outburst she had when her brother threatened to escalate his self-harming behaviours. Upon reflection, Roxanne shared that she believes a calm reaction to be more helpful than one that is panicked or highly emotional.

I wish I could have been a little bit more calm the day that he did that. I overreacted and freaked out. I did kind of get mad at him actually, at the time, because I was so in shock. I wish I could have reacted to that in a little bit more of a calmer manner. . . At the time I think I was concerned about how I felt instead of how he felt. (Roxanne)

Several participants shared stories in which their emotions – often fear, panic, or worry – overtook them, and for that period of time, their own emotions had to take priority over the emotions of their friend. From these stories it seemed the constant subjugation of caregiver emotions is a contributing factor to the caregiver burden and burnout experienced. Although not helpful, this candid expression of emotions often seems genuine and justified. Gordon provided the following advice on how best to manage the emotions that caregivers are expected, if not entitled to have, while still being helpful:

Take it as calmly as you can. Let them see your emotions but don't get hysterical. Let them know that this is hurting you too. It's not easy, but if you can take a more calm approach maybe you can talk them into getting help. . . The calmer you are the easier it is to think in a lot of ways. So think it through before you even respond. Even if there is an awkward pause or an awkward silence. It's not an easy thing to ever go through, but just take it in, take in as much as you can at that time and then process it. (Gordon)

Attempting to motivate with guilt. Occasionally, in an attempt to motivate their friends toward wellness and recovery, friend-caregivers used less than optimal tactics. The consensus among the participants of Study Two is that attempting to motivate friends with guilt is an unhelpful action that often results in frustration and resentment. For example, Wendy shared that she became frustrated when her sister would not engage in social activities and would not attend school, and consequently felt alone and unproductive. In an attempt to help motivate her sister to re-engage in her life, she suggested that she was “letting others down”, that “she should be able to do this” and that

“she was not even trying to get better”. Although she had her sister’s wellbeing in mind, Wendy discovered that guilt is not a helpful motivator.

Kent believes that checking a friend for scars or signs of self-harm is a guilt trip tactic, and should be completely avoided. Kent shared that this approach serves to make the self-harming friend feel guilty, but instead of motivating them to stop self-harming they feel worse about themselves and more likely to continue self-harming.

Checking is in and of itself a kind of an attack on the person. . . Asking to see those marks is kind of like the person is looking for evidence, looking for something accusatory to run on. (Kent)

Kent also shared that caregivers can accidentally say things that serve to make someone who is self-harming feel guilty. Kent urged caregivers to be cautious in their wording, and wary of inadvertently making people feel guilty. One example that Kent provided is making statements such as: “But there are so many people who love you”. These types of remarks imply that the person’s self-harm is not justified, and in doing so, the person’s feelings are not validated. By pointing out how good someone has it, and how many people care about them, it implies that their self-harming behaviour is nonsensical and stupid. Moreover, Kent pointed out that although people might care about them, the self-harming person would not be self-harming if they felt fully supported, and if they *felt* people cared about them. In this way, the statement: “But there are so many people who love you” serves to make the person feel guilty and unjustified in their actions, rather than reassured and supported.

Saying that ‘there’s so many people who care about you,’ saying that ‘oh all these people love you’ is a terrible statement to go with because hearing that from a

friend . . . well it means you [the caregiver] don't understand the situation, you don't understand that the people you're listing off right now aren't necessarily fully there for them. They don't fully support them. So when somebody says that to someone, everything else that they say after is just negated. (Kent)

In sum, the participants understood wanting to motivate their friends toward wellness, but had discovered that actions or words that introduced feelings of guilt were poor motivational tactics.

Shouldering all the responsibility. Upon reflection, several participants determined that one of the most unhelpful actions they took as caregivers was to try shouldering all the caregiving responsibility themselves. They came to realize that it was simply too much pressure and stress for them, and consequently, both they and their self-harming friends suffered. Unfortunately, at the time, these friend-caregivers felt “stuck” with the responsibility and did not feel like there were good alternatives. Gordon shared his thought process:

What I definitely should have done differently was actually get her parents involved. We've got to tell your parents, we've got to get this solved – was my initial response. And she said 'no, we can't tell them, keep it secret, keep it secret.' Well, then my deal with her was if this happens again, not only do I get your parents involved, I'm putting your ass in the hospital until you can be responsible enough without constant surveillance. (Gordon)

Although Gordon presented an ultimatum to his girlfriend, he spent months wondering if he did the right thing. He described living in fear that she would hurt herself or kill herself and it would have been his fault for not involving others sooner. Similarly,

Starlight was an adamant advocate for getting others involved in order for the self-harming friend to receive best care, and in order to avoid caregiver burn-out. She shared the following advice:

Get people involved cause you can't do it alone. And they obviously can't. So people need to be involved, like external forces that are trained to deal with these sorts of things. . . Worrying that a breach of trust will do more harm than good if other people are involved, well, I felt that way for a long time, but it's just necessary. If you're passionate about your friend surviving, you should probably get them help. (Starlight)

Ignoring or minimizing the seriousness of self-harm. Several participants described how tempting it was to ignore their friend's self-harm. Because they did not want it to be true, and the prospect of supporting them was so overwhelming, an avoidant approach was far more appealing than a direct approach. Indeed, some participants shared that they suspected their friend was self-harming, but remained quiet in hopes that the situation would resolve itself. Wren summarized this sentiment:

I feel the worst thing to do is act like it's not a big deal, because I think for the first time when someone shows or expresses that this is what they're doing, you don't want it to be true. You don't want it to be real. And so I think a lot of people find it scary, so they just try to say 'well, don't do it again, it'll be okay.' I think that's the worst thing to do because it is serious and it is – it is something that should affect you emotionally. (Wren)

In retrospect, participants believed that ignoring potential self-harm, or minimizing how serious self-harm behaviours are, is an ineffective and unhelpful approach to caregiving.

5.5.3. Actions related to help-seeking. Extant literature has provided conflicting information about friend-caregivers' roles in help-seeking for self-harm. Past research has provided examples of friend-caregivers opposing help-seeking from mental health professionals, as well as examples of friend-caregivers supporting seeking help from professionals. The participants in Study Two provided more details on why and how mental health professionals can be both avoided and encouraged among the friend-caregiver population. In the current sample, some participants did indeed work to prevent the involvement of professionals, while other participants did the opposite, and worked to introduce professional involvement. The participants' stories add context to this conundrum.

Acting to prevent the necessity of professional involvement. The primary reason that friend-caregivers attempted to prevent the involvement of mental health professionals was it went against the self-harming individual's wishes. The participants repeatedly shared that had it been up to them, they would have involved parents, teachers, therapists, and other professionals. However, the participants were road-blocked in carrying out help-seeking actions because their friends were resistant to this course of action.

At times, friend-caregivers opted not to involve professionals because they were afraid of betraying their friends' trust. Self-harming friends would demand that their self-

harm be kept a secret, and would insist that “good friends” would not tell. For example, Wren shared her experiences with a friend who was resistant to formal help:

She didn't want me to tell anybody because she knew that if she told someone they would take her to the hospital and she didn't want that. She didn't want that and so she told me I'm not allowed to tell anybody kind of thing. (Wren)

Wren, afraid to put the friendship in jeopardy, refrained from telling anyone for months and months. Eventually, her friend’s self-harm became too severe, and fearing for her safety Wren opted to tell a school guidance counsellor. Wren’s reaction to involving others clearly illustrates the experience of many young people torn between loyalty to their friend and fear for their friend’s life:

There came a point when I was well, she won't trust me anymore if I say anything, but at the same time I can't do anything anymore. It's out of my hands. So I went to the guidance counsellor. . . It was kind of a wash over of guilt, and I was like ‘oh no this is exactly what she didn't want me to do.’ Then I was relieved because I knew it's a good thing. I just cried and cried because it was kind of overwhelming. . . The moment it became known, it was like ‘thank goodness it isn't just on me anymore, because that was a lot on my shoulders’ . . . And she was really, really mad at me, which was hard, but she was going to die. So I think in the end it was - I know it was the right thing to do now. But even still I still feel kind of guilty. (Wren)

Indeed, Wren’s friend was extremely angry that she had been “betrayed”, and that Wren’s disclosure had resulted in her hospitalization. Wren’s concerns were justified, in that her friend felt she had been disloyal and she had to work to repair the damage in the relationship.

Occasionally, friend-caregivers opted not to involve professionals because they believed their friend was too fragile, embarrassed, or self-conscious to benefit from speaking to a stranger. Rather than have their friend confront the shame and discomfort involved in formal help-seeking, they did not insist on seeking formal help, and instead tried to focus on informal help. For example, Krissy believed her friend was too self-conscious to ever speak to a professional, so instead she connected her friend with a personal trainer, for a more informal type of support that she believed would be better received.

I didn't really take her to formal help because she was so self-conscious about people finding out. But like I said, I talked to a trainer, and we go to the gym every day together just to keep in a routine. . . So yeah, definitely not formal stuff because she would not participate in therapy or anything in case somebody found out.

(Krissy)

Krissy, like other friend-caregivers, decided that their friend would not accept help from a professional, so instead tried to find a type of support that would provide benefit. In this way, friend-caregivers act to prevent the necessity of professional involvement.

There were also instances in which the friend-caregiver held little regard for the abilities of professionals, and instead believed that informal supports and good friendship was the key to recovery. For example, Kent believed that informal supports were often more effective than professional supports. Therefore, he tried to optimize the support his friend received from her friends and family in hopes of avoiding the need for professional involvement.

I wanted to make sure that she was talking to her other friends and family because they were the ones always around her. Then, by asking that, I felt that was me helping her so that she's communicating with those people and at the same time helping her find help. And, we were always encouraging each other just to being doing stuff and saying active and stuff like that. (Kent)

Acting to assert the necessity of professional involvement. Alternatively, some participants took an active approach to asserting the importance and benefit of professional involvement. Depending on their means and resources, this assertion of professional involvement took the form of verbal support, financial support, or practical support. Some participants demonstrated their support of professional help-seeking by visiting their friend in the hospital, or by accompanying them to their therapy appointments. Other participants made it known that they would inform parents, teachers, or others if they felt their friend was at risk of hurting themselves. For example, Wendy had routinely informed her parents or teachers of the need to take her sister to the Emergency Room, and her sister often approached her to assist in seeking help in this way. Similarly, Starlight often intervened in emergency situations by calling her friend's parents or the police, and considered this part of her caregiving role. Alternatively, Roxanne's involvement in formal help-seeking included making appointments with professionals and driving her brother to his appointments.

Other friend-caregivers described desperately wanting their friend to have formal support, but not being able to convince their friend of its merits. For example, Gordon shared that he had encouraged, begged, and insisted that his girlfriend to see a therapist, but she adamantly refused. Gordon relayed a story in which he made an appointment for

his girlfriend to see a therapist without her knowledge, drove her to the office, and begged and pleaded with her to go inside:

She got to the point where I drove her to a counsellor, I said I'll pay for it. I'll do anything, I don't care, expense is no worry to me. I'll pay for it, you go and you don't have to worry about it. And she wouldn't get out of the car. . . I talked to her about this, it was probably a good 45 minutes of coaxing. And she just would not budge. And finally, I just gave up. (Gordon)

In sum, friend-caregivers were often proponents of formal help-seeking, and did their best to involve others based on their friend's need and wishes. Another factor which warrants mention, is the level of self-harm severity. Those participants who opted for informal supports and worked to prevent the necessity of professional help were often dealing with a lower severity level than those participants who reported actively seeking professional involvement.

5.6 Support Needs

The participants of Study Two were a wealth of information on the gaps and opportunities for supporting individuals involved in the process of recovery from self-harm. When discussing the type of support that was needed, participants were often prompted to pass along advice or imagine the perfect solution. Therefore, the following discussion of support needs includes both the needs and possible solutions. Despite their varied experiences as friend-caregivers, the key support needs they identified were similar. Two superordinate themes emerged in this topic area: support needs for themselves (friend-caregivers) and support needs for others.

5.6.1 Support needs of friend-caregivers. Friend-caregivers disclosed that they themselves were in desperate need of support while they were assisting their friend in recovering from self-harm. Due to the difficult task of caregiving, the emotional toll they were experiencing and the negative repercussions on many aspects of their lives, friend-caregivers believed they would have benefitted from several types of supports. When discussing the type of support they needed, participants identified the need for more information, the need for more emotional support, as well as a need to maintain a separate and healthy life apart from their caregiving duties. Throughout their stories, participants provided practical ways in which these needs could be better met.

Informational support needs. Participants repeatedly emphasized their need for more information. They believed that additional information on self-harm, as well as on caregiving for someone who self-harms, would have improved the support they offered to their friend. As previously discussed, several participants had little to no experience with self-harm prior to their caregiving role, and felt overwhelmed and lost in the task. See Table 3 for an overview of friend-caregivers' informational needs.

Table 3

Friend-caregivers' Informational Support Needs

About self-harm	About caregiving for self-harm
Reasons why people engage in self-harm	How to confront someone you suspect of self-harming
Warning signs that someone may be self-harming	What resources are available for caregivers
Warning signs that someone's self-harm is becoming more severe	What resources are available for someone who self-harms
The self-harm cycle	Where to access reliable information
The seriousness of self-harm	When to involve professionals/adults
The <i>experience</i> of self-harm	

The lack of knowledge and comfort with self-harm is reflected in the fact that participants asked for information on the basics of self-harm. Friend-caregivers believed information on the following would be helpful to caregivers: the reasons why people engage in self-harm, the self-harm cycle, warning signs that someone may be self-harming, warning signs that someone's self-harm may be increasing in severity, and the seriousness of self-harm. Moreover, participants requested information be provided that counter the common misperceptions and stigma surrounding the self-harm phenomenon.

Apart from requests for basic, practical information on self-harm, participants also desired information on the *experience* of self-harm. Participants believed that in order to best provide care, they needed to have a better understanding of what someone who self-harms thinks and feels. For example, Starlight emphasized that judgmental caregiving is ineffective, and therefore understanding the experience of self-harm is beneficial. Starlight also pointed out that simply doing what a caregiving how-to book says is ineffective without empathy.

A person's job is not to fix somebody, it's to support them. And I don't think that it's possible to effectively be a support person when you don't even make an effort to understand. I think being supportive, a large part in that is empathy, being able to be empathetic. And it's such a difficult concept for a lot of people to understand that haven't actually personally gone through it. That, like most people are like why would you want to cut yourself, like why would you want to burn yourself, like, doesn't it hurt? And if they come at it from 'I don't understand how you could do this, this is what this book says,' it's not going to work. . . . When the chances of a counsellor being successful is so low, then a person who think they can just read

and help is ridiculous. The biggest part of getting help for caregivers is to know what the hell they're going through. (Starlight)

Friend-caregivers also requested information on the task of caregiving. Apart from lacking knowledge about self-harm itself, the participants were keenly aware of their lack of knowledge about supporting someone who self-harms. In this regard, they requested basic information on how to be a caregiver. For example, they wanted to know how best to deal with a friend who self-harms, what sort of resources are available to them and their friend, as well information on where to get good information. Participants made the following points:

I'd like to know how to deal with it better and there is really no literature that's like you should this step by step by step. There's nothing like that out there. I wish it was more certain... and more options, things like that. (Wendy)

I think more understanding on that aspect as to what are the actual resources you can go to. Who can you actually talk to? Why you should be going to authority figures in certain situations and why sometimes you should just be talking to that person directly instead? Just being like what can I do to prevent this? (Kent)

I wish I had known, and I wish someone talked about self-harm earlier, even in schools or something like that. I wish that it was a more educated topic. I wish I had understood why it's a solution, because I didn't understand that this, for some reason, takes away her feeling of not feeling. It's stereotyped really bad to be for attention. It's got a really bad stigma that you're only doing it so people will notice,

but in my opinion, even if that's the case, is that not a call out for help? Enough that you're willing to cut yourself up for people to notice? (Wren)

Krissy described exactly what she wished she had been taught about caregiving, and how she would structure an instructional course for other caregivers:

Well, I would first of all teach them how to have the initial talk [about self-harm]. Like, you can't just go in there all aggressive and stuff. You got to ease yourself into it. So I'd teach them how to have uncomfortable talks with the people and kind of coach them on how to. You can't really raise somebody's self-worth by yourself. But, like, how to influence how they feel about themselves. Just like empowerment kind of thing. Well, I would give them more things to look out for, like warning signs obviously. When to get other people involved. Like, parents or medical attention or whatever. I would just give them a rigorous course on how to talk to the people, what to do, why they're doing it. I'd just, I'd want them to understand what is going through the person's head. Because if you don't have empathy and to understand why they're doing it that you can help them. (Krissy)

Informational support solutions. The major way in which this information should be distributed is through the education system. Participants believed that schools would be the best information avenue. Specifically, participants identified health classes as the class in which curriculum could be altered to provide information on self-harm and on caregiving. Alternatively, guest speakers and educational workshops could be offered. Participants considered this the best informational avenue because it could reach people at a young age, and it would reach the most number of people. Given the high likelihood

that anyone and everyone in school could be confronted with a self-harm caregiving situation, participants felt that the educational system was the best avenue.

Maybe it is something that should be taught in school, or there should be presentations or something. Something just to make everyone aware, and not just if you're going through it, but just something that would make everyone aware in case they ever do come across it. (Gabbana)

Indeed, participants expressed a common sentiment that the educational system had failed them in a way, by not preparing them for such a momentous life challenge or for seemingly glossing over the topic of self-harm. Kent felt that the “taboo” nature of self-harm had unfairly resulted in the lack of information provided in school:

You always hear 'oh if your friend is going to self-harm go make sure you tell someone'. But in reality that only kind of helps the short term solution. That doesn't help a long term solution. I think that's where a lot of information is lacking, especially for people in high school. . . there is no discussion about it because it's such a taboo topic and a taboo topic in society. (Kent)

Similarly, Wren felt the lack of coverage about self-harm in the school systems was a shame.

If you don't understand self-harm and you just try to find it on the internet, that's not the best thing to do either. I wish that it was talked about more in a more realistic sense, I guess, in schools or in things like that. Because self-harm and suicide, they're kind of dodged around a little bit and I don't think they should be because I think there's people that need to understand what their friends are doing

or need to even understand what they're doing. And I think that that needs to be addressed more. (Wren)

Emotional support needs. Apart from better and more accessible information, participants described needing better and more accessible emotional support. Friend-caregivers often feel over-burdened, drained, and stressed in their role. As such, they reported needing support in the form of understanding, encouragement, willingness to listen, and a better sense of camaraderie. Starlight summarized the sentiment when she admitted, “I needed my own support people”. She went on to describe that instead of moral support from her family and friends, she was in fact discouraged to act as a caregiver for her friend. She wanted her family and friends to realize that caregiving is an important role to her, and consequently provide help where they could. Similar to other participants, both Starlight and Wren expressed their desire to have loved ones provide a listening ear:

*It would have been nice to have somebody to sit down and like hash things out with.
(Starlight)*

I needed someone else to talk to. I needed a therapist in the sense that I just needed to go sit and talk to someone and just let it all out, and then I can start again. As so much was being kept inside. It's not that I needed advice on how to fix it, which is important too, but before that I would have just like someone to listen while I vented about everything that happened. (Wren)

Emotional support solutions. In order to satisfy their need for understanding, encouragement, willingness to listen, and camaraderie, participants suggested that

support groups be made available to friend-caregivers. Time and time again participants came to the same solution for their emotional support need: a support group comprised of other caregivers. The crux of this solution is being in the company of other caregivers who intimately understood the situation. In this way, friend-caregivers would feel less alone, could share caregiving tips and resources, and would be given the opportunity to feel heard. Gabbana described what would make a support group helpful to her:

Knowing that they were going through the same kinds of things as I was and not just telling someone what I was going through. I guess actually communicating how you're dealing with it. . . It would have been nice to know some ways to deal with it, just to cope with it. Yeah, I definitely think that would have been more helpful than going to see a counsellor or something, and instead talking to them about what was going on. (Gabbana)

Some participants suggested different spins on this basic 'support group' idea. For example, Wendy believed that a reflective group would be most helpful in making her a better caregiver.

I think a very reflective group would be best. Because looking back on your own experiences and kind of analyzing why you're where you are today - I think that's what would help me personally. . . What are you unhappy with? What can you change? What can't you change? What actions are you going to take? (Wendy)

Wren suggested a recreational support group that both individuals who self-harm and friend-caregivers could attend together. Wren believes that there are more supports available for families, but it is friends who help individuals struggling with self-harm become more social and active.

I think, you know how they have therapy groups for people who self-harm and they have group sessions where if you self-harm you can go and talk to other people that self-harm? I wish they had just, especially for teenagers and adolescents and stuff, some kind of program where my friend and I could have gone. And as much as it's sitting there and talking about stuff, it's also about activities. I'm not saying games and stuff, but rather than just sitting around and talking, like 'this is what I go through', having a way to meet people and make it a way that it's a night where my friend doesn't have to feel so sad and lonely, because she's busy and stuff. (Wren)

Although participants occasionally mentioned the potential benefit of having more understanding families or having the opportunity to speak with a therapist for themselves, having a support group was by and large the most popular solution to the emotional needs they experienced while caregiving.

Need to maintain a healthy life separate from the caregiving role. Lastly, participants described the need to keep themselves healthy, as well as maintain who they are as a person apart from being a caregiver. Participants described how easy it is to “lose yourself” or let caregiving “consume your life”. Several participants felt that maintain a healthy life separate from the caregiving role was one of the most important caregiver needs. Starlight asserted that caregivers need to be supported in maintaining their own life, and not sacrificing their own health for that of a friend.

Solution to maintaining a healthy life separate from the caregiving role. Several participants shared advice regarding keeping healthy despite a taxing caregiving role. Wendy shared that she focused on her school-work, tried to eat well and exercise, kept up with her hobbies, surrounded herself with supportive people, and “pretty much

just kept busy”. Similarly, Roxanne suggested: regular exercise, taking time to de-stress, confiding in someone, and letting out your emotions.

Starlight asserted that “a single person cannot be a sole support system” and advised other caregivers to take the time and the space they needed in order to keep themselves healthy. Finding supports and activities that allow for multiple roles, not just the ‘friend-caregiver’ role is essential. Wren added the following advice about getting other people involved so that there is a support team, rather than a single support person:

You're not letting them down, so take a break. It's hard because at the time you're so worried that if I take a break and just have time to myself, something bad is going to happen. I was always thinking that. But you can't help them if you are so exhausted and so down on yourself. That's not helping them in any way. . . That is when I was like 'well maybe I should give some of the responsibility to someone else too. There comes a point when having two people drowning in the lake isn't going to save anybody. (Wren)

5.6.2 Support needs of those who self-harm. Through their support of someone recovering from self-harm, friend-caregivers become intimately familiar with the needs of their recovering friends. As such, the participants of Study Two had several ideas about the support needs of individuals struggling with self-harm. By contemplating their caregiving experiences and their friends’ recovery journeys, the participants could identify what went well, as well as what was missing. When discussing the type of support their friends needed, participants identified the need for improved understanding and follow-up for self-harm in the healthcare system, the opportunity for their friends to

connect with others who understand the self-harm struggle, and the need for improved awareness and education about self-harm in the school system.

Improved understanding and follow-up for self-harm in the healthcare system.

In observing their friends' interactions with the healthcare system, the participants had become largely disillusioned with the care and support being provided by mental health professionals. Several participants felt that health professionals were focused too exclusively on keeping people "physically safe" while disregarding whether or not they were "emotionally safe". For example, Starlight shared one incident in which her friend had severely cut her arm and had to be taken to the Emergency Room. While there, health professionals stitched her arm then sent her home with little to no follow-up services provided. Several participants had similar stories in which they felt that "self-harm" was treated with contemptuous or dismissive attitudes by health care providers.

Gabbana shared the following story, in which she described feeling at a loss after receiving poor services for her sister.

There were a couple of night my parents had taken her to the ER because she would be completely blowing up and making big threats, not just threatening to kill herself and stuff like that. And she had asked them a couple of times to take her in. Both times they went and she didn't get admitted because they said it wasn't a serious enough case. She did want help. She wanted to know what was wrong that was causing her to do that. . . What were we supposed to do now to try and help her when we don't even know where the problem is coming from? It was extremely stressful and for a while I thought it was just that she was going to end up killing

herself because we didn't know what else to do. No one else that we were seeking help from really gave us any other options of what to do. (Gabbana)

Gabbana described being admitted to hospital as a “last resort” and when her sister was denied admittance feeling completely bewildered as to what to try next. If you have exhausted your last resort, what is there left to try?

Furthermore, some participants felt that the mental health professionals with whom they were in contact could benefit from a better understanding of self-harm. Starlight, for example, believed that there were informational gaps in the mental health care system about self-harm, and provided the example of her friend's counsellor:

Though the counsellor was incredible and awesome and I can't say anything negative about her, it was obvious that there were holes in whatever she was working from. And even her vast experience working with self-harm wasn't enough. I felt like the experience was too rocky, like it shouldn't have been that up in the air in terms of what we were trying. (Starlight)

Opportunities to connect with others who understand the self-harm struggle.

Participants also believed that their friends needed support from other individuals who had a first-hand understanding of self-harm. Preferably, their friends could connect with individuals who had recovered from self-harm and could speak to the recovery process. Participants believed that a special kind of support comes from people with shared experiences. In order to achieve this type of support, several participants suggested support groups for individuals who self-harm. Roxanne believed that a support group may help her brother feel less alone:

Maybe, like a support group kind of thing. Because I think most of the reason why he was like that in the first place was because he felt alone. So yeah maybe if he'd went to a support group or something that would help. Because I don't know, I think that would help myself if I was going through something. Like I said before it's always better to know that there's someone else going through the same things as you. I think it's helpful because then you don't feel so alone. (Roxanne)

Alternatively, a few participants presented the idea of mentorship support, wherein someone who has recovered from self-harm could provide moral and informational support to individuals still in the recovery process. Participants believed that a mentor would be in the best position to provide support and information, while presenting as less intimidating and more understanding than therapists. Starlight shared her idea about a mentor support system:

Some sort of combination of the counsellor that's an ex-self-harmer, that is more like a friend or buddy. . . Maybe a mentor where people sign up for it like a volunteer opportunity. (Starlight)

Another participant presented the idea of support through mentorship, but suggested that mentors and people who are currently self-harming be connected via email. Cerra described compiling a list of names and email addresses of recovered individuals who were willing to communicate via email about their experiences of recovery. This list of volunteers could be distributed to individuals currently struggling with self-harm, and these individuals could take the first step to reach out for support. Cerra described some of the benefits of email mentorship:

So it wouldn't be hard to like email someone. And you could just make up a random email without your name, and you could just anonymously email this person, or they could do like the same. Like, they could not include their name at all, and you would just not know their name at all, and you would just discuss your experiences and how you feel. . . I feel it would have more pros because you could get emotional yourself and just like cry it out if you're typing it out. So you wouldn't be around people and the fact that you'd be completely anonymous. If you go to a group, you could potentially see those people again around the same city.

(Cerra)

Whether through support groups, mentors, or email mentorship, friend-caregivers believed that connecting with others who intimately understood the struggle with self-harm and who may have tips on how to improve the recovery process would greatly support their self-harming friends.

Improved awareness and education about self-harm in the school system.

Throughout their time as caregivers, the participants of Study Two had encountered many misperceptions and stigma about self-harm. Moreover, they felt that avoiding the subject in the school system only served to perpetuate the negative and misinformed perceptions about those who struggle with self-harm. As such, friend-caregivers identified improved awareness and education about self-harm in the school system as a key support need for those who self-harm.

Wendy felt that the school system does not do the topic of mental illness justice, and this limits young people's understanding of mental health concerns generally, and self-harm specifically.

We know mental illness is there, but we don't know too much about it and we want to talk about. Of course it's an emotional issue and no one wants to be singled out in that area, or think 'they're talking about me', but it is important to understand what you're going through. (Wendy)

Similarly, Vollie suggested a way in which the school system could improve awareness and information about self-harm:

Maybe if you had someone who has self-harmed, just to tell kids what it feels like and what they go through, I think that would also help. You know a lot of kids learn through experience and learn through seeing it instead of just reading it on a piece of paper. (Vollie)

Vollie also suggested awareness campaigns or fundraisers for self-harm. She felt that initiatives such as Pink Shirt Day to raise awareness for bullying could be adapted for self-harm in order to decrease stigma and increase understanding.

I think there needs to be more programs and an awareness for mental health. Again, starting at a young age because it can happen at that young age, even though I think people try not to think that it does. (Vollie)

Participants felt that if information and awareness was promoted early in the school system, there might be a preventative effect on self-harm. Alternatively, individuals who self-harm may have a better support system due to more informed friends and teachers. Furthermore, decreased stigma could result in decreased shame and secrecy, making help-seeking more palatable.

5.7 Discussion of Study Two

Study Two expands our understanding of the lived experience of friend-caregivers supporting a friend in their recovery from self-harm. Through the perspectives of these friend-caregivers, Study Two contributes to the existing literature by providing a more subjective and personal account of what the experience of recovery looks and feels like for key support people. To date, there is little information about the friend-caregiver experience in self-harm recovery; therefore, the current study illuminates a thus-far dark facet of the self-harm experience. Through in-depth interviews the experience of friend-caregiving was examined in terms of the experience of the caregiving role, actions in the caregiving role, and perceived support needs. In the following section I will: situate the results of Study Two in the current literature, demonstrate how this new-found understanding of friend-caregiving extends and contributes to this literature, and provide implications regarding friend-caregivers' experience of the caregiving role, the actions they took as friend-caregivers, and support needs.

5.7.1 Implications for the experience of the friend-caregiving role. As previously discussed, friends can play a key caregiving role during recovery from self-harm. Indeed, much trust is placed in friend-caregivers, and in so doing, much responsibility is also placed upon these caregivers. True to the general caregiving literature, the current study indicates that when caregiving for someone who self-harms, caregiver burden is common, and caregiver burnout is possible.

The current study greatly extends the current literature on friend-caregivers by identifying a specific population and directly querying their experiences as caregivers. Past research has established the importance of friends to the recovery process by

providing statistics on friends' involvement. For example, Evans and colleagues (2005) determined that adolescents who self-harm identify fewer sources of support than adolescents who do not self-harm, and instead rely more heavily on their peer friendships. Indeed, 85% of adolescents identified a friend as the person to whom they felt "most able to talk to" about their self-harm. Moreover, adolescents identified friends as the preferred source of support prior to engaging in self-harm, and the preferred source of help after engaging in self-harm (Evans et al., 2005). Despite friends being the preferred confidant and caregiver of those who self-harm, friend-caregivers are rarely the focus of research studies. Instead of directly recruiting and surveying friend-caregivers themselves, past research has garnered some limited information on the friend-caregiver experience through other types of research designs. For example, Bresin and colleagues (2013) presented young adults (who may or may not have had caregiving experiences) with hypothetical vignettes depicting a "self-harming friend", and queried how the young adults may feel and react. Similarly, Klineberg and colleagues (2013) conducted qualitative interviews with young adults to investigate how people communicate about self-harm among friends. Unfortunately, this sample of participants did not necessarily have friend-caregiver experiences. Muehlenkamp and colleagues (2010) surveyed adolescents about supporting self-harming friends; however, the survey was part of a large school-based self-harm prevention program. As such, the survey was geared toward program evaluation and focused on answering specific program-related questions (e.g., Did peers experience significant changes in their levels of discomfort and avoidance of self-harm after participating in the school-based program?). Finally, past studies have queried self-harming adolescents about their friends' involvement. For example,

Boekmann and colleagues (2008) asked a sample of self-harming adolescents how their peers perceive and react to self-harm. Therefore, the current study advances the existing body of literature as friend-caregivers were specifically recruited, friend-caregivers were treated as the subjects of interest, and friend-caregivers' subjective experiences were queried.

Extant research has described the sorts of roles and responsibilities that friend-caregivers have taken during the recovery process. For example, Curtis (2010) portrayed friend-caregivers as "help-seekers" and described their role as encouraging or assisting in procuring formal help. Alternatively, Rodham, Gavin, and Miles (2007) conducted a study of friend-caregivers on self-harm message boards, and characterized their interactions as: providing validation, crisis support, and listening to venting. Rodham and colleagues (2007) suggested that self-harming individuals desire and seek support and understanding from their friends. The current study adds the friend-caregivers' subjective experience of their objective duties. Past research has explored the roles friend-caregivers play; however, never have friend-caregivers been asked how they perceive these roles and responsibilities. For example, past research (Curtis, 2010) has indicated that friend-caregivers assist in help-seeking; however, results from the current study depict this role as acting as "The Go-Between".

The current study contributes context and richness to the phrase "help-seeking", as we now know that friend-caregivers often feel that they are walking a tight line between the "us" of friends, and the "them" of professionals. Help-seeking can involve playing both sides, speaking two languages, knowing when to keep confidences and when to break silence. In the same way, past literature suggested that friend-caregivers provided

support and understanding to their self-harming friends, but results from the current study allow us to elucidate this experience further and we now have a sense of how friend-caregivers may perceive their part in this caregiving act. Indeed, due to the current study we now know that friend-caregivers perceive their role to be that of “The Rock” in the middle of a swirling lake of negative emotions and experiences.

The current study also contributes experiential richness to the phrase “support and understanding”, as we now know what friend-caregivers may feel while they are providing this support to others. They themselves feel like they are drowning in that same lake. The concept of support and understanding does not capture how inundated friend-caregivers feel, how sacrificial they must be of their own wellness, or how long their role may endure. This is not a half-hearted or occasional endeavor. Instead, their caregiving is a full-fledged and costly effort of long duration.

In terms of emotional experiences of friend-caregiving, the current study provides information on the scope and timeline of emotions. The current participants shared that a wide range of emotions were involved in their experience, including: anger, numbness, despair, panic, hopelessness, helplessness, and more. Furthermore, participants shared that certain emotions (e.g., disbelief, shock) are common when first becoming aware of a friend’s self-harm, while other emotions (e.g., anger, helplessness) are common after providing care for a long period of time. In addition, participants shared that even after their friend had recovered from self-harm, they had residual emotional experiences, or felt more prone than before to certain emotional reactions. Friend-caregiving appears to have profound, and long-lasting emotional effects. Disseminating information on typical emotional experiences while caregiving for a self-harming friend may be beneficial. New

friend-caregivers may be comforted in knowing that their uncomfortable emotional reactions are typical and to be expected. New friend-caregivers may also benefit from being able to act early on in order to prevent or reduce long-lasting and residual emotional difficulties.

Other consequences of caregiving may include: diminished physical and social health, an altered approach to friendship, and an altered view of oneself. Given that caregiving for a self-harming friend often takes place in adolescence or young adulthood – known for being formative years – it is little wonder that caregiving is perceived to be a formative experience. The participants' stories serve to debunk the myth that caregiving in one's adolescence is a paltry or secondary contribution. Rather, friend-caregiving is a substantial and often self-sacrificing act that appears to have the power to shape a young person's world and self-perception. A few participants noted that there seems to be more supports available for family members than for friends of individuals who self-harm, and they would like to see this changed. I hope that the current study serves to demonstrate how invested, involved, and invaluable friend-caregivers are to the recovery process, and in so doing, generate more supports for this caregiving demographic.

Past research has established that friends experience challenges, in that they often feel uncomfortable with the topic of self-harm (Muehlenkamp et al., 2010), have difficulty understanding the behaviour (Klineberg et al., 2013), and feel that their friend's self-harm has negatively impacted their friendship (Boekmann et al., 2008). The current study directly asked friend-caregivers what challenges they experienced, and determined that friends primarily struggle with a lack of information on self-harm and caregiving, as well as difficulty in managing their own stress and emotions. These findings serve to

better inform the development of supports or services provided to friend-caregivers. In the current study friend-caregivers identified several pieces of information that they felt were a) lacking in their education, b) lacking in ready availability, and c) of most potential help to their caregiving endeavor. Therefore, supports and services should aim to address this specific list of informational requests (please review Table 3). Friend-caregivers also emphasized their struggle in managing the emotional toll of caregiving. Given the dearth of information and preparation they had for their caregiving role, the stress of responsibility and concerns for their friends' safety made for an extremely overwhelming task. Therefore, supports and services should also aim to improve caregivers' ability to cope with the emotional toll.

5.7.2 Implications for actions in the friend-caregiving role. Friend-caregivers provide social, emotional, and practical help to their friends, and often find themselves in charge of both informal and formal support seeking. A better understanding of the roles friend-caregivers play in the self-harm recovery process can inform on how to best to support and utilize friend-caregivers to prevent future self-harm in young people and to speed recovery in current cases. The participants eagerly passed on advice to future friend-caregivers in hopes of giving more guidance than they themselves had.

Helpful and unhelpful caregiving actions. In performing caregiving actions, regardless of good intentions, friend-caregivers are apt to act in both helpful and unhelpful ways. The current study serves to inform upon which actions friend-caregivers believe to be the most helpful, and which are less helpful. The participants of Study Two shared that they often wished they knew "what exactly to say", or they struggled to find

the words in difficult conversations with their self-harming friends. Therefore, efforts have been made to render their advice to future caregivers as practical as possible.

Participants emphasized the importance of openly addressing self-harm and approaching the subject directly. Participants recognized that this is often counter-intuitive, as one's instinct may be to avoid or ignore such a distressing and confusing behaviour. Relatedly, participants found that ignoring or minimizing the seriousness of self-harm is detrimental to the recovery process. Participants found that avoiding direct conversations about their friends' self-harm did not allow time for quiet eventual recovery as hoped, but instead allowed time for the self-harm to grow more severe. Given the power of peer influence in adolescence and young adulthood, minimizing the gravity of self-harm could send the message that self-harm is indeed not a serious problem. If it is not a serious problem, it logically follows that there is no need to cease the behaviour.

Participants also emphasized interacting with one's friend with non-judgement. Often this state of non-judgement is difficult, as everyone has their own beliefs and perceptions about the act of self-harm. Becoming aware of one's own biases and beliefs about self-harm could assist in maintaining a non-judgemental stance. Similarly, becoming familiar with the phenomenon of self-harm, and educating oneself about the rationale and experience of self-harm could assist caregivers in adopting a non-critical approach. Extant research suggests that adolescents tend to have biases and misperceptions about self-harm (Boekmann et al., 2008; Bresin et al., 2013).

Just as participants advised to avoid judgement, they also advised to avoid introducing guilt into caregiving techniques. Although tempting to try and motivate a self-harming friend with the notion that they "can do it if they try harder", or to "think of

all the people that care about them”, these motivational techniques can actually serve to make the individuals feel ashamed. Past research on the underlying motivations for engaging in self-harm have implicated affect-regulation purposes such as self-punishment, distracting from internal-pain, and reducing feelings of guilt and self-hatred as key reasons to self-harm (Briere & Gill, 1998; Polk & Liss, 2009). As such, introducing more shame or guilt is unlikely to aid in the recovery process, and is more likely to add proverbial fuel to the fire.

Participants advised on the importance of making one’s support known to a friend, as well as making that support readily available to them. The current participants related that offers of support needed to be directly stated, stated often, and presented in such a way that demonstrated they were available whenever and however their friend needed. The current participants’ discovery that offers of support must be somewhat blunt and forceful is in line with past research that has suggested that depressed individuals encounter several barriers to the successful offer and receipt of social support. First, interactions between depressed individuals and their loved ones are often characterized by misunderstanding and conflict, leading to unsuccessful offerings of social support (Vollmann, Scharloo, Salewki, Dienst, Schonauer, & Renner, 2010). Second, depressed individuals often display certain behaviours (e.g., social withdrawal, pessimism, dependency, negative self-statements) that result in diminished offers of social support (Stice, Rohde, Gau, & Ochner, 2011). Third, as individuals’ depressive symptoms increase, their intention to seek or receive help decreases (Rickwood, Deane, Wilson, & Ciarocchi, 2005). Indeed, this help negation effect is strongest for informal sources of support, such as friends (Rickwood et al., 2005). These barriers to the successful offering

and receiving of social support result in low perceived social support by individuals suffering from depression (Vollmann et al., 2010). The current results indicate that individuals who are engaging in self-harm may experience barriers to social support that are similar to the barriers experienced by individuals with depressive disorders. Indeed, it is likely due to these same barriers to social support that friend-caregivers in the current study found they needed to explicitly state their desire to be supportive, and dedicatedly prove their willingness to deliver support.

Although participants advised making support readily available to self-harming friends, the current participants also counselled not to be the only source of support. The participants found that shouldering all of the caregiving responsibilities left them at risk of burnout and their friends at risk of receiving less than optimal care. This advice is consistent with past caregiver literature. Lower client and caregiver distress have been demonstrated to be associated with wider caregiving networks (Tausig, 1992) as well as with lower amount of time spent caregiving (Baronet, 1999). For some participants in the current study, sharing responsibility meant involving mental health professionals, for others it meant involving the self-harming friends' family members, while for other participants, it was enough to ensure that their friend had informed others about the self-harm. Friend-caregivers should be informed about the benefits of wider caregiving networks and the risks of caregiver burnout.

Participants also advised to avoid emotional outbursts, and instead opt for a calmer approach. Participants described becoming so overwhelmed with the situation that they could no longer put their emotional needs below that of their friends, and their distress, panic, and anger came bubbling to the surface. The emotional outbursts appear to be a

consequence of caregiver burnout. The wider caregiver literature corroborates the harm of emotional outbursts. A review of caregiver burden in mental illness (Schulze & Rossler, 2005) indicates that caregivers' negative emotional responses (such as outbursts) to stressors can subsequently increase the stressor itself, and thus, higher caregiver distress results in more negative patient outcomes. Past research involving caregivers of family members with severe depression also indicates that caregivers who are emotionally overinvolved or emotionally volatile experience greater caregiver burden (Heru, Ryan, & Madrid, 2005); as such, there is all the more motivation to share the caregiving role rather than shoulder the entire responsibility.

Finally, participants agreed that social and leisure activities were important to keeping their self-harming friends healthy and well. Encouraging and promoting these activities were a key part of their caregiving roles. Advocating for continued involvement in social and leisure activities is in line with past research, as such activities have been found to both prevent (Desha & Ziviani, 2007) and remediate (McCauley et al., 2015) mental health issues (such as depression) in adolescents.

Involvement in help-seeking. The current study contributes to the existing literature by providing context to past research indicating that friend-caregivers can facilitate as well as avoid professional help-seeking (Mahdy & Lewis, 2013; Pietrusza et al., 2011). The current results indicate that friend-caregivers may avoid seeking professional help for their friend if it would go against their wishes, if they hold little regard for professionals' ability to intervene, or if they prefer to focus on informal supports in their caregiving. A preference for emphasizing informal supports to prevent the need for formal supports is in line with past research, as high quality social support

(outside the household) has been demonstrated to be related to lower medical or professional help-seeking for self-harm, while poorer quality social support was associated with higher likelihood of medical contact (Wu et al., 2011). Friends tend to help avoid formal professional contact if at all possible. In the current study, some friend-caregivers did opt to assert and encourage professional involvement; however, this was more likely when the friend's self-harm was more severe and when friend-caregivers felt more educated about self-harm.

The current study illustrates how integral friend-caregivers can be to formal help-seeking; however, friend-caregivers must be able to a) recognize severity of self-harm, b) know the benefits of formal supports, and c) know how to access formal supports. If allied health professionals want friend-caregivers (who arguably hold the most amount of sway over self-harming individuals) to endorse formal supports, allied health professionals must educate friend-caregivers. In addition, in the current study, friend-caregivers were not actively discouraging formal help-seeking. Instead, they were actively working to prevent the need for formal help-seeking. The assessment of "need" for help may, unfortunately, be misevaluated.

5.7.3 Implications for support needs.

Support needs for friend-caregivers. Given how optimally situated friend-caregivers are to positively influence and support self-harming individuals, it is important that they themselves are prepared for this role. The current study corroborated the message from past research (Klineberg et al., 2013; Muehlenkamp et al., 2010) that friend-caregivers are uninformed, unsupported, and overwhelmed with the caregiving task. The current participants disclosed that they were in need of informational support,

emotional support, and support to maintain a healthy life separate from their caregiver role. By supporting caregivers, self-harming individuals are indirectly supported, and their recovery made more likely.

In terms of informational support, friend-caregivers requested information about self-harm, as well as the caregiving role. The participants believed that this information would help them be more effective, prepared, and empathetic caregivers. Of note, participants assertively believed that the school system was the optimum venue in which to receive this information. According to the participants' experiences, the school system treats self-harm as a taboo subject, provides scarce and incomplete information, and does a poor job of preparing adolescents for potentially life-threatening challenges. By glossing over such important information, the school system is perpetuating the stigma, misperceptions, and low rates of help-seeking associated with self-harm. Participants wished that they had been provided information about self-harm early in their adolescence, and believed that this would have helped prevent self-harming behaviours in their friends, and would have helped improve their caregiving efforts. Participants suggested: a) altered curriculum to include education about self-harm, b) additional workshops or guest lectures by recovered individuals, c) awareness campaigns and fundraisers, and d) brochures or other reading materials about self-harm made available at school.

Several extant studies (Evans et al., 2005; Fortune et al., 2008) have indicated that primary prevention in schools is essential to counteract the self-harm problem in adolescents; however, there is only one known study that examines such a school-based program (Muehlenkamp et al., 2010). Using a sample of 274 adolescents, Muehlenkamp

and colleagues (2010) evaluated the effectiveness and feasibility of the Signs of Self-Injury (SOSI) program (Jacobs, Walsh, McDade, & Pigeon, 2009) to: a) increase knowledge of self-harm, b) improve attitudes and perceived ability to respond and help self-harming peers, c) increase help-seeking behaviours, and d) decrease acts of self-harm among adolescents. This school-based program consists of a video segment, including psychoeducation and a series of vignettes, followed by a moderated class discussion. There were significant improvements in accurate knowledge about self-harm as well as significant changes in attitudes toward self-harm at the five-week post-program follow up. Specifically, adolescents reported less discomfort and avoidance of their friends' self-harm. Moreover, there was a significant increase in the approach/helping desire attitude, indicating that the adolescents were more open and willing to help a self-harming friend. However, there were no significant increases in self-reported formal help-seeking behaviours for oneself or for one's friends. In addition, to assess a prevalent perception that discussing self-harm in schools will entice, encourage, or otherwise "give kids the idea" to engage in self-harm, Muehlenkamp and colleagues (2010) evaluated iatrogenic effects of the school-based program. The self-reported acts of self-harm in the month just prior compared to just after implementation of the SOSI program did not significantly increase. Instead, there was a trend toward a decrease in self-harm acts. The authors conclude that the SOSI school-based program holds promise as an effective prevention program. Future research is needed to replicate these findings, and to assess efficacy in various age groups. In addition, qualitative inquiries should focus on student (friend-caregiver) satisfaction with this program or similar programs.

In terms of emotional support, friend-caregivers most wanted understanding, encouragement, willingness to listen, and a sense of camaraderie. Although some participants suggested that speaking to a counselor, improved communication among the caregiving network, or more understanding parents would have been beneficial, the most common suggestion was a caregiver support group. Participants believed that meeting with a group of other caregivers would provide the emotional support they needed, while also affording them the ability to share tips, lessons learned, and resources.

Past research on support groups for caregivers of individuals with mental illness (Cook, Heller, Pickett-Schenk, 1999; Heller, Roccoforte, Hsieh, Cook, & Pickett, 1997) have demonstrated emotional (e.g., reduced feelings of subject burden and burnout), relational (e.g., improved relationship with the care-recipient), and practical benefits (e.g., greater knowledge about the mental illness and available services). Indeed, a survey of 131 caregivers who had been involved in a caregiver support group revealed that the most frequently experienced benefits included: better advocacy for the care-recipient, better emotional coping, more knowledge about the mental illness, more information about services, more ability to cope with stigma, more information about available interventions, and less isolation because of their concerns (Heller et al., 1997). Despite caregivers of self-harming individuals reporting the same types of support needs as caregivers of other forms of mental illness, there is a dearth of research focused on support groups for caregivers of self-harming individuals. Although friend-caregivers report highly similar informational and emotional support needs as family-caregivers, there is a lack of research focused on support groups for friend-caregivers. Given the current participants' stated support needs and the perceived helpfulness of support

groups, future research should examine the feasibility and efficacy of a friend-caregiver support group for self-harming individuals.

In addition, friend-caregivers believed that they needed to maintain a healthy life separate from their role as a caregiver. Several participants shared experiences in which they had become “lost” in the caregiving role, and felt that their life had become consumed by caring for their friend. In order to maintain a healthy balanced life, participants spoke about: a) staying involved in social and leisure activities that they enjoyed, and b) not being the sole caregiver. Again, participants felt that they would have benefitted from information about the risks of caregiver burnout, the importance of maintaining a balanced lifestyle while caregiving, and the benefits of a wider caregiving network. Such information should also be provided in the school-system.

Support needs for self-harming individuals. According to friend-caregivers, their self-harming friends would most benefit from: a) improved understanding and follow-up for self-harm in the healthcare system; b) the opportunity to connect with others who understand the self-harm struggle; and c) improved awareness and education about self-harm in the school system.

The participants shared several stories with the common theme of health professional contempt, misunderstanding, and dismissal. Friend-caregivers witnessed the healthcare system tending to their friends’ physical well-being (e.g., administering stitches or pumping stomachs) while neglecting their emotional well-being. Most self-harming individuals avoid revealing their behaviour to professionals, and certainly avoid the intrusive and frightening experience of a hospital visit. As such, when self-harming individuals do present at the emergency room, it is often a last desperate resort. The

participants in the current study emphasized the need for follow-up, emotional support, and recommended resources when someone who self-harms presents at the emergency room. Health care providers should be educated on the experience of self-harm in order to better recognize and empathize with the desperation that prompts an emergency room visit, and the hopelessness that results from being turned away without follow-up or the provision of additional resources. In addition, friend-caregivers perceived allied health professionals to have a contemptuous and dismissive attitude of self-harm, which served to limit the efficacy of the services they provided. This perception is in line with past research which has demonstrated that emergency room staff (Cleaver, 2014; Rees, Rapport, Thomas, John, & Snooks, 2014) and clinical staff (Saunders, Hawton, Fortune, & Farrell, 2012) often have discriminatory and disdainful attitudes toward individuals who present with self-harm. There are some indications that educational interventions can significantly change health professionals' attitudes about patients who self-harm, and that these attitudinal changes are long-lasting (Patterson, Whittington, & Bogg, 2007). Although informational workshops and educational opportunities have been met with past success, the addition of *experiential* workshops or guest lectures that emphasize the experience of individuals who self-harm may be all the more successful. In order to remedy misperceptions and improve empathy, allied health professionals should be exposed to the lived experiences of people who have recovered from self-harm.

In addition, the participants felt that their self-harming friends would have benefitted from opportunities to connect with other people who understood the struggle of self-harm. Although they themselves tried to be as understanding and sympathetic as possible to their friends' struggle, their experience was that their efforts were in some

way, qualitatively, not *enough*. True understanding and the ability to speak from experience seemed highly valued among this population. Therefore, several participants believed that support groups or mentorship programs in which participants had access to others with first-hand experience of self-harm would be exceedingly beneficial.

Recent reviews of therapeutic interventions for self-harm have indicated that several types of group treatment are effective in reducing self-harm behaviours (Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015; Turner, Austin, & Chapman, 2014); however, the precise mechanism of action is unknown. The various group treatments that were found to be effective were not “support groups” per se, but did involve the gathering of individuals who were intimately familiar with the self-harm struggle. Although the active ingredient of these treatments are unknown, it is possible that the support and understanding of other self-harming individuals was a contributing factor. Future research should consider the question of active ingredient in group treatment for self-harm. In addition, future research should consider the benefit of “mentors” who have themselves gone through the recovery process and can speak from their own successful experience.

Unanimously, the participants asserted that the best way to improve awareness and education about self-harm was through the school system. Because of the negative impact of stigma on help-seeking, and misperceptions on help-offering, participants believed that education about self-harm needs to be provided to all adolescents, and not just provided to adolescents after they begin self-harming. Although recent years has seen an increase in attention paid to self-harming behaviours in adolescence, the awareness it not equivalent to the enormity of the dilemma, and is not necessarily highlighted in the

school-system. If the school system is meant to educate and prepare children for difficult and likely challenges, self-harm should be one of the key agenda items. Just as children are provided with information on the risks, alternatives, and resources associated with other unhealthy behaviours (e.g., alcohol and drug misuse, unsafe sex practices), so to should they be prepared to avoid or manage self-harm. Participants suggested various ways of incorporating self-harm education into the school system, including: a) altered curriculum to include education about self-harm, b) additional workshops or guest lectures by recovered individuals, c) awareness campaigns and fundraisers, and d) brochures or other reading materials about self-harm made available at school.

6.0 Study Three (Parent-Caregivers)

6.1 Introduction to Study Three

Parents can play a vital role in their child's recovery from self-harm. Oftentimes parents recognize the need for help, and supply the resources required for formal help-seeking as well the support and caring that is crucial to informal help. Past research has indicated that parental reactions to self-harm can either serve as a barrier or facilitator to recovery from self-harm (Byrne et al., 2008; Gelinas & Wright, 2013).

Although parents have the potential to exert a strong positive influence over their children, these parents are often struggling with their caregiver role. Past research has indicated that parents struggle with the emotional as well as practical components of parent-caregiving (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Parents have questions about self-harm itself, how to parent someone who self-harms, and how to get help for their child. While trying to manage their child's difficult emotions, these parents are also faced with having to manage their own fear, sadness, and bewilderment. In the fight against self-harm, parents should be one of the healthcare system's greatest resources and allies. Instead, parents report a disconnect from the healthcare system, and feel misunderstood during their child's recovery process.

This chapter will explore parents' personal experiences in supporting a child's recovery from self-harm. In particular, how the parent-caregiver role was experienced, what action was taken as a parent-caregiver, and the support needs of all involved will be examined. Though not all perspectives or experiences of these participants were identical or unanimous, certain commonalities can be found, and certain conclusions can be drawn from their stories.

6.2 Summary of Study Three Participants

Ten parents of children who had recovered from self-harm participated in Study Three. Due to the sensitive nature of the subject, and the participants' expressed desire to remain as anonymous as possible, I have chosen not to describe each individual's story. Instead, I will provide collective descriptive information about their demographics and experience with self-harm recovery. In order to introduce the participants in as full and meaningful way as possible I will include direct quotes that illustrate the descriptive information.

The sample of parents included nine females and one male. Participants ranged in age from 35 to 59 years old, with the average age being 46 years. In terms of ethnicity, seven participants identified as Caucasian, two participants identified as Aboriginal, and one participant identified as Caribbean. In terms of relationship status, eight participants were married, one participant is divorced, and another one participant is in a common-law relationship.

In terms of caregiving, participants reported acting as a parent-caregiver for self-harm for an average of four years. The duration of caregiving for self-harm ranged from one to ten years. The participants reported that on average, their children began self-harming at age 13. However, the age of onset ranged from 11 to 17 years of age. When asked what type of self-harm their children engaged in, the most common responses included cutting, burning, self-hitting, head banging, and suicide attempts. The majority of participants reported that their children self-harmed at least 20 times. Four participants reported having children who self-harmed more than 50 times. At the time of the study,

the time since recovery for the participants' children ranged from six months to fifteen years. The average time since recovery was 3.5 years.

Participants shared stories depicting a range of experiences with their children's self-harm. Some parents had become suspicious that their child was self-harming and eventually confronted them. For example, Elsa described finding blood on her daughter's clothes, razor blades and knives hidden in her room, and bloodied tissues in the trash.

Elsa recalled:

I confronted her right away. She knows me as a straightforward person. I don't mince any of my words. I said 'I know what you're doing, I know what it can lead to, and I need you to stop.' . . . and that's when every day I started pulling up her sleeves and her pant legs to see where she's cut next. (Elsa)

Some participants recalled a very gradual escalation of self-harm, in which their child began with mild behaviours that progressively become concerning and dangerous acts of self-harm. For example, Brandie described her daughter's progression through self-harm behaviours:

She just started with eraser burns on herself. So I started noticing and she said it was a game the kids were playing. Then she started taking scissors and cutting with the scissors in her legs, and then it moved to her arms. Then it got quite intense, and at the height of the bullying. . . she had a nervous breakdown . . she had scissors and ended up cutting herself and then went down to the basement at school and tried to hang herself in the basement stall. (Brandie)

Other participants were completely unaware of their child's self-harm, until they were told by a teacher, a therapist, or a friend. For example, Hope shared that she was completely taken aback when she was informed about her daughter's self-harm:

The school called me one day, and it was the counsellor. She said not to be alarmed but she did have to let me know that there's been a little incident and my daughter had cut herself in the bathroom. I was just devastated. (Hope)

In hopes of providing extra insight and clarity on the participants of Study Three, I offer an excerpt from my field journal. These words were written when nearing the end of recruitment and data collection for Study Three.

There are scores of previous studies about 'problem parents' who have in some way aided and abetted their child's self-harm. Research has correlated self-harm to parental abuse, neglect, criticism, hostility, lack of warmth, poor communication, etc, etc. Research that examines parental influence always seems to advertently or inadvertently point blaming fingers at parents. The more I meet parents for my study, the more I find myself wondering – where is all the research about 'normal', well-meaning, hard-working, blameless parents? The parents I have encountered during this process are not flawless, but certainly do not match the unflattering picture of parents that past self-harm research has painted. (Field Journal)

6.3 Summary of Themes

The method of data analysis described in Chapter 3 was used to identify themes from the interviews with parents. Three topic areas (experience of the caregiving role, actions in the caregiving role, and support needs) were queried, resulting in nine superordinate themes, and various subthemes. The categories, superordinate themes, and

subthemes are listed in Table 4, which as a whole describe a parent's experience in supporting a child's recovery from self-harm.

Table 4.
Summary of Themes from Study Three

TOPIC AREA	SUPERORDINATE THEMES	SUB THEMES
Experience of the Caregiving Role	Emotional experience of caregiving	<ol style="list-style-type: none"> 1. Shock and disbelief 2. Anger and frustration 3. Saddened and hurt 4. Fear and dread 5. Alone and abandoned 6. Helpless and defeated 7. Trapped and tentative
	Parental experience of caregiving	<ol style="list-style-type: none"> 1. Altered parenting style 2. New parenting procedures 3. Parental self-blame and insecurity 4. Fear of being judged as a bad parent
	Familial experience of caregiving	<ol style="list-style-type: none"> 1. Spouse 2. Siblings 3. Extended relatives
	Challenges and struggles with caregiving role	<ol style="list-style-type: none"> 1. Knowing how to parent in a self-harm situation 2. Managing the emotional toll of caregiving
Actions in the Caregiving Role	Helpful	<ol style="list-style-type: none"> 1. Engaging in honest conversations 2. Emphasizing positive coping and activities 3. Interacting with understanding and affection 4. Taking protective precautions 5. Pursuing recovery with persistence
	Unhelpful	<ol style="list-style-type: none"> 1. Failing to acknowledge the seriousness of self-harm 2. Failing to maintain discipline and reasonable expectations
	Involvement in help-seeking	<ol style="list-style-type: none"> 1. Criticisms of the help-seeking process 2. Lessons learned from the help-seeking process
Support Needs	Support needs of parent-caregivers	<ol style="list-style-type: none"> 1. Informational support needs 2. Individual counseling needs 3. Peer support needs
	Support needs of those who self-harm	<ol style="list-style-type: none"> 1. Improved delivery of care within the healthcare system 2. Treatment options that emphasize interpersonal connection 3. Improved awareness and education about self-harm in the school system

6.4 Experience of the Caregiving Role

The participants of Study Three varied in the objective details of their caregiving; however, these same participants reported striking similarities in the subjective interpretations of their role. The participants had learned about their child's self-harm in various ways, had sought different types of help, and provided different types of caregiving. Regardless of the particular details of these caregiving experiences the participants' perceptions, feeling, and interpretations of caregiving were largely analogous. Four superordinate themes emerged when discussing their experiences as parent-caregivers: the emotional experience, the parental experience, the familial experience and repercussions, and the challenges and struggles associated with the caregiving role.

6.4.1 Emotional experience of parent-caregiving. As anticipated, the parents recounted a wide array of emotions that were tied to their caregiving experience. Indeed, the experience was often likened to a "rollercoaster", in that the parents felt they had experienced extreme emotional highs and lows with quick interchanges between. Many participants reported several distinct and intense emotions. The following summary of parent-caregiver emotional experiences is by no means exhaustive, but is meant to demonstrate the most common emotional extremes experienced.

Shock and disbelief. Without exception the parents described shock and disbelief when first discovering that their child was self-harming. Many participants were bewildered by the act of self-harm itself, as they were unfamiliar with the phenomenon and found the behaviours "freakish" and "jarring". Other participants were shocked that it was "my kid", in that they had thought their child was too well-adjusted or had too many

good things going for them. Lorraine and Meredith describe their emotional experience after learning that her daughter was cutting:

At first shock. I think at first it was just disbelief. Like, this isn't the kid I raised. I was just like, 'why?! Why are you so unhappy?!' (Lorraine)

I was completely caught off guard, and never thought in a million years that would be my kid, ever. (Meredith)

Anger and frustration. Many parents expressed reactions of anger and frustration to their child's self-harm. In the early stages, parents seemed to interpret self-harm as a selfish and immature act. Although this perception often changed as they became more familiar with their child's situation, parents first had to manage their feelings of anger. Abe struggled so much with his anger that he eventually sought anger management. In retrospect, Abe was able to identify that his anger came from a place of misunderstanding.

In the beginning, anger was the toughest because I didn't understand why she was acting the way she was acting. That was one of the hardest things I ever had to deal with I think. . . Once I understood what she was going through, I felt bad for her. I felt sad for her that she had to go through these things. (Abe)

Similarly, Deirdre and Anita described feeling frustrated with their daughters' actions and lack of regard for others.

At the beginning it was anger. You're mad at her [the daughter] because it's like 'oh, grow up and smarten up.' So there's lots of anger at the beginning. And all of it is directed towards you and your child. (Deirdre)

Even though she knew, she knew about my health problem and her grandmother has heart problems, that didn't seem to stop her selfishness. I'd get angry at her, very upset you know. . . It was also because I have other children. I know it could have a negative effect on them. (Anita)

Saddened and hurt. Witnessing their child in so much emotional pain often brought parents emotional pain. Several participants disclosed that they themselves began to experience low mood and depression while caregiving for their child. Apart from feeling sad for their child, the participants also felt sad for themselves. Parents expressed feeling a sense of loss or bereavement that left them hurt.

Just realizing when she was cutting herself just what she was doing to herself – that killed me. It just hurt, it hurt me. I hurt. I hurt for her. She was in that much pain and I don't think I realized how much pain she was really in until I realized about the cutting. (Lorraine)

Other parents expressed feeling hurt that they were not enough to keep their child happy and healthy. For example, Brandie revealed that she was hurt when her love and her care were not enough to keep her daughter well.

When she tried to hang herself they had to call the police to settle her down. I couldn't even settle her down. That was hard too, because usually I can calm her and I couldn't. That hurt. . . There is still sadness for me and I don't think that will ever go away. (Brandie)

To add to the emotional pain, some participants felt unable to fully express their own pain because they had to be focused on their child. Elsa described not allowing herself to feel too depressed:

I think I went through a bit of a depression myself, but I didn't want to sink down that low because I wouldn't have been able to do anything for her. (Elsa)

Fear and dread. Parents painted a heart-wrenching picture of living in fear. Some parents were afraid to do or say the wrong thing and accidentally “set off” their child. Other parents were afraid of coming home from work to find their child dead by suicide or accidentally cutting too deep.

A lot of days I expected to come home and find that she killed herself. . . I also have kind of an understanding that she many never be totally okay, and that I do need to keep an eye on her to watch for signs. (Lorraine)

The participants described living with a constant and consuming sense of foreboding, and no matter what they did, they were never free of dread.

I was afraid. It was tough; the first six months it was all I worried about. That's all I worry about constantly, is losing her. I thought 'she's doing good, she's doing good,' but of course that little bit of doubt would make me worry like crazy.

(Brandie)

In fact, participants consistently said that even years after their child had recovered from self-harm, they still harboured secret fears that they would revert back to old self-harming habits.

That she might go back to that dark place...I'm scared for it all the time. But then I think, she will just absolutely stop because she doesn't want her own daughter to go

through that. (Elsa)

Alone and abandoned. At various points while caregiving parents felt alone in their experience. They felt as though no one understood what they were going through and no one wanted to help. Even as they were withdrawing from friends and family, it was as though these parents desperately wanted someone to reach a hand out toward them and pull them in. In reference to needing emotional support from family and friends, Brandie said:

I really did feel kind of isolated. I felt I was on my own a lot of the times. It just felt like everybody always just had advice on what I should do, and not really anything for how I was feeling about it . . . I don't think anyone ever asked how I was doing. (Brandie)

Parents expected allied health professionals to offer help and understanding, but often were disappointed and left feeling abandoned. Deirdre felt that no one truly understood that her daughter's self-harm was a coping mechanism, and having to explain self-harm left her feeling isolated.

So then you get angry at the system and frustrated because you can see what's happening and almost nobody else can. And they don't really take the time to find out [about the self-harm] because there's so many other issues out there that can get the spotlight. This one just falls to the back. (Deirdre)

Abe recalled feeling like he was the only one experiencing this difficult situation and the only one in emotional turmoil. When asked what message he would like to pass on to other parents he shared the following:

*I think the one thing I did hear eventually that helped was 'you're not in this alone.'
You're not the only one. You're not the only ones going through this. There are
others. You feel so isolated. Because you don't want other people to know so you
kind of keep everything in, you try and keep everything inside you, you try to keep
everything inside your house, and it just - one of the best things is to know that
there's other people out there going through the same thing. (Abe)*

Helpless and defeated. As time wore on parents began to feel defeated. They described feeling useless and powerless to help their children. Even if their child had made progress, relapses and setbacks could bring about a sense of helplessness. Lorraine described being at a loss as to what to do for her daughter.

*Yeah, you hit despair, really just throwing your hands up not knowing what to do
anymore. You don't know how to help. You don't know what helps and what hurts.
What makes things better or what makes things worse. And then, yeah, it just, it
hurts you. (Lorraine)*

Sarah expressed trying everything she could for her daughter and still feeling like she was coming up short:

*My biggest emotion was helpless. Like I love this child so much and she doesn't
love herself. Why? What can I do? And I just – like I would say or do pretty much
everything – any resource or avenue that we did take, I initiated it. But I was just at
a loss. (Sarah)*

Trapped and tentative. Looking back over their experiences, many parents identified feeling emotionally trapped by their child. They felt that their child wielded

power and control while they were left frantically trying to pacify, protect, and react. In fact, several participants used the phrase “held emotionally hostage” to describe their state of being during that time of caregiving.

There is a lot of uncertainty. What if I did something differently? Would it have been better? It's a guilt-fear cycle, which is just ridiculous because I'm an adult and I should know better. But, it's almost like she holds the family hostage sometimes. (Deirdre)

Similarly, several participants described “walking on eggshells” as they experienced great uncertainty and nervousness in how to interact with their child. Parents were extremely tentative in their approach, fearful of devastating repercussions if they erred. In fact, Meredith described feeling so trapped and tentative in her caregiving, that when her daughter had to be admitted to hospital she experienced some sense of relief. Finally it was no longer up to her.

At first I felt a little bit defeated when she was admitted, that nothing was working and that it had come to that. But then again I think that I felt a lot of relief because it was just really hard to deal with all that was going on at home. I just felt exhausted, like constantly walking on eggshells. I think – honestly – I think she was keeping us emotionally hostage. (Meredith)

6.4.2 Parental experience of caregiving. Apart from the emotional upset experienced, the participants experienced significant upset to their sense of parenthood. They were forced to question the way in which they parented and how they saw themselves as parents. Many participants had particular emotional and practical reactions that were specifically related to parenting.

Altered parenting style. In retrospect, parents were able to identify ways in which they altered their parenting style or approach after caregiving for a self-harming child. Several participants shared that they became more understanding, sensitive, and compassionate toward their child. Some parents changed their approach to parenting specifically for their self-harming child, other parents changed their approach to parenting only younger siblings, and still other parents described an improved understanding of adolescents in general. Parenting styles often were altered to become more hypervigilant or protective. Through their experiences in caregiving for a child who self-harms, parents described becoming more conversational instead of confrontational. Hope shared that growing up she was taught not to cry in front of others, and emotions were to be kept private. Through her experience caregiving for her daughter, Hope altered her parenting style to be more open and honest about her own emotions.

I broke down and cried in front of her and told her that I loved her and I didn't want to see her hurting herself anymore. That emotional sharing had more impact than setting in place more rules for us. That hurt I expressed to her, I think really resonates with her. (Hope)

Revised parenting procedures. Apart from style, parents also altered their parenting procedures and tactics. Due to their caregiving experiences the participants made conscious and deliberate decisions to revise household rules and regulations. Again, some participants revised their parenting procedures in relation to their self-harming child, whereas other participants used their newfound experiences to revise parenting procedures for other siblings. Deirdre spoke about her experiences parenting from fear, in that she had fewer consequences for her self-harming daughter than for her

other children because she was afraid of inadvertently escalating her daughter's self-harm.

It changed. With my older two kids the rules were very black and white. This is what you were allowed to do, this is what you weren't allowed to do. There were spankings, there were consequences. With [my self-harming daughter] I'm afraid to put on too many consequences. I shouldn't be, and I know I shouldn't be, but we are. We have a tendency to give into her a little bit more even to this day, because we don't know what will happen if we don't. (Deirdre)

Similarly, Brandie described becoming less strict and less likely to enforce household rules with her daughter.

There would be conflict. Because she wouldn't want to do things that she should have been doing and you really don't want to tip her over the edge, so you kind of back off a little bit. . . It was hard to juggle keeping her emotionally well and then parenting as well. (Brandie)

Meredith took the opportunity to reflect on her experience in revising parenting procedures, and was not certain the revisions were beneficial. She described becoming more “supportive”, and now wishing she had stayed “protective”. Looking back, Meredith believes she should have made unpopular rules that kept her daughter safe. Meredith shared her rationale for adopting more lenient and supportive rules:

I was thinking that if I became too controlling and too in her face, well I was just worried that she would become more secretive. I wanted her to be able to come to me. I wanted to be the confidant. (Meredith)

Parental self-blame and insecurity. Another large part of the parental experience was the self-blame, guilt, and insecurity that the participants felt as parents. Several participants had, at one point or another, blamed themselves for their child's actions. These participants wondered if they had erred as parents or wondered if the self-harm reflected poorly on their parenting abilities. For example, Hope and Claire describe their thought process after first learning about their respective daughters' self-harm:

I'm blaming myself. What did I do? What did I miss? What did I forget to teach her? We are our own worst critics after all. (Hope)

Guilt that you didn't parent well enough. I still feel that guilt, I think. If only I had done something more. If somebody could have taken away one emotion, taking away the guilt would have made the biggest difference. (Claire)

Other participants hit a "breaking point" in which some part of them wanted to walk away completely from their parenting role. Lorraine had a tumultuous few years caregiving, full of her daughter's outbursts, verbal attacks, hospitalizations, and near misses. Lorraine described reaching the end of her proverbial rope:

I'd done everything I can think of to help her and I just feel like nothing is working and nothing is helping. At the worst points she would blow up on me. And there's something inside saying 'I'm done, done with you. I don't know what to do with you, but I'm done with you'. I was ready to walk away. I don't know how I would have done it. Before, I can't imagine as a parent that you'd ever reach that point. (Lorraine)

Anita described a similar breaking point, in which she questioned whether or not she would have become a mother if she knew it was going to be as difficult as it was.

I had harsh feelings. At one point, I just thought, you know what, if someone had told me this is what parenting was going to be like, I would have decided to not have children. (Anita)

In many ways, these participants feared they were bad parents, and used incidents such as a child's self-harm, or reaching their breaking point as "proof" that there were bad parents.

Fear of parental judgment. In the same vein, the participants were afraid that others would think they were bad parents. Believing that they would be blamed for their child's actions, parents anticipated the judgment of others. Many participants told stories of keeping their child's self-harm a secret from friends and family. Claire expressed the sentiment well:

I don't think I shared my emotions with anybody. I think they just all stayed inside. People have preconceived notions about children and parents that self-harmed. That was part of it, that people wouldn't think you're a bad parent or wonder 'what's wrong with her.' So yeah, you really did pick and choose who you told for those reasons. (Claire)

6.4.3 Familial experience of caregiving. Throughout their stories the participants often spoke about how caregiving influenced and impacted their family relations. Over and above the effect on their experience of parenting, caregiving for a self-harming child also had an effect on their experience of family. In particular, participants described

experiences involving their spouse, their other non-self-harming children, and their extended relatives and general sense of family.

Spouse difficulties. Deciding how to parent a child who self-harms was made all the more difficult by deciding how to co-parent a child who self-harms. Spousal teams tended to disagree on parenting strategies, and their stress and negative emotionality about the situation acted as fuel for the fire. Brandie noted that the extra stress and uncertainty involved in parenting a self-harming child creates a whole new dynamic between spouses.

We didn't figure out how to be on the same side. Especially during this time we did not get along at all. . . Him and I definitely argued a lot about how to discipline her and how to care for her and things like that. We definitely didn't agree on how to approach things. (Brandie)

Sarah emphasized that disagreements about parenting can quickly turn into disagreements about the spousal relationship:

It made it very difficult on our marriage and very difficult as a parent, because we never felt like we're on the same page. And when you seem to be fighting each other on parenting then you're fighting each other as a couple. (Sarah)

Sibling difficulties. Many of the participants in Study Three had multiple children. The siblings who did not engage in self-harm were reportedly negatively impacted. Some parents described direct negative effects, such as siblings frequently hearing suicidal rants or happening upon their sister cutting herself. Other parents described indirect negative effects, such as siblings receiving less attention because the parents' time was consumed by the self-harming child. For example, Sarah shared:

I do feel like I let my [other daughter] down a lot. Because you're so focused on the one with the problems that you do feel like she's being neglected to some degree. . . I still don't think [my self-harming daughter] has really realized that she's not the only one who went through it. The whole family did. (Sarah)

Many parents expressed a fear that their other children would also begin to self-harm because of what they had witnessed. Claire shared that she chose not to tell her other daughter about her sister's self-harm because she did not want her to be unduly influenced.

We never told her sister. I was scared she would find out then. I don't know if I was scared that she would be scared of what was going on. I don't know if it's because it was so confusing. We didn't know what was going on. (Claire)

Extended relative difficulties. Caregiving for a self-harming child was experienced as quite isolating. The participants described becoming estranged from their extended relatives. Deirdre said she spent so much time at the hospital and at appointments with her daughter that there was no time left for family get-togethers and functions. In fact, she said that caregiving was so time consuming that the family stopped taking trips and vacations. Consequently, she noticed that family bonds began to loosen. Meredith described family strain that came from hiding her daughter's self-harm from extended family members. Meredith felt that the extended relatives would not understand self-harm:

We didn't tell our families because we didn't want them involved. It is sort of shameful but we didn't want people to freak out and get so upset over what was happening. And I knew the two families would have different perspectives on what

was happening. One family would be 'oh she's attention-seeking' and one family would be devastated. (Meredith)

In sum, the participants felt that their emotional, parental, and familial lives and experiences had all been significantly impacted by their caregiving.

6.4.4 Challenges and struggles with the caregiving role. Throughout their stories, participants shared many challenges and struggles that they had encountered during their experience of caregiving. However, when directly asked what was the biggest challenge or struggle that they encountered as a parent-caregiver, the participants' responses boiled down to two issues: not knowing how to parent in self-harm situations, and managing the emotional toll of caregiving.

Knowing how to parent in self-harm situations. The participants of Study Three all remarked on how little they knew about parenting a self-harming child. Self-harm was a new concept for many of them, and one which they had not expected to encounter in their own household. Several participants wished that there was a parenting manual to help guide parents through difficult decisions and situations that arise from self-harm. Claire was succinct in stating the root of the problem:

The biggest challenge? Not having a clue what was going on. Not understanding the illness. Not understanding what to do about the illness. (Claire)

A general lack of knowledge and sense of preparedness to parent in a self-harm situation was a common theme. For example, Abe noted that one of the biggest challenges for him was deciding how to react when his daughter would threaten to cut herself. Abe felt that often his daughter was calling his bluff and manipulating him as a parent, but also felt as though he could not take that risk.

That was very difficult for us, knowing what to say. You can't minimize it [threats of cutting herself], but there were times when we made our own threats. 'If you're going to do that, then we're calling the hospital, we're calling the police'. We really couldn't know how serious she was. She could be cutting and next thing you know she's thinking 'I'm just going to cut until I kill myself.' (Abe)

Sarah noted that one of her greatest struggles was finding the balance between maintaining her daughter's privacy and preserving her daughter's safety.

Finding her cutting tools and hiding them. I wanted to respect her privacy and yet on the other hand I wanted her to be safe. So, sometimes I went through her things. I think that was one of the biggest struggles, is trying to respect her privacy but yet keep her safe. (Sarah)

As part of their parenting duties the participants had to liaise with their child's school and advocate for their child in this arena. In doing this, parents had to understand self-harm as well as explain it to others. Participants like Deirdre found this to be an extremely challenging task. Deirdre struggled to effectively get the school on board, on her side, and working with her toward her daughter's wellness.

Getting the school and the school board to realize that my daughter wasn't a write-off, that there were things they could have done to get her to graduate with her peers. That was the biggest challenge. I think if that could have happened she would have been a different person than what she is today. (Deirdre)

Parenting a self-harming child brings about difficult decisions and situations, and the participants did not feel adequately prepared or knowledgeable.

Managing the emotional toll of caregiving. While navigating the parental part of the caregiving experience participants were also struggling with the emotional part of caregiving. Repeatedly participants shared that the most challenging part of the experience was managing their own emotions. These parents lived day in and day out in fear that their child would not survive the ordeal. Parents were worried that their child would not ever recover and were consumed by thoughts that they were helpless to change the situation. Parents also expressed concern about letting their own negative emotions impact their children.

I think the most challenging thing was worrying that she wouldn't recover. That she wouldn't get better. That was the hardest, worst thing. And just seeing her so in pain. Seeing and knowing how much pain she was in was really hard to handle. You felt so helpless. At some points you just felt like you were drowning. Though there was no help and it was never going to get better. (Lorraine)

Having to wake up every morning and go check her room to make sure she wasn't dead. It gets you every time. . . It was a big struggle to say positive around her. (Elsa)

The fear of thinking that you're going to lose your child. That was really, really tough. You worry all the time. Just seeing them in so much pain and really not being able to help. And trying not to add to whatever was bothering her. Trying not to also bring her more down. (Brandie)

6.5 Actions in the Parent-Caregiving Role

6.5.1 Helpful actions. The participants of Study Three had supported their children via many different actions. The participants spoke about learning through trial and error, never being certain that a particular action would work, and ultimately, still not knowing the best course of action when parenting a self-harming child. Regardless of lingering uncertainty, the participants were eager to share whatever actions had proven helpful to them. In summarizing these parents' advice and experiences with helpful caregiving actions I have sought to include that which is generalizable to many instances of self-harm, rather than focus on specific actions for specific self-harm cases.

Engaging in honest conversations. In reviewing their experiences, the participants felt that striving for open communication with their children was incredibly helpful. Parents encouraged having honest conversations about all facets of self-harm, including: asking questions about how self-harm made their child feel better, querying triggers of self-harm, discussing consequences and practicalities of self-harm, presenting benefits of treatment, and relaying how self-harm made them as parents feel. The participants felt that by engaging in honest conversations with their children they were building a sense to teamwork, conveying a nonjudgmental attitude, and improving their own understanding of the situation. Elsa summarizes parents' recommendations to maintain honest conversation:

You have to be honest with them. Definitely you have to be straight. . . I kept telling her over and over again how much I loved her and I wished she would stop hurting herself. 'Stop hurting yourself, it's not doing you any good. It's leaving your body permanently scarred, and it's hurting your mom.' I know that talking about it to her

honestly and openly all the time helped me a lot. . . If I would have stopped talking to her, she would have shut right down, but I had questions after questions. 'Why are you doing this? How are you feeling when you cut yourself? Does it make you feel better? What makes you want to hurt yourself? What can we do instead?' (Elsa)

Emphasizing positive coping and activities. Parents found some success in helping their children learn and practice alternate coping strategies. Similarly, parents found that involving their child in enjoyed activities served to improve their coping and keep them distracted from using self-harm. Parents caution that it can be difficult to entice children to buy-in to alternate coping strategies, or to engage in positive activities; however, persistence is rewarded.

A parent's role is to try and help them [their children] to learn better coping skills. To learn that you don't have to hurt yourself to cope with whatever the stress may be. (Lorraine)

Meredith spoke about using distraction techniques, and trying to get her daughter involved in other activities at times when she was at risk of harming herself. She provided the following example:

When we found her mood was getting really low and she was being mean to us, instead of freaking out and saying 'that's not how you talk to us; that's so disrespectful,' we started saying things like: 'Hey, do you want to go downstairs and have a workout? Are you hungry? Do you want to go for a walk? Do you have any homework?.' We would try to talk about things to sort of distract, and we tried to change the dynamics of what was happening. (Meredith)

Meredith also talked about the importance of coaching one's child on how to use positive coping.

If you can distract them from what is bothering them, from what makes them want to cut, then I think it can be helpful. I did talk very openly that in our house cutting is a negative coping mechanism. When you feel the need to cope then it means you are not using your positive coping, and then we do a lot of talking, like 'what's your positive coping? What is it that you can do if you feel like you need to cut?'
(Meredith)

Interacting with understanding and affection. Parents emphasized the importance of demonstrating understanding and affection with their child. Abe counselled to “take the self-harm seriously”, and Deirdre similarly asserted “validate, and realize that these feelings are very, very real to your child”. The participants recalled that there were times when it was difficult to shower their child in love and affection, but asserted the importance of telling their children how much they were loved. Hope shared what interacting with understanding and affection looked like for her:

I started spending more time with her, telling her even more so that I love her. Hugging her when she comes home, saying 'you're safe and you're loved.' As frustrating as it was at times – sometimes I was just like 'why are you doing this?!' But knowing when to bite your tongue, because there were times when I wanted to yell at her and get angry, but it's not going to help. She just needed to be reminded constantly that she was loved and cared for and she was in a safe place. (Hope)

Taking protective precautions. All of the participants spoke about learning to become watchful of their child. The participants advocated keeping a close eye on one's

child's in order to catch suspicious behaviours (e.g., wearing long sleeves in the summer) and signs of dangerous changes in moods (e.g., withdrawing from friends). At times, parents felt that more proactive and protective measures must be taken. When parents felt that their children were at serious risk of harm they advocated taking actions that limited access to triggers and means of self-harm. A few of the participants in Study Three recommended taking away sharp objects and instruments that their children used to self-harm. Elsa shared:

I had to hide my own razor blades to shave my legs. In order for her to shave her legs and under her arms I had to be there in the room. Which wasn't fun for me, but at least I got to take the razors away with me after. . . I think I had all the knives and the razor blades in my car at one point in a box and I would bring them back and forth with me into the house. But, she knew she couldn't be around these things. (Elsa)

Other parents noted their child's triggers for self-harm, and limited access and exposure to those triggers. For example, Hope's daughter was being cyber-bullied, and Hope knew that reading comments on the internet acted as a trigger for her daughter to self-harm. Consequently, Hope took protective precautions and made rules about when and where her daughter could access the internet. Similarly, Meredith began limiting her daughter's access to her cell phone at night.

We also took away her cell phone. When she had her phone – I think she was doing a lot of cutting late at night because she'd be on social media all night, or messaging people who were bad for her. Her mental health was deteriorating because I think she was exhausted. . . She went into withdrawals and was really

angry and really hostile, but we just powered through it, and our child began sleeping by 9:30 or 10:00 at night. (Meredith)

Like Meredith, parents found it difficult to take strict and protective precautionary actions with their child, but ultimately found these actions to be helpful.

Pursuing recovery with persistence. When asked what message they would like to pass on to other parent-caregivers, the participants of Study Three voiced the importance of acting persistently. These parent-caregivers know all too well how discouraging and demotivating the process of recovery can be. However, after much perseverance many of these parents finally found a way in which to help their child recover, and could not imagine what might have happened if they had stopped searching.

Keep trying. Try different things. You have to be your own advocate I think. There are a lot of things out there. So, yeah, keep trying different things. Don't give up just because one thing you tried didn't work. Throw everything at it. (Lorraine)

Never give up. Keep looking for solutions. (Deirdre)

Really push for the help for your child, even when they may not want that help, you still have to find someone that they can talk to. (Claire)

6.5.2 Unhelpful actions. In retrospect, the participants of Study Three were able to identify several types of actions that they regretted as a parent-caregiver. Indeed, many participants described trial-and-error learning, in which they discovered many unhelpful actions along the way to finding some helpful ones. At the time, these participants were operating with the best of intentions, and thus, their “unhelpful” actions are not meant to blame, but rather to instruct future parent-caregivers. In summarizing the participants’

advice and experiences, I have sought to include that which is generalizable to many instances of self-harm, by capturing the underlying intent and experience, rather than document every type of unhelpful action a caregiver could take.

Failing to acknowledge the seriousness of self-harm. In reflecting upon their caregiving experiences, participants noted that when they failed to acknowledge (and act on) the seriousness of their child's self-harm, the situation further deteriorated. Parents occasionally ignored, or only passively addressed signs that their child was self-harming. At other times, parents minimized the seriousness or severity of their child's experience. For example, early on his caregiving, Abe felt that his daughter's concerns were trivial, and the triggers that led to her self-harm were minor. Abe's dismissal of his daughter's problems were ultimately unhelpful as it was often the cause for arguments and hurt feelings.

Even when things seem really small and inconsequential to you, but has your kid really upset, you need to respond to how upset they are. The problem I had was minimizing situations. That certainly didn't help matters. I think that escalated things a lot of the time. (Abe)

Brandie believed that she failed to acknowledge the seriousness of her daughter's self-harm when she delayed acting upon the knowledge of self-harm. Although she was aware of certain self-harm behaviours, she did not intervene or address the self-harm directly. Looking back, Brandie felt that she should also have sought outside supports and professional help sooner than she did, and that this failure delayed her child's recovery.

I should have realized that she was so depressed. I didn't act once it started getting worse. It became more serious . . . Looking back, I would not have waited. I was

uncertain to send her to the hospital. I just wished I knew beforehand and I could have prevented a lot of things. (Brandie)

Failing to maintain discipline and reasonable expectations. In retrospect, some parents felt that they had been too tentative, indulgent, and lenient in their parenting during that time. Several participants wished that they had instead taken a tough love approach. The participants shared that they were afraid of pushing their children too far, were worried about negative reactions, and saw their children as quite fragile. In the end, parents believed that their approach was not helpful, and that maintain discipline and reasonable expectations would resulted in better outcomes.

I would have taken a little bit more time off work at that point in time and done a little bit of the tough love approach. . . Knowing what I know now, we probably could have pushed a little harder. It might have agitated her a little bit more, she might have done a little bit more cutting, but she also might have gone the other way. It might have forced her to realize that she's a grown up now. (Deirdre)

I wish I would have done things differently with discipline and responsibilities. You know, I wish I would have taught her to be a little more self-independent, more responsible for her actions, you know. (Anita)

You know what I think I should have done? I was trying to baby gloves her; I was trying to be supportive and be open and be approachable, but I think maybe I should have been a little harder, but I was worried of pushing her over the edge. I really should have gone into her room and I should have cleaned it. I think that I

should have done a sweep and we should have removed all blades from our house.

At the time, I think you have to take control. (Meredith)

6.5.3 Involvement in help-seeking. Parents acted as the driving force behind all help-seeking endeavours. The common theme throughout parents' stories was their willingness to try anything, and accept anything offered. Parents described seeking out any and every possible source of support for their child, and exhausting their resources to ensure their child tried every option. In telling their stories, parents mentioned seeking out psychiatrists, psychologists, therapists, social workers, general practitioners, school counsellors, teachers, and others. Rather than summarize the help-seeking actions taken by these parents, I have chosen to summarize their major criticisms of the help-seeking process, as well as their lessons learned.

Criticisms of the help-seeking process. Several participants had complaints about the types of care that were not offered to them or their children. The parents felt that their children's self-harm had greatly affected them as parents, and had affected their family as a whole. As such, parents reported wanting a more family-based approach to treatment. Parents criticized the care they had received from professionals when that care was solely focused on the child, without including or involving other family members.

We never saw someone together. Which actually I think probably would have been a good idea – to have the family there. Her sister, she must have known things were wrong of something was going on, and she had problems afterwards too. She must have been stressed. (Claire)

Another type of care that parents felt their child should have been offered was admission to a hospital. Over half of the participants in Study Three relayed stories in

which they had fervently sought help from all avenues, only to have their child become more severe. Occasionally, parents would push and plead with their child to go to the hospital. For many of these parents, and many of these children, presenting to the Emergency Room was viewed as the last resort. Presenting to the hospital meant that you had exhausted all other options, that you were the worst of the worst, and that you were truly “crazy”. Parents cried as they told of the day where their child was at her breaking point and finally conceded to going to the hospital. With glimmers of hope that this would be the beginning of the end, parents would rush to the hospital. Not long after, these desperate parents and children would be turned away. “Not severe enough”, “not immediate risk” or “not appropriate for admission” were the messages they received. Parents disclosed being at a total loss of what to do next, or what else to try after their last resort refused them. Moreover, parents expressed disappointment that when turned away, they were not offered any other services, options, or resources. Lorraine’s story exemplifies parents’ frustration with the lack of resources at the hospital:

My daughter wanted so much to be better. I called her counselor and said ‘She finally wants help. She’s ready to put herself into a mental health unit or something. What do we do?.’ He said the best way to access the system is to go the ER. . . We sat in emergency through the whole night. She had a little meeting with the psychiatrist and he basically said that there’s really nothing he could do. All he can do is let us phone the receptionist and make an appointment for her to come in. After laying herself on the line, and saying ‘really people, I just need someone to help m,’ she got sent home. Sent away. I took her home that morning and left her at home because I had to go to work. And I honestly expected that when I came home

she would be dead. That she would kill herself because she was that bad. By some miracle, she didn't. . . I phoned the psychiatrist office to get an appointment. It was a six to eight month wait. (Lorraine)

Other participants had complaints about the types of care that they did receive. Some parents found that mental health professionals would fixate on other problems their child was experiencing, and fail to address the self-harm. Other parents found that allied health professionals were most concerned about providing a diagnosis, but not treating whatever the diagnosis may be. After a long waitlist Deirdre finally had her daughter seen by a psychiatrist. After many appointment focused solely on diagnosis, Deirdre thought the following:

Quit putting labels on her and figure out what to do about it. Stop labelling it and just tell me what to do. (Deirdre)

Other participants were frustrated with the care providers with whom they had contact because they seemed unknowledgeable about self-harm, and often confused the act of self-harm with suicide attempts. Deirdre encountered this lack of distinction between self-harm and suicide across many health professionals.

We had the same problem with that counsellor too. Not understanding what self-harm was all about, what it was for. We had a huge issue with people thinking she was trying to commit suicide. . . For the longest time when we took her to the hospital they would have the psych nurse come in and be saying 'suicidal thoughts,' and everything in her medical charts would say 'suicidal.' No, she's a cutter. Get some education people. (Deirdre)

In sum, parents were critical of care that was not family-based, that seemed misinformed about self-harm, that focused on problems other than self-harm, and that was focused on diagnosis rather than treatment. A resoundingly common experience among parents was being turned away from the hospital when at their most desperate. Although parents recognized that hospitals are not equipped to take everyone, they were dismayed at the lack of support or resources offered to those who were turned away.

Lessons learned from the help-seeking process. From their experiences in help-seeking, parents learned certain lessons. Furthermore, these parents had advice they wanted to pass on to future parents in similar predicaments. A unanimous lesson learned and piece of advice was the message “try everything”. The participants exhorted future parents to not give up, to push past help-seeking failures, and to be willing to try whatever was offered. Despite their complaints and criticisms, all the participants in Study Three eventually found certain combinations of supports and tactics that led to the recovery of their children. Several participants asked the rhetorical question “What if I we had stopped looking?” and did not like the potential outcome of that course of action.

The participants also advised parents to push harder for information, resources, and options. The participants recognized how disempowered parents can feel when they are overwhelmed, but emphasized that it is the parent’s job to advocate for their children. Claire voiced her lesson learned in this regard:

I’d push a lot harder. I’d push a lot harder for information from the psychiatrist. Push the family doctor just to see what resources are in the city. It’s hard to push when you’re in so much turmoil and you don’t know what’s going on, but you need to assert your wants and needs to professionals. (Claire)

Finally, the participants recommended involving one's child in the help-seeking process as much as possible. Often parents were met with resistance from their children in their help-seeking endeavours. In order to bring their children alongside and ensure their involvement, parents found success in getting their child's input. Similarly, parents found that therapy was not helpful if their child did not get along with the therapist. Giving the child some say in making help-seeking decisions was key. For example, children were given power to choose a therapist, decide whether to do counselling in or out of school, or given the option of getting involved in community or cultural groups. Claire shared her experience in getting her daughter involved in the help-seeking process:

I was having problems finding someone that she would talk to. She would say 'I won't talk with them.' I said "it can't continue like this. If you won't talk to the ones I find, then you have to find someone yourself". And actually, she did. (Claire)

Emphasizing collaboration in help-seeking was often met with success.

6.6 Support Needs

The participants of Study Three were a rich source for information on the needs of people involved in recovery from self-harm. The participants readily identified gaps in the currently available supports, as well as potential solutions to these gaps. When discussing the type of support that was needed, participants were often prompted to pass along advice or to imagine the perfect solution. Therefore, the following discussion of support needs includes both needs and possible solutions. Two superordinate themes emerged in this topic area: support needs for parent-caregivers and support needs for self-harming children.

6.6.1 Support needs of parent-caregivers. Parents disclosed that while supporting their children in recovery from self-harm they were themselves in desperate need of support. In reviewing their caregiving role parents felt that various types of support would have made a significant difference to the quality of their mental health as well as to the quality of their parenting. When discussing the type of support they needed, participants identified the need for more information, the need for more individual counselling, and the need for more peer support. Throughout their stories, participants suggested various ways in which these needs could be better met.

Informational support needs. Throughout their stories the participants frequently expressed how uninformed and unprepared they felt for parent-caregiving for someone who self-harms. The participants were unknowledgeable about the phenomenon of self-harm as well as how best to seek help and how best to parent these behaviours. The participants expressed many of the same informational needs. See Table 5 for an overview of parents-caregivers' expressed informational needs.

Table 5

Parent-caregivers' Informational Support Needs

About self-harm	About caregiving for self-harm
That self-harm exists, and is prevalent	How to maintain discipline for a child who self-harms
Reasons why people engage in self-harm	How to maintain appropriate expectations for a self-harming child, without pushing too hard
Warning signs that someone is self-harming	How to access and navigate the healthcare system
The self-harm course	Where to access reliable information
The seriousness of self-harm	
The triggers for a self-harm episode	

Some parents expressed that they wished they had known that self-harm happens, and in fact, happens frequently. Prior to their own child engaging in the behaviour, some parents had no knowledge of self-harm. Parents asserted that despite self-harm being highly prevalent, it is not a trivial behaviour, and parents should know that it is serious. The participants believed that more information and awareness about self-harm as a form of mental illness, and an issue distinct from suicidality, is important for parents. Another common informational request was in regard to the rationale, or reasons why children engage in self-harm. Parents thought it important to understand that individuals self-harm as a stress relief and as a way to manage emotions. The warning signs that one's child may be engaging in self-harm was another popular informational request. Parents also wanted to know what to expect in terms of the course of self-harm. In addition, parents wanted information on the triggers that may first lead to self-harm, as well as those triggers that keep a child at risk of self-harming. Deirdre explained why she would have liked to have been informed about triggers:

I think the biggest thing is probably the triggers. Every person that self-harms has triggers that causes them to self-harm...whether it be stress, anxiety, a relationship, for some people it's a family trigger, some people it could be work, could be any number of things. But there's always triggers. I would have spent more time looking for my daughter's triggers and disabling them so that the opportunities wouldn't have manifested themselves. Because whenever she fought with her friends, she would hide in her room and cut. Well, if you fight with your friends, then your mom makes you come sit and watch TV with her, you're not going to cut,

right? Then the crisis would be averted. But I didn't know her triggers. I didn't know that there were triggers. (Deirdre)

Parents also desired information regarding how to care for a child who self-harms. For instance, the participants had many questions about parenting (e.g., how hard to push self-harming children to fulfill expected roles and obligations, how to maintain discipline when one's child is already "punishing" themselves). The participants also had questions about how to access help and appropriate services for their children. Parents wanted more information on who first to contact after discovering one's child self-harms. Parents requested more informational supports regarding accessing and navigating the healthcare system. Lorraine shared:

It would have been nice if there was a more clear cut path into the mental health system. If there was a map almost, about using and accessing the mental health system. . . Because it just seemed like you're left to navigate it all on your own. (Lorraine)

Informational support solutions. When participants were asked how best to get this information to parent-caregivers, they offered several suggestions. First, parents believed that more awareness and information should be generated through the healthcare system. Parents suggested brochures (e.g., "Is your child self-harming?") that are available in the waiting-rooms of doctor offices, resource materials or guides available to be ordered through the healthcare system, or information available by calling the 24/7 healthlink phone numbers. Hope emphasized how anonymous call-in options are good informational resources for people who are feeling too ashamed to seek information in-person:

If there was an information session or workshop or something like that out there, they hopefully would provide resources. So even providing anonymous resources, if you're feeling uncomfortable about admitting something is wrong in your home, or you have a hard time asking for help, here's the number we have and you can make an anonymous phone call or whatever. They have the kids help phone that is like that, so something for parents too. (Hope)

Specifically for information on accessing and navigating the healthcare system, parents suggested having a decision-tree flowchart that provides guidance on whom to call or contact. Moreover, many parents had felt that their child's therapist or counselor should have provided more information directly to them as parents. Therefore, parents suggested that the healthcare system could be more informative by having therapists or doctors spend more time with parents and not just with the self-harming children. Secondly, apart from information through the healthcare system, parent-caregivers also recommended utilizing the school system. Information sessions or workshops held by or hosted by schools were presented as a viable information option. Finally, a few parents suggested increasing the awareness of self-harm by television commercials or advertisements through social media. For example, Meredith likened the need for parental awareness of self-harm to the need for parental awareness of drug-use, and suggested the following:

You know, like 'signs and symptoms to see if your kid is doing drugs'? I think there should be more social awareness of the symptoms of cutting. I think people pay attention to commercials on mental health awareness . . . I think there should be

something about mental wellness and adolescence. I know social media awareness is huge as well. (Meredith)

Individual counselling needs. Over the course of caregiving, parents experienced significant stress and deteriorating mental health. Consequently, several participants felt that individual counseling or therapy would have helped tremendously. The participants wished for validation of their own uncomfortable emotions and experiences, feeling listened to without judgment, and an opportunity to feel a release through venting. Some participants also wanted professional advice on how to deal with their child's self-harm, how best to parent, and how best to keep themselves healthy. For example, Meredith shared:

I wish I'd had therapy. People able to just validate your feelings, a place to just go and try to talk about how you're feeling. . . A lot of people don't want to tell their spouse 'I feel despair, I feel worthless, I feel like a failure.' You don't really want to say that to other people, so I think it's better if you could say it in a healthy environment. (Meredith)

Unfortunately, several participants expressed the detrimental effect that stigma had on their help-seeking. Some parents felt very uncomfortable admitting they themselves needed counseling, and had refrained from seeking this type of help. Other parents had difficulty making their own treatment a priority, while being so focused on seeking treatment for their children.

Individual counselling solutions. Various strategies were suggested when participants were asked how best to fulfill their individual counseling needs. Many participants said simply "go to counseling despite all hesitations". These participants

advised taking advantage of any employment assistance programs that parents may have, or take advantage of counseling offered through community mental health services.

Participants asserted that parents need to make their own treatment a priority in order to be the best caregiver possible for their children. Sarah advocated for pushing past the barriers created by stigma, and seeking individual counselling:

I guess one of the biggest things is there's nothing wrong with going to see a counsellor. A lot of people still think if you see a counsellor you're not strong, you're not whatever. There's a stigma to it and they don't want anybody to know. Well, so what? You know, the way society is these days there's probably more people going to counselling than not to be honest. There's nothing wrong with asking for help. (Sarah)

Recognizing how difficult it can be to admit needing help, participants also offered suggestions other than traditional individual therapy. In particular, participants encouraged the utilization of social supports. If you cannot lean on professional supports, you need to find trusted people in your social network on whom you can rely and be “counseled”. One participant suggested that anonymous call-in services could be provided by professionals in order to supply much-needed individual counseling support while limiting the shame and stigma felt by parents.

Peer support needs and solutions. Throughout the participants’ stories a desire for peer support emerged as a theme. Parents repeatedly emphasized how much they would have liked to connect with other parents in similar circumstances. The participants believed that their peer support needs would best be fulfilled through peer support or

family support groups. Over and over the participants shared how desperately they wanted to hear and feel that they were not alone:

I wanted to hear ‘you’re not alone’. . . You feel so isolated. Because you don’t want other people to know, you keep everything in, you try and keep everything inside you, you try to keep everything inside your house. One of the best things is to know that there are other people out there going through the same thing. (Abe)

In a support group it would be about having something there to tell me: ‘I hear you, it is that way, you’re not crazy, that is definitely how we’re all feeling.’ (Deirdre)

My emotional needs? To know someone else that was going through it. To be able to talk to other parents that were going through it. So you wouldn’t feel like you were alone. (Claire)

Moreover, the participants wanted to be able to share without fear of judgment. Peers in similar circumstances would understand their struggles and refrain from placing blame. Looking back on her experiences, Meredith exclaimed “I wish someone had told me it’s not my fault!”. In addition to a lack of blame and judgment, participants also sought validation of their own emotions and experiences. Claire and Brandie requested the following:

Provide us support groups for families. So you know you weren’t the only parent going through this, that there are other parents, any economic social group can go through this. You don’t get singled out somehow. Because then you could have somebody that you could talk freely with that would understand what you were

talking about and wouldn't judge you. (Claire)

You need a way to express what you're feeling, and maybe other people there would have the same feeling, so you wouldn't feel like you're a failure. (Brandie)

The participants believed that peer support would allow for information sharing, and ultimately improve their caregiving. Participants wanted peer support in order to exchange parenting strategies, share coping strategies, and gain new perspectives on how to manage their child's self-harm.

It's good to get together and compare each other's stories. It kind of gives you a perspective on what needs to be dealt with first, I guess. (Anita)

Some participants, like Sarah, felt that peer support should be made available for both parents and self-harming children. She asserted that what was needed was "a family solution to a family problem". Because self-harm affects the whole family, and everyone involved can benefit from hearing about others' experiences and strategies, Sarah felt that family support groups were a good option. She shared her vision of a perfect family support group:

I was most desperate for a support group with other people who have been through the same thing. Something where us as a whole family could have gone, as a family way of coping. . . Even if it was only eight sessions or whatever, where you got to sit there and discuss things. 'This is what's worked for us,' you know? And there was of course a counsellor or mediator as well. But you can get more of a perspective from other parents on how they've dealt with things, and then you know you're not alone. (Sarah)

In sum, parents wanted to feel that they were not alone, that they were understood, not judged, and validated. Additionally, parents felt that peer support or family support groups would allow them to exchange ideas, perspectives, and strategies with other people who were also struggling with self-harm.

6.6.2 Support needs of children who self-harm. As the driving force behind most help-seeking endeavours, parent-caregivers are often highly familiar with the needs of their self-harming children. Indeed, the participants of Study Three had several ideas about the support needs of children struggling with self-harm. In contemplating their caregiving experiences and their children's recovery journeys, the participants were able to identify what supports were well-received, and what supports could be improved. With regard to their children's support needs, participants identified the need for improved delivery of care within the healthcare system, improved treatment options that facilitated children's connection with others and their coping abilities, as well as improved awareness and education about self-harm in the school system.

Improved delivery of care within the healthcare system. Parents felt that certain aspects of the delivery and provision of services within the healthcare system needed to be improved upon in order to sufficiently support self-harming individuals. Many participants had experienced long waitlists before their child was seen by a mental health professional. These participants asserted that waitlists needed to be shorter or alternative services offered during the wait time. These improvements to expedited care are especially important given the urgency and potential for harm associated with self-harm. Abe expressed his frustration in getting his daughter seen by professional in a timely fashion:

It's about getting into somebody in a reasonable amount of time. I just don't know how often we talk about what a lack of help there was out there . . . Getting into those resources in a shorter period of time, because by the time they're able to get to that point of seeing someone, it's too late. (Abe)

Other participants noted that other “adolescent issues” such as teen pregnancy or substance abuse have specialized services, whereas self-harm does not. In parents experience, self-harm was instead only treated peripherally. Lorraine in particular noted that there was no coordinated care for self-harm.

There was no coordinated effort of coordinated help. It's like you can access all these little pieces, but there's no one really putting it all together and approaching it in a holistic way. My main frustration was with the coordination of help. That's where I would really like to see it get better for other parents in the future.

(Lorraine)

Another key support need of individuals who self-harm is an alternative service or resource when turned away from the hospital. Many participants were left feeling like there were no options being provided to their child when she was at her most desperate and when she was most at risk. These parents believed that delivery of care needed to be improved in this specific circumstance.

Treatment options that emphasize interpersonal connection. Parents who had witnessed success through the receipt of counselling believed it was fruitful when their children felt they could connect to their therapist and feel heard. Claire described what type of therapist was finally able to help her daughter:

Being comfortable with the person is important. Knowing that they seem to care about you and you're not just an individual who is going to talk for an hour and then you're going to go away. Then you're going to come back and talk and they're not going to have a clue who you talked about. The therapist my daughter found – he did know who she was talking about, he remembered who those people were.

(Claire)

Other parents suggested that self-harming individuals may find success if given the opportunity to connect to peers in similar circumstances. For instance, Meredith suggested a support group for self-harm where people could connect with others as well as a group facilitator:

I wish there was support group for teens, like AA or NA for cutters. I wish that someone was there leading and dictating how this group would be, and doing a lot of positive reinforcement. Like 'good job, you haven't cut in three weeks! That's amazing. Keep on track. What's working for you? Share what's helping you. Tell the others how you're coping.' *(Meredith)*

Several parents noted that coping skills were useful for their children; however, these skills were not the sole solution. Parents believed that their children were more in need of “someone to talk to”. Indeed, parents believed that children would not try alternative ways of coping unless the person who shared the coping strategies was trusted, respected, and liked. Instead, parents believed that the therapeutic relationship was integral to making headway toward recovery.

Improved awareness and education about self-harm in the school. The participants of Study Three marveled at how little self-harm specifically, and mental

health in general are discussed in schools. As such, the parents believed that there is little awareness or recognition of self-harm among adolescence until it is too late. Many parents wished for preventative programs or awareness campaigns that advertised the pitfalls of engaging in self-harm as well as the more healthy coping strategies available. Furthermore, parents felt that if self-harm was more openly discussed in schools it would improve help-seeking among children. Higher levels of awareness would decrease the stigma associated with self-harm and would increase adolescents' knowledge of where to go for help. Claire emphasized teaching children how to stay mentally well:

Mental wellness. How do you stay mentally well, and what happens, and what does it look like not to be mentally well? . . . You need to start it really young because you have people as young as nine, who are depressed. And how do they recognize it? The same with the self-harm – I firmly believe it should be taught in school by either social workers, psychologists, or psych nurses. . . Educate students the same as you educate them about physical illness. Physical wellness and mental wellness go together under one umbrella called wellness, and you should start teaching both at a young age. There are things you can do to stay mentally healthy. (Claire)

Meredith emphasized that by addressing self-harm openly in schools it would serve to destigmatize the behaviour:

Do you know what the problem is? The problem is I think that the schools still think if you talk about it, it gives them the ideas to do it, which is not necessarily true because they will already have the ideas to do it. . . So if you talk about cutting it doesn't mean all of a sudden your kid is going to become a cutter. I think it's in the approach and the way that it's taught. Just to say, like, ' this is not good, this is

*negative coping.’ If it’s approached with not a shameful, but a negative spin on it. .
. But it’s not talked about and if you don’t talk about it, the results are kids are
doing things behind people’s backs. (Meredith)*

In sum, parents believed that self-harming adolescents would be better cared for with improved service delivery from the healthcare system, opportunities to connect with and learn from therapists, and improved awareness and early education about self-harm and mental wellness.

6.7 Discussion of Study Three

Study Three expands our understanding of the lived experience of parent-caregivers supporting a child in their recovery from self-harm. Moreover, Study Three affords us the opportunity to learn from those individuals who have been at the front of the proverbial battle lines. The perspectives of parent-caregivers contributes to the existing literature by providing a more subjective and personal account of what the experience of recovery looks and feels like for key support people. Through in-depth interviews the experience of parent-caregiving was examined in terms of the experience of the caregiving role, actions in the caregiving role, and perceived support needs. In the following section I will: situate the results of Study Three in the current literature, demonstrate how this new-found understanding of parent-caregiving extends and contributes to this literature, and provide implications regarding parent-caregivers’ experience of the caregiving role, the actions they took as parent-caregivers, and support needs.

The current study extends and contributes to past research by recruiting those parent-caregivers who have participated in all stages of their children’s self-harm.

Whereas past research has recruited parents with currently self-harming children, the

current study purposefully examined those individuals whose children had recovered from self-harm. By using only participants with children that had recovered from self-harm the current study was able to contribute to the body of literature in several unique ways. Firstly, the current participants could use their experiential knowledge to comment on what did and did not work, or what did or did not contribute to the recovery process. Secondly, the current participants could comment on a longer timespan or duration of the caregiving experience than participants from past studies who had not yet experienced the recovery process through to completion. Thirdly, the current participants had the benefit of hindsight. Whereas past research participants were often interviewed in the midst of their caregiving experience (Oldershaw et al., 2008; Raphael et al., 2006), the current participants were able to comment on past experiences, using a retrospective perspective.

6.7.1 Implications for the experience of the parent-caregiving role. As previously discussed, parents play an important role in their child's recovery from self-harm. Past research has documented the struggle that parents experience in fulfilling this role (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Indeed, past qualitative research has highlighted that parent-caregivers feel overwhelmed, unprepared, and uninformed (Lindgren, Åström, & Graneheim, 2010; Trepal et al., 2006). The current results corroborate these past findings in that the current participants reported many similar emotional experiences, parental experiences, and familial difficulties.

The current results indicated that parents' emotional experience of caregiving often begin with shock and disbelief, and can transform into a wide range of other negative emotions, including feeling: anger and frustration, sadness and hurt, fear and dread, alone and abandoned, helpless and defeated, as well as trapped and tentative. Moreover, the

current results demonstrated that even after their child has recovered, parents continue to experience many of these emotions. The shock that their child engaged in self-harm, the anger for putting the rest of the family through the ordeal, the fear of losing one's child, the seclusion from others, and the uncertainty of lasting recovery continue to linger long after one's child ceases self-harm. Results from the current study bolsters existing knowledge of parent-caregiver experiences by conveying the long-standing nature of parents' emotional turmoil.

Similarly, the current study also provides perspective as to how long-standing other changes are to the parental aspects of the parent-caregiver experience. Past research has also highlighted that parent-caregivers have concerns about their parenting abilities and style (Byrne et al., 2008; Oldershaw, 2008). For example, past participants, whose self-harming children were in treatment at the time of the research, indicated that they were nervous about triggering future episodes of self-harm and consequently their ability to set limits and maintain boundaries as parents were compromised (Oldershaw, 2008). Because the current participants could examine their experiences retrospectively they were able to identify how their parenting had changed in the long-term and for the younger siblings of a self-harming child. The concerns about parenting abilities and the changes to parenting style were often enduring. As parents' caregiving experiences often included feelings of shame, failure, and concern that others' would view them as bad parents, efforts should be made to destigmatize the parental experience of self-harm. The destigmatization of adolescent self-harm should extend to include parents of self-harming adolescents. Help-seeking and social support-seeking would be made easier if parents were not concerned with others' judgement of their parenting abilities.

In past research parent-caregivers have reported negative effects on their families. For example, some parent-caregivers found it difficult to balance parenting one's self-harming child while meeting the needs of their other children (Oldershaw, 2008), and others found that the focus on one's self-harming child through off the balance of regular healthy family dynamics (Byrne et al., 2008). In the current study, parent-caregivers again reported negative effects on their families. The current participants emphasized the difficulties in maintaining positive spousal relationships while caregiving for a self-harming child. The finding that spousal relationships, and not just familial relationships, are negatively impacted during caregiving allows for a more comprehensive understanding of the parent-caregiver experience. The strained spousal relationships are particularly disconcerting given the potential effect on parenting. Spousal conflict means that each parent is experiencing less social support (from each other) as well as increased personal stress. Given the difficulties experienced by spouses, future interventions could incorporate spousal elements. Learning how to act as partners during such a stressful time, improving communication about parenting strategies, and enhancing spousal solidarity could prove beneficial to both parent-caregivers and self-harming children.

Past research has established that parents experience challenges while caregiving for self-harming children. Parents experience difficulty with: making sense of their child's self-harm, managing negative emotions, executing good parenting, and garnering the support they need from health professionals (Byrne et al., 2008; Lindgren, Åström, & Graneheim, 2010; Oldershaw et al., 2008; Raphael et al., 2006). The current study directly asked parent-caregivers what challenges they experienced, and determined that parents primarily struggled with knowing how to parent in the self-harm situation, and

managing the emotional toll of caregiving. This information serves to better focus any supports or services offered to parent-caregivers. The healthcare system needs to be responsive to that which parents struggle most. In the current study parent-caregivers identified struggling with self-harm specific situations (e.g., what to do when one's daughter threatens to cut herself, whether or not to invade one's daughter's privacy in order to search for knives). In addition, parent-caregivers felt overwhelmed by self-harm specific emotional tolls (e.g., fearing that one's daughter would eventually commit suicide, hiding their own negative emotions to protect one's daughter). Therefore, supports and services should aim to provide education and advice about self-harm specific situations, as well as to provide outlets and strategies to improve caregivers' abilities to cope with the emotional toll. Because parents worry about their ability to parent, as well as their ability to cope with negative emotions, services could emphasize empowering parents and supplying coping tools.

6.7.2 Implications for actions in the parent-caregiving role. Parents identified several actions that, in retrospect, they believed were helpful in bringing about their child's recovery from self-harm. In turn, parents also identified actions that they believed were unhelpful, or detrimental to recovery. Parents often initiated actions or decisions that were the driving force behind help-seeking. A better understanding of which parental actions help or hinder recovery can be used to inform and support future parent-caregivers. Likewise, a better understanding of which parental help-seeking action best procures mental health services can be used to inform and improve the services offered. The current participants eagerly passed on advice in hopes of guiding others and improving others' parent-caregiver experiences.

Helpful and unhelpful actions. Reflecting on the actions they took as parent-caregivers allowed the participants of Study Three to gain perspective on what was helpful or unhelpful at the time. First, parents noted that engaging in open and honest conversations about self-harm is extremely beneficial. Parents found this task difficult, and directly addressing their child's self-harm was counter to their natural inclinations. This is in line with past research, indicating that parents have difficulty understanding, and thus talking about self-harm (Oldershaw et al., 2008). Poor communication between adolescents and their parents can lead to the adolescent feeling isolated from the rest of the family, and can cause the adolescent's problems to seem insoluble (Tulloch et al., 1997). In order to counteract the negative effects of poor communication, parents need to be able to speak about self-harm in a way that is free of judgement, hostility, and criticism. Supports and services would do well to offer psychoeducation on the benefits of open communication and the pitfalls of poor or delayed communication. Moreover, supports and services could include psychoeducation on how to communicate about self-harm effectively, and include topics such as: how to confront one's child when self-harm is suspected, how to share one's own feelings about self-harm, and how to communicate about self-harm in a collaborative way.

Other parent-caregiver actions, such as emphasizing positive coping and distraction activities, could be used preventatively. Teaching coping strategies to one's children at an early age could serve to prevent the urges to use self-harm as a way to manage one's stress and negative emotions. If parents were taught how to instruct their children on positive coping strategies they would be in a better position to a) help their child refrain from engaging in self-harm, and b) help their child cease self-harm behaviours.

Therefore, programs and services should consider implementing widespread psychoeducation to all parents regarding positive coping and activities for children.

Taking protective precautions, such as limiting access to sharp objects or the internet, was very difficult for parents in the short-term. However, parents believed that these actions were worth it in the long-run, and ultimately kept their child safer. Similarly, parents found it difficult to maintain discipline and appropriate expectations when dealing with their self-harming child. The parents' uncertainty and fear led them to become more permissive and lenient in their parenting. The participants of Study Three later regretted their actions, as they believed them to be ultimately unhelpful. In order to support parents in making the difficult (but helpful) parenting decisions and actions, supports and services available to families with self-harming children should include parenting classes. Many self-harm specific dilemmas arise, and parents are at a loss in these unfamiliar situations. Specific instruction, direction, and support for parents with self-harming children could help them employ the more helpful actions.

Another unhelpful action of note was parents' failure to take self-harm seriously. Past research has indicated that parents are not well informed about self-harm, and this includes its repercussions, detrimental effects, and potential to escalate in severity. Parents need to be more aware and better informed about self-harm in general before they can appropriately address it if/when their own child begins to self-harm. As one of the current participants noted, parents are often informed about the ill-effects of adolescent drug abuse, alcohol use, and unsafe sex; perhaps it is time for self-harm to be added to that list of dangerous behaviours.

Involvement in help-seeking. Through their respective ordeals, the participants of Study Three had several criticisms of the help offered to families dealing with self-harm, as well as several lessons learned. Participants believed that self-harm was a “family problem” as it impacted all family members, and as such, required a “family solution”. Several participants suggested a family-based approach to treatment, in which all family members, or at least the parents and self-harming child could meet together with a mental health professional. In fact, this suggestion is in agreement with a recent critical review of self-harm intervention studies (Brent, McMakin, Kennard, Goldstein, Mayes, & Douaihy, 2013). Extant randomized clinical trials that aimed to reduce the intensity and frequency of self-harm and suicidality were examined with respect to treatment components, comparison treatments, samples composition, and outcomes. The majority of studies that showed any effect on suicidality or self-harm had a focus on family interactions and involvement. The authors concluded that treatments that focus on the augmentation of protective factors, such as parental support, can be of significant benefit.

Another exceedingly frequent request was for more alternatives or resources when a self-harming child is refused admission to the hospital. For many parents, presenting at a hospital emergency room in hopes of hospital admission is a last resort, and signifies that both they and their child are at the end of their ropes. As inpatient wards at a hospital have a limited number of beds, and typically reserved for those individuals who are at serious risk of suicide or harming others, not all cases of self-harm are granted admission. This fact, and the purpose of hospital inpatient units may need to be better advertised. Parents shared that they had difficulty navigating the mental healthcare system, and often did not know who to contact, or what steps to take in order to receive care. Taken

together, it would appear that parents would benefit from more information on a) what resources are available to them and their child; b) how to access these resources; and c) in what circumstances they can expect admission to hospital.

Parents were often disappointed by mental health professionals' response to their child's self-harm. Either care providers would fail to address the self-harm, focus on diagnosis rather than treatment, or misinterpret self-harm as a suicide attempt. As parents had themselves struggled to understand self-harm and become informed about the clinical phenomenon, they expected mental health professionals to have done the same. A review of healthcare professionals' perceptions of self-harm indicate that a lack of education, lack of personal confidence, and the perception of self-harm controllability contribute to widespread negative attitudes (McHale & Felton, 2010). More widespread awareness and psychoeducation about self-harm for various mental health professionals (e.g., psychiatric nurses, social workers, psychologists, psychiatrists) appears to be warranted. Systemic education is required to improve the understanding and care provided by healthcare professionals.

In terms of lessons learned, the participants of Study Three relayed that parents of self-harming children must try all the supports and resources they are offered. It is important not to give up hope because eventually, with perseverance, they found that the key to their child's recovery. Similarly, parents learned that they had to keep pushing healthcare providers for those supports and resources. The participants shared that parent-caregivers main role in help-seeking is to be an advocate.

Finally, parents learned that taking a collaborative approach to help-seeking is often met with more success and less pushback from their children. Involving their children in

making help-seeking decisions and actions was beneficial for their relationship as well as to the ultimate success of their child's help-seeking experience. Of note, extant research has indicated that therapists who take a collaborative approach to providing help to self-harming adolescents are also met with more success. Idenfors and colleagues (2015) conducted semi-structured interviews with adolescents and young adults who had recently had their first contact with a mental health professional for self-harm treatment. These participants emphasized the importance of personal input when help-seeking and help-receiving. Indeed, these participants believed that interventions failed when the treatment proceeded according to the opinions or policies of the provider, rather than according to their own stated needs and desires. Both parents and healthcare professionals should be aware that shared decision-making and collaborative efforts are likely to increase a self-harming adolescent's treatment engagement and adherence.

6.7.3 Implications for support needs.

Support needs of parent-caregivers. Given how optimally situated parent-caregivers are to positively influence and support self-harming individuals, it is important that they themselves are supported in this role. Unfortunately, the current study corroborated the message from past research that parent-caregivers are instead uninformed, unsupported, and overwhelmed with the caregiving task. In general, caregivers of the mentally ill experience high levels of stress with low levels of support (Ohaeri, 2003) and the caregivers of individuals who self-harm are no exception. The current participants disclosed that they were in need of informational support, individual counselling, and peer support. By supporting caregivers, self-harming individuals are

indirectly supported, and their recovery made more likely; therefore, increased attention and awareness to caregivers' plight is warranted.

In terms of informational support, parent-caregivers requested information about self-harm, as well as about caregiving for self-harm. The basic nature of the information that was requested indicates that there are still large gaps in the general population's awareness of self-harm. As the parents suggested, awareness campaigns, advertisements, and informational sessions provided through the school and healthcare systems would improve parents' general understanding of self-harm. The types of self-harm information that was requested by parents also indicates that *reactively* providing information to parent-caregivers is not enough. In order for this information to be of use, parents need to know that self-harm exists, is prevalent, and what the warning signs are prior to discovering that their own child engages in these behaviours. Therefore, the current study indicates that information needs to be provided *preventatively*.

Parents' frustration with the lack of information they received from healthcare professionals indicates that standard practices may need to be re-evaluated in self-harm situations. For instance, several parents whose children were regularly seeing mental health professionals (i.e., psychiatrists, psychologists, counsellors) still felt uninformed and somewhat neglected in the process. Mental health professionals should consider altering their standard practice to include more time spent directly with their clients' parents. At the very least, mental health professionals should be aware of parents' desire for more information, and have informational resources (websites, books, brochures) available for them. One study that examined caregivers of individuals with severe mood disorders found good success in offering "educational packets" to caregivers (Heru et al.,

2005). The “educational packets” that were provided to caregivers contained information about: mood disorders, the importance of caregiver wellness, and how to request more supports and get a referral for themselves. Heru and colleagues (2005) found that the vast majority (83%) of caregivers found the packets to be helpful, many appreciated being directly supported, and some caregivers proceeded to request referrals for themselves through the avenues provided. Similar educational packets could be offered to parent-caregivers of self-harming adolescents with similar success, given the informational requests made by the participants of Study Three.

Finally, parents indicated that there was a dearth of information and instruction on pathways to appropriate care. The healthcare system should consider making more clear and explicit the availability and accessibility of programs and services through itemized steps, guidelines, or “help phone” options. This particular informational need is novel to the current study, as past research has not so explicitly indicated the need for pathways to care information for self-harm.

In terms of individual counselling needs, parent-caregivers felt they would benefit from validation of their emotional experiences, feeling listened to, and receiving professional advice. Unfortunately, parents were often deterred from seeking counselling for one or more of the following reasons: perception of stigma, perception that they did not deserve counselling, or perception that they did not have the time or resources for counselling. Perceived stigma (e.g., fear of being viewed as a “bad parent”, fear of being blamed for your child’s mental illness) is a common experience among parent-caregivers, and often results in avoidance behaviours (Corrigan & Miller, 2003). Moreover, parents’ beliefs about the deservedness of counselling stem from the notion that they should have

nothing to complain about because they are not the one with the mental illness. The (mistaken) sentiment is “if anyone gets help it should be my child”. Finally, parents believe that their time and resources should be dedicated to caring for their child, and not for caring for themselves. Future research should examine ways in which to counter mistaken parental perceptions about help-seeking. Future research could focus on the development and evaluation of educational campaigns aimed at counteracting parental stigma and self-blame.

In terms of peer-support needs, parent-caregivers wanted to feel understood, be heard without judgement, share strategies, and improve their sense of isolation. The parent-caregivers believed that peer-support groups with other parents of self-harming children would fulfill these needs. Indeed, peer-support groups have been used among other parent-caregivers to much success (Abramowitz & Coursey, 1989; Cook, Heller, & Pickett-Schenk, 1999; Gatta et al., 2011). Support-group involvement has been associated with lower caregiver burden and with lower levels of formal service utilization among parents of young adults with mental illness (Cook et al., 1999).

Based on the current results, it would appear that multi-family psychoeducation groups (MFPGs; Fristad, Gavazzi, Centolella, & Soldano, 1996) should fulfill the needs reported by parents of self-harming adolescents. Participants in an MFPG come from different family groups, but typically are dealing with the same type of disorder or problem behavior in their patient family member. Some MFPGs advocate for a portion of the time to involve both patients and family members in the same group (Fristad, Gavazzi, & Soldano, 1998); however, the majority of MFPGs are exclusively for the family members. The inclusion of multiple family members, with the option of including

the self-harming adolescent would also fulfill the current participants' desire to have a more family-based emphasis on education and treatment. The majority of MFPGs dedicate a portion of the meeting time explicitly to psychoeducation, followed by a portion of the meeting dedicated to supportive problem-solving, in which participants can share strategies, discuss coping, and problem-solve parenting dilemmas (Fristad et al., 1996; Fristad et al., 1998). MFPGs take a client-focused approach, in that they provide parents of mentally ill children with what they report needing: accurate information on their child's condition, suggestions on how to cope, and access to social support. The strategies used are aimed at reducing caregiver burden and consequently improving both family and child functioning (Goldberg-Arnold, Fristad, & Gavazzi, 1999).

The current study gives every indication that an MFPG delivered to families dealing with self-harm would be well-received and highly effective. To my knowledge, no such family-oriented support group has been offered within the self-harm population. Future research is needed to develop and evaluate MFPGs for use within self-harming populations.

Support needs of those who self-harm. According to parent-caregivers, their self-harming children would most benefit from: a) improved delivery of care in the healthcare system; b) treatment options that emphasize interpersonal connection; and c) improved awareness and education about self-harm in the school system.

The participants shared several stories with the common theme of poor or limited delivery of care within the healthcare system. In particular, parents were exasperated with long waitlists, poorly coordinated care, no self-harm specific services, and no alternative resources or supports offered when their child was refused hospitalization. Past research

has indicated that the highest risk period for recurrent suicidal or self-harm acts is within one to four weeks of discharge from psychiatric hospitals or hospital emergency rooms (Brent et al., 2013). Therefore, those children who are turned away from the hospital without alternative sources of care are at great risk. Past clinical research and the current study jointly indicate that parents are desperate for alternative sources of support when their child is discharged from hospital, and indeed, they have every reason to be. Contact-based interventions, such as follow-up letters, postcards, and telephone calls, that are implemented following a hospital visit, have demonstrated potential to reduce repeated self-harm (Carter, Clover, Whyte, Dawson, & D'Este, 2007; Evans, Evans, Morgan, Hayward, & Gunnell, 2005; Vaiva et al., 2006). In fact, a text-messaging intervention to reduce the repetition of self-harm after presenting at an emergency room is currently in development (Owens et al., 2011). Future research should continue to investigate what types of resources and options (including contact-based interventions) may be efficacious for self-harming adolescents who find themselves turned away from psychiatric hospitalization.

The participants of Study Three also believed that self-harming adolescents needed treatment options that emphasized interpersonal connection. In their experience, parents saw the most improvement when their children were able to trust and bond with their therapist. The importance of the interpersonal connection with one's therapist has also been emphasized by the adolescents themselves. Self-harming adolescents and young adults assert that in order to speak openly and honestly with one's therapist you must feel listened to in a nonjudgmental manner, be invited to share your own narrative, and trust that the professional is competent to provide care for self-harm (Idenfors et al., 2015).

Apart from the support needs that could be filled in the healthcare system, parent-caregivers believed that the school system should also be fulfilling certain support needs of their children. Parents believed that schools should contribute to self-harm prevention, awareness, and education. Often, parents suggested prevention programs or curricula that focused on adolescent “mental wellness” and positive coping strategies. Parents also suggested incorporating self-harm awareness campaigns within schools to help prepare adolescents as well as destigmatize the behaviour.

7.0 Conclusion

7.1 Integrated Discussion

The results of the proposed study offer much-needed insight into the roles and experiences of individuals who have recovered from self-harm, as well as their primary social support people. Knowledge of recovered individuals', friend-caregivers', and parent-caregivers' perspectives on self-harm aid in formulating a better understanding of how their individual experiences and roles come together to form integrated and interactive help-seeking and recovery processes.

Each individual study in the current work contains many important insights and implications; nevertheless, the information that finds corroboration and consensus across studies is highly valuable. The key messages in the current study are those that were passed on by all participants – recovered individuals, friend-caregivers, and parent-caregivers. This section will summarize the key messages across participants' stories.

7.1.1 Direct communication is essential. Each participant group emphasized the importance of openly communicating about self-harm. Recovered individuals cited one of the most helpful parental actions to be *assertively taking action*, which included directly approaching the topic. Through their stories, recovered individuals indicated that initially they were not appreciative of parents' communication or involvement, but ultimately, were able to say with confidence that it was "exactly what was needed". Moreover, recovered individuals shared that the opposite, indirect communication about self-harm, was experienced as abandonment, or a lack of caring, and was detrimental to the situation. Similarly, recovered individuals also cited one of the most helpful friend actions to be *mutual sharing and open discussion* about self-harm. They wanted their

friends to be able to directly communicate about self-harm, ask questions if needed, and mutually share surrounding thoughts, concerns, and feelings.

Friend-caregivers shared that *openly addressing self-harm* was one of the most helpful actions they took in their caregiving role. Friend-caregivers asserted that it was extremely difficult, particularly with their few resources and limited understanding of self-harm. Nonetheless, friend-caregivers believed that they could not be effective in their caregiving role without the information and understanding that came from directly communicating about self-harm.

Parent-caregivers echoed the other participants, in that they felt that engaging in honest conversations was one of the most helpful actions they took as caregivers. Parents experienced open and honest communication as contributing to a sense of a teamwork with their child, conveying a nonjudgmental attitude, and improving their own understanding of their child's self-harm. Several parents described using the opposite approach, in which they suspected self-harm but avoided openly addressing or directly asking. Although temporarily easier to handle, avoidance proved to be unhelpful and divisive. Over and above direct communication between parent and child, parents also believed that direct communication should be encouraged between all family members, and that siblings should also benefit from honesty and openness.

All three participant groups advocated for more direct communication about self-harm within schools. How can we expect children and adolescents to step up and communicate directly and honestly about their self-harm behaviours when this has never been modeled for them? By failing to openly address self-harm in schools, the taboo and

secretive nature about the behaviour persists, and open disclosure of self-harm (before it becomes severe) becomes even less likely.

7.1.2 Viewing self-harm as attention-seeking is disadvantageous. All three participant groups independently brought up the supposed attention-seeking nature of self-harm. In fact, recovered individuals believed that dispelling the myth of attention-seeking was one of the most important pieces of information about self-harm. Recovered individuals shared that they were prevented or hampered from seeking informal or formal help for their self-harm because they were afraid of being seen as attention-seeking. The stigma of being viewed as attention-seeking or manipulative prevented much-needed help. In addition, caregivers shared that this stigma negatively impacted their caregiving experience as well. Some caregivers felt that the quality of their help was adversely impacted because of their misperceptions and false beliefs about self-harm. Other caregivers avoided seeking social support for themselves because they were concerned that friends or extended relatives would think poorly of their self-harming loved one. The view that self-harm is manipulatively engaged in for attention is disadvantageous. Instead, self-harm is genuinely engaged in for other reasons (e.g., depression, emotional pain, inability to cope with overwhelming emotions) that legitimately warrant attention.

7.1.3 Self-harm has widespread and longstanding influence. All participants and all participant groups experienced self-harm as life changing. Many individuals believed they were no longer the same person due to their self-harm or caregiving experiences. Indeed, many participants believed that their experiences were still affecting and influencing them, even after recovery. Lingering effects, those changes that continue on even after the initial situation has ceased, were endorsed by many participants.

Furthermore, participants experienced self-harm as reaching into many parts of their lives – affecting them emotionally, physically, and socially. Self-harm is sometimes treated as a symptom of something else, a lesser-known negative coping mechanism, or a joke. The current study demonstrates that self-harm is a problem in and of itself, is a behaviour that warrants more attention, and is anything but a joke.

7.1.4 Supports are desperately needed for those who self-harm and their caregivers. Everyone involved in the self-harm recovery process expressed the need for supports. Table 6 summarizes the support needs of recovered individuals, friend-caregivers, and parent-caregivers.

Table 6
Overview of Multiperspective Support Needs

	According to Recovered Individuals	According to Friend-Caregivers	According to Parent-Caregivers
Support Needs of Recovered Individual	<p>Informational support:</p> <ul style="list-style-type: none"> - Seriousness of self-harm - Self-harm is not attention-seeking - Alternatives to self-harm <p>Emotional support:</p> <ul style="list-style-type: none"> - Being told directly they are loved and cared for - Physical touch and presence - Sensitivity when discussing self-harm <p>Tangible support:</p> <ul style="list-style-type: none"> - Improved follow-up from healthcare system - More information/advertising about where and how to seek help 	<p>Improved understanding and follow-up for self-harm in the healthcare system:</p> <ul style="list-style-type: none"> - Follow-up services or resources following an ER visit - Less discriminatory attitudes from allied health professionals <p>Opportunity to connect with others who understand the self-harm struggle:</p> <ul style="list-style-type: none"> - Support groups/mentorship programs <p>Improved awareness and education about self-harm in the school system:</p> <ul style="list-style-type: none"> - Alter curriculum to include self-harm - Guest speakers who have recovered from self-harm - Awareness campaigns/fundraisers - Brochures/reading materials 	<p>Improved delivery of care within the healthcare system:</p> <ul style="list-style-type: none"> - Shorter waitlists - Coordinated, specialized care for self-harm - Educated/nonjudgmental health professionals - Alternatives when turned away from ER <p>Treatment options that emphasize interpersonal connection:</p> <ul style="list-style-type: none"> - Feel listened to by one's therapist - Establish trust - Connect to therapist or others in a group setting <p>Improved awareness and education about self-harm in the school system:</p> <ul style="list-style-type: none"> - Teach "mental wellness" and coping strategies - Destigmatize self-harm through discussion and education
	According to Recovered Individuals	According to Friend-Caregivers	According to Parent-Caregivers
Support Needs of Friend-Caregivers	<p>Informational support:</p> <ul style="list-style-type: none"> - Seriousness of self-harm - Self-harm is not attention-seeking - Alternatives to self-harm 	<p>Informational support:</p> <ul style="list-style-type: none"> - Information on self-harm (warning signs, rationale, <i>experience</i> of self-harm, etc) - Information on caregiving (where to access resources, when to involve a parent, etc) <p>Emotional support:</p> <ul style="list-style-type: none"> - Understanding, encouragement, willingness to listen, sense 	

		<p>of camaraderie</p> <ul style="list-style-type: none"> - caregiver support group <p>Need to maintain a healthy life separate from one's caregiving role.</p> <ul style="list-style-type: none"> - Stay involved in social/leisure activities - Avoid being the sole caregiver 	
	According to Recovered Individuals	According to Friend-Caregivers	According to Parent-Caregivers
Support Needs of Parent-Caregivers	<p>Informational support:</p> <ul style="list-style-type: none"> - Seriousness of self-harm - Self-harm is not attention-seeking - Alternatives to self-harm 		<p>Informational support:</p> <ul style="list-style-type: none"> - About self-harm (seriousness, triggers, warning signs, reasons, prevalence, etc) - About caregiving (How to maintain discipline, how to access/navigate the healthcare system, etc) - Brochures, healthlink phone services, awareness from GP <p>Individual counselling:</p> <ul style="list-style-type: none"> - Validation of emotions, feeling listened to without judgement, professional advice <p>Peer support:</p> <ul style="list-style-type: none"> - Not feel alone, feel understood, share parenting strategies and ways to cope, - Peer support group

As suggested in the literature, friends and parents play integral roles in the recovery process (Gelinas & Wright, 2013; Heath et al., 2008) and have valuable insights into the needs of caregivers and self-harming individuals alike. Of note, the participants did not suggest support wants, but support *needs*. All participant groups reported significant distress and truly struggled with the recovery from self-harm experience. Across participants groups, a common trend was the reporting of limited supports and resources. Disappointment with the follow-up services and resources offered through the healthcare system, and dissatisfaction with the education and resources offered through the school system was voiced throughout participants groups.

7.1.5 School systems are integral to self-harm education and awareness.

Across participant groups, the school system was believed to be an underutilized mechanism for self-harm education and awareness. Recovered individuals and caregivers alike adamantly asserted that a) all individuals would benefit from improved awareness and education about self-harm, b) information should be provided preventatively at an early age, and c) self-harm information should be provided under the scope of general health and not treated differently than other “adolescent health” topics addressed in school. In this way, adolescents: learn about self-harm prior to initiating the behaviour, have the opportunity to select other coping strategies, are introduced to the topic in a way that delimits the potential for stigma, and are better prepared to help themselves as well as help friends with self-harming behaviours, For these reasons, the participants believed that no other venue or platform would be better at providing self-harm education and awareness than schools.

In terms of practical implications, steps should be taken to make the school system a platform for self-harm awareness and education. School systems should be made more aware of the need and the specific desire for education to come through the school setting. Mental health professionals should collaborate with educational professionals to develop workshops, introduce guest speakers, and revise curriculum to better address self-harm. Based on the current study results, the educational activities introduced in the school setting should include information about the *experience* of self-harm. As several participants suggested, having a guest speaker come into classes to speak about his or her *experience* recovering from self-harm may go a long way in dispelling myths, destigmatizing self-harm, and decreasing the notion that one is alone and isolated in their own experience of self-harm.

7.1.6 Psychoeducational support groups are believed to hold widespread treatment potential. Another commonality across participant groups was the suggestion for peer support groups. Recovered individuals, friend-caregivers, and parent-caregivers all discussed the benefits of receiving psychoeducation and sharing experiences among other people in similar circumstances. Truly feeling understood can only come from interactions with others in comparable circumstances, and participants believed support groups were the answer. Past research has demonstrated the efficacy and acceptability of peer support groups for a wide range of presenting problems, and have been widely utilized among caregivers to good success (Abramowitz & Coursey, 1989; Bjornstad & Montgomery, 2005; Gatta et al., 2011).

In terms of practical implications, the healthcare system should be made better aware of self-harming individual's and caregivers' support needs. As one participant

suggested, educational opportunities for healthcare professionals could include a guest lecture by someone who has recovered from self-harm in order to share the *experience* of self-harm. In addition, I suggest that a caregiver (friend, parent, or both) also be involved in the guest lecture. Healthcare professionals often interact with caregivers and likely have a limited understanding of the experience and struggles encountered specifically by caregivers. Finally, the healthcare system should develop psychoeducational peer support groups for individuals recovering from self-harm as well as for caregivers.

7.2 Future Directions

The lived experiences of those individuals and their caregivers who have overcome self-harm are a source of invaluable knowledge and expertise. Future research and clinical innovations would do well to utilize the experiential knowledge of these key players. Based on the current study, I believe that future research should focus on a) incorporating the voices and opinions of clients (i.e., self-harming individuals or their caregivers) and b) developing, implementing, and evaluating supports based on the clients' expressed needs and wants.

Future research should consider how best to provide education and promote awareness about self-harm in the school system. A good next step would be to hold focus groups on how to feasibly structure and roll-out school-based initiatives. Focus groups should include participation from educators, school-board policy makers, mental health professionals, and individuals who have recovered from adolescent self-harm.

Future research should consider how best to design, implement, and evaluate psychoeducational peer support groups for individuals struggling with self-harm as well as their caregivers. In particular, future research should investigate the use of MFPGs

among this population. Given the success MFBGs have had in different populations (Fristad et al., 1998; Goldberg-Arnold et al., 1999; Sanford et al., 2006; Uehara, Kawashima, Goto, Tasaki, & Someya, 2001), and its fulfillment of parent-caregivers' requests for supports (e.g., family-based, focus on education and sharing strategies, option to include the "patient" adolescent, etc), there is a strong basis on which to proceed with this type of psychoeducational peer support group.

In recent years this has been a push to incorporate modern technology into interventions for self-harming adolescents (Daine et al., 2013; Owens et al., 2010). In the current study, the idea of mentorship surfaced several times, and one particularly creative participant suggested having mentors available via email. An email mentorship program for self-harming adolescents is an innovative intervention that would fulfill many of the adolescents' stated support needs. To take it a step further, an email mentorship program for caregivers may also be a helpful program. The option to contact another parent (or friend) who has seen and experienced the process of recovery, ask questions, receive advice, and feel supported and understood would certainly have been a welcome resource among the current participants. In the same vein, modern technology could be utilized to provide psychoeducation about self-harm to adolescents and their caregivers. Internet-based interventions have been used to treat and psychoeducate among a plethora of mental health concerns, with good success (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Using the Internet as the forum for providing support and information has many advantages, such as: increased accessibility, decreased cost, improved anonymity, and improved immediate access. Among those who self-harm and their caregivers, an Internet-based psychoeducation program would mean that regardless of age or financial

means, help could be accessed. Furthermore, for a highly stigmatized behaviour like self-harm, the increased anonymity of Internet interventions could improve help-seeking. Future research should consider how to design, implement, and evaluate programs that incorporate modern technology.

7.3 Strengths and Limitations

Self-harm gives every indication of being a multifactorial problem that likely needs a multifactorial solution. A primary strength of the current study is that it approached the problem of self-harm using a multi-dimensional perspective. To my knowledge, no other study of self-harm has investigated the process of recovery from self-harm through both caregiver and care-receiver lenses. Therefore, the current study provides a more comprehensive view of the self-harm recovery experience than past research has provided. Indeed, the number of participants involved in the current study is quite large by IPA standards (Smith, Flowers, & Larkin, 2009), and allowed for the three-study design.

Another strength of the current study is the novel use of recovered individuals and caregivers of recovered individuals as participants. Previous research has not ascertained the perspective of those individuals who have the lived experience of recovery from self-harm. By examining the retrospective perspectives of recovered individuals, I gained insight into the wants and needs of a sub-population that is often secretive and uncommunicative. Oftentimes, individuals who are currently self-harming are reticent to present to mental health professionals or researchers (Evans et al., 2005; Klineberg et al., 2013); therefore, their perspective on what would be most helpful for them is rarely

heard. By consulting those individuals who have overcome self-harm, we gain the opportunity to learn from successful journeys and outcomes.

The current study offers valuable and novel insights into the recovery process from self-harm; however, there are several limitations that also offer direction for future research. First, all participants were self-selected. Therefore, those individuals who agreed to share their stories may be a different ‘type’ of person, and their stories may not be representative of a random sample of recovered individuals or caregivers. Second, all the participants were Saskatchewan residents, and their experiences (particularly in regard to the healthcare system and available resources) may not generalize to others in different geographical areas. Third, there was an unequal gender distribution, with far more female than male participants. Therefore, the stories of male friend-caregivers, parent-caregivers, and recovered individuals may be underrepresented. There was no stark incongruence between the stories and experiences of the male participants in contrast to female participants in the current study. Fourth, the severity of the sample resulted in some blending of self-harm and suicidality. As such, the experiences recorded in the current study cannot be considered a pure self-harm narrative. Approximately 83% of self-harming individuals experience suicidal ideation, 40% make a suicide plan, and 26% engage in a suicide attempt (Laye-Gindhu & Schonert-Reichl, 2005); therefore, a “pure” self-harm narrative may be quite rare, and is in any case, not representative of the common blend of problems within a self-harming population. Finally, the subjective nature of the qualitative research, and the potential for researcher bias in IPA is a potential limitation. A different researcher, in a different time, place, or frame of mind may have identified different themes than did I. However, appropriate measures were

taken to ensure the rigour and trustworthiness of the chosen qualitative method, and I as a social-constructivist researcher have acknowledged my likely influence on the data analysis process. In the interest of transparency and researcher disclosure, I present an excerpt from my field journal that highlights what is likely my largest influence on the interviews themselves:

I find myself emotionally exhausted after each interview. Upon reflection, I realize that my exhaustion comes from feeling useless. In clinical practice I have interviewed countless clients with stories just as emotionally tumultuous as my participants. The difference? In clinical practice I have something more than semi-structured questions to offer. I have become accustomed to being more helpful and feeling more able to provide something useful to my clients. During interviews, I want to provide psychoeducation, I want to provide therapy. I have noticed that my semi-structured interviews become peppered with validating statements and positive affirmations. Ultimately, I hope this research moves from mere questions and answers and instead translates into practical, clinical, and helpful interventions. (Field Journal)

8.0 References

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9.0 Appendix A

Recovered Individual Screener Questionnaire

***** With your permission, I'd like to go through a few quick questions to see if you're eligible to participate in this study. It should take approximately 5 minutes. I want to make sure that your experiences fit with what I've proposed to research.**

***** After this phone interview, if you are eligible to participate, I'd like to schedule a time for us to meet in-person. At that point in time we would have a much longer interview (approximately 90 minutes), and I'd have you complete a few brief questionnaires.**

***** Do you have any questions before we begin?**

1. What is your name?

2. What is your phone number?

3. Have you ever intentionally (i.e., on purpose) done something to hurt or injure yourself, without suicidal intent?

Yes / No

4. If yes, what types of things did you do to hurt yourself?

5. In total, over your entire life, how many times have you deliberately hurt yourself?

6. How many years ago was the last time that you deliberately hurt yourself?

Parent Screener Questionnaire

***** With your permission, I'd like to go through a few quick questions to see if you're eligible to participate in this study. It should take approximately 5 minutes. I want to make sure that your experiences fit with what I've proposed to research.**

***** After this phone interview, if you are eligible to participate, I'd like to schedule a time for us to meet in-person. At that point in time we would have a much longer interview (approximately 90 minutes), and I'd have you complete a few brief questionnaires.**

***** Do you have any questions before we begin?**

7. What is your name?

8. What is your phone number?

9. Has one of your children ever engaged in deliberate self-harm behaviours?

Yes / No

10. If yes, what types of things would they do to hurt themselves?

11. If you had to estimate, how many times in total have they hurt themselves?

12. How many years ago was the last time that they deliberately hurt themselves?

13. For how long were you actively involved in supporting them?

Friend Screener Questionnaire

***** With your permission, I'd like to go through a few quick questions to see if you're eligible to participate in this study. It should take approximately 5 minutes. I want to make sure that your experiences fit with what I've proposed to research.**

***** After this phone interview, if you are eligible to participate, I'd like to schedule a time for us to meet in-person. At that point in time we would have a much longer interview (approximately 90 minutes), and I'd have you complete a few brief questionnaires.**

***** Do you have any questions before we begin?**

14. What is your name?

15. What is your phone number?

16. Has one of your friends ever engaged in deliberate self-harm behaviours?

Yes / No

17. If yes, what types of things would they do to hurt themselves?

18. If you had to estimate, how many times in total have they hurt themselves?

19. How many years ago was the last time that they deliberately hurt themselves?

20. For how long were you actively involved in supporting them?

10.0 Appendix B

Demographic Information – Recovered Individual

1. What is your gender? Male Female
2. How old are you? Age: _____
3. What is your current employment status? (Select all those that currently apply)
- Employed-full time Employed part-time Employed
 Student On disability Other (please specify)

4. What is your current occupation? _____
- How long have you worked at this job? _____ years

5. What is your highest level of education? (Please circle)
- 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Trade school Masters Doctorate
High School University

6. What is your ethnic origin?
- Aboriginal_____/ African_____/ Asian ____/ Caribbean_____/ European_____/
- Latin, Central, or South American_____/ Mediterranean_____/ Middle Eastern_____/
- Other_____/

7. What is your current relationship status?
- Single Divorced Common law/cohabiting
- Married Separated Dating
- Widowed Other (please specify)

8. What are your current living arrangements? (Check all that apply.)

- Living alone
- Living with one or both parents
- Living with significant other
- Living with other relatives
- Living with roommates
- Living with spouse/partner
- Living with children
- Other (please specify)

9. What is your current household income?

- Less than 30,000 30,000-49,999 50,000-99,999
- 100,000-199,000 greater than 200,000

10. Have you ever had past contact with a mental health professional (e.g., psychiatrist, psychologist, school counselor, social worker)?

Yes / No

If yes, on how many separate occasions? _____

11. Have you ever been given a psychiatric diagnosis by a mental health professional?

Yes / No

If yes, what were the diagnoses given? _____

15. To your knowledge, how many times total did your child self-harm?

16. For how long has your child been recovered?

17. For how long were you caring for, and supporting your child?

- Living alone
- Living with one or both parents
- Living with significant other
- Living with other relatives
- Living with roommates
- Living with spouse/partner
- Living with children
- Other (please specify)

9. What is your current household income?

- Less than 30,000
- 30,000-49,999
- 50,000-99,999
- 100,000-199,000
- greater than 200,000

10. Have you ever had past contact with a mental health professional (e.g., psychiatrist, psychologist, school counselor, social worker)?

Yes / No

If yes, on how many separate occasions? _____

11. Have you ever been given a psychiatric diagnosis by a mental health professional?

Yes / No

If yes, what were the diagnoses given? _____

12. How old were you and your friend, while your friend was self-harming? _____

13. To your knowledge, what type of self-harm did your friend engage in?

14. To your knowledge, how long had your friend been self-harming?

15. To your knowledge, how many times total did your friend self-harm?

16. For how long has your friend been recovered?

17. For how long were you caring for, and supporting your friend?

11.0 Appendix C

Deliberate Self-Harm Inventory – adapted

- 1. Have you ever intentionally (i.e., on purpose) cut your wrist, arms, or other area(s) of your body, without intending to kill yourself?**

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

- 2. Have you ever intentionally (i.e., on purpose) burned yourself with a cigarette?**

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

- 3. Have you ever intentionally (i.e., on purpose) burned yourself with a lighter or a match?**

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?

- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

4. Have you ever intentionally (i.e., on purpose) carved words into your skin?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

5. Have you ever intentionally (i.e., on purpose) carved pictures, designs, or other marks into your skin?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

6. Have you ever intentionally (i.e., on purpose) severely scratched yourself, to the extent that scarring or bleeding occurred?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?

- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

7. Have you ever intentionally (i.e., on purpose) bit yourself, to the extent that your broke skin?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

8. Have you ever intentionally (i.e., on purpose) rubbed sandpaper on your body?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

9. Have you ever intentionally (i.e., on purpose) dripped acid onto your skin?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?

- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

10. Have you ever intentionally (i.e., on purpose) used bleach, comet, or oven cleaner to scrub your skin?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

11. Have you ever intentionally (i.e., on purpose) rubbed glass into your skin?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

12. Have you ever intentionally (i.e., on purpose) broken your own bones?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?

- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

13. Have you ever intentionally (i.e., on purpose) banged your head against something, the extent that you caused a bruise to appear?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

14. Have you ever intentionally (i.e., on purpose) punched yourself, to the extent that you caused a bruise to appear?

Yes / No

If yes:

- a) How old were you when you first did this?
- b) How many times have you done this?
- c) When was the last time you did this?
- d) How many years did you do this before you stopped?
- e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?

15. Have you ever intentionally (i.e., on purpose) done anything else to hurt yourself that was not asked about in this questionnaire? If yes, what did you do to hurt yourself?

- a) How old were you when you first did this?
- b) How many times have you done this?

- c) When was the last time you did this?
 - d) How many years did you do this before you stopped?
 - e) Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment?
- 16. How many times in total (including your entire life) have you deliberately hurt yourself using any of these self-harm behaviours?**
- 17. Over what length of time were you deliberately hurting yourself?
_____ (months), _____ (years).**
- 18. Taking all of these behaviours into account, when was the last time you deliberately hurt yourself?**

12.0 Appendix D

Interview Guide – Recovered Individuals

Introduction

1. Tell me a little bit about yourself.
2. Tell me about your experience with self-harm.
3. Tell me what made you decide to participate in this type of study.

Question Topic #1: Parents' Role

1. What was your parents' role in your self-harm experience?
 - a. *While you were involved in self-harm, were your parents helpful? Harmful? Aware?*
 - b. *Did your parents' roles change when you began to self-harm?*
 - c. *Did your parents take different roles/responsibilities with respect to your self-harm?*
2. How did you experience your parents' involvement with your self-harm?
 - a. *In what ways were your parents involved?*
 - b. *What feelings did you have about them being involved in that way?*
 - c. *How did you interpret, or understand, their reactions/responses to your self-harm?*

Question Topic #2: Friends' Role

1. What was your friends' role in your self-harm experience?
 - a. *While you were involved in self-harm, were your friends helpful? Harmful? Aware?*
 - b. *Did your friends' roles change when you began to self-harm?*
 - c. *Did your friends take different roles/responsibilities with respect to your self-harm? How many friends had an active role, or were actively involved?*
2. How did you experience your friends' involvement with your self-harm?
 - a. *In what ways were your friends involved?*
 - b. *What feelings did you have about them being involved in that way?*
 - c. *How did you interpret, or understand, their reactions/responses to your self-harm?*

Question Topic #3: Help-seeking Process

1. What was your experience with help-seeking for self-harm?
 - a. *Was seeking out help difficult? Easy? A big decision?*
 - b. *What was going on for you when you started thinking about reaching out?*

2. Did you seek formal help for your self-harm? Why or why not?
 - a. *How did you choose this type of formal help?*
 - b. *What sorts of things did you consider when deciding to seek formal help?*
3. Did you seek informal help for your self-harm? Why or why not?
 - a. *How did you choose this type of informal help?*
 - b. *What sorts of things did you consider when deciding to seek informal help?*
4. Is there anything you would have done differently in terms of help-seeking?
 - a. *What advice would you give about help-seeking to someone in a similar circumstance?*

Question Topic #4: Recovery Process

1. What was your experience with recovering from self-harm?
 - a. *Can you describe any steps, or stages that you experienced while recovering?*
 - b. *Are there lingering effects from your experiences with self-harm?*
2. What was most important to your recovery?
3. Who was most important to your recovery?
4. Is there anything you would have done differently to aid in your recovery process?
 - a. *What advice would you give about recovery from self-harm to someone in a similar circumstance?*

Question Topic #5: Support Needs

1. In which ways do you wish your parents had supported you?
 - a. *While self-harming, was there something in particular that you wanted or needed from your parents?*
2. In which ways do you wish your friends had supported you?
 - a. *While self-harming, was there something in particular that you wanted or needed from your friends?*
3. What information do you wish your social supports had known?
4. What was the most helpful response/reaction you received from your social supports?
 - a. *What made this a positive response/reaction for you?*
5. What was the least helpful response/reaction you received from your social supports?
 - a. *What made this a negative response/reaction for you?*

Conclusion

1. Is there anything we haven't covered, that you think was a key part of your experience?
2. What advice would you give to someone in a similar circumstance?

Interview Guide – Parents

Introduction

1. Tell me a little bit about yourself.
2. Tell me about your experience with self-harm.
3. Tell me what made you decide to participate in this type of study.

Question Topic #1: Parents' Role

1. What was your role in your child's self-harm experience?
 - a. *Did your role change after learning about your child's self-harm?*
2. How did you experience your child's self-harm?
 - a. *How did you come to understand it?*
 - b. *How did it affect you?*
3. How did your child's self-harm behaviours affect your role as a parent?
 - a. *Did it affect how you parented your other children?*
 - b. *Did it affect how you viewed yourself as a parent?*

Question Topic #2: Role in Help-seeking

1. What was your role in seeking help for your child?
2. Is there anything you would have done differently in seeking help? If so, what?
 - a. *What advice would you give about help-seeking to someone in a similar circumstance?*
4. What (if anything) was important to your child finding help?

Question Topic #3: Role in Recovery

1. What was your role in your child's recovery process?
 - a. *What went well as you supported your child through the recovery process?*
 - b. *Did your role change as your child gradually recovered?*
2. Is there anything you would have done differently to aid in the recovery process?
 - a. *What advice would you give about the recovery process to someone in a similar circumstance?*
3. What (if anything) was important to your child recovering?

Question Topic #4: Challenges/Struggles

1. What did you find most challenging in your role as a parent of someone who self-harms?
 - a. *As a parent, what did you find most difficult?*
2. What did you struggle with most during your experiences with a child who self-harms?
 - a. *Personally, what did you find most difficult?*
3. What part of your life was most affected?

Question Topic #5: Support Needs

1. During that time, what were your support needs?
 - a. *What sort of support would you have most benefitted from?*
 - b. *If any, what sort of emotional support did you want from others? What sort of tangible support? What sort of informational support?*
2. During that time, what information did you need?
 - a. *Looking back, what information/knowledge would have been most helpful to you?*
3. During that time, what type of involvement did you want from programs or services?

Conclusion

1. Is there anything we haven't covered, that you think was a key part of your experience?
2. What advice would you give to someone in a similar circumstance?

Interview Guide – Friends

Introduction

1. Tell me a little bit about yourself.
2. Tell me about your experience with self-harm.
3. Tell me what made you decide to participate in this type of study.

Question Topic #1: Friends' Role

1. What was your role in your friend's self-harm experience?
 - a. *What did you feel was your job or responsibility?*
2. How did you experience your friend's self-harm?
 - d. *How did you come to understand it?*
 - e. *How did it affect you?*
3. How did your friend's self-harm behaviours affect your friendship?
 - a. *Did it affect how you acted as a friend to other people?*
 - b. *Did it affect your how you viewed yourself as a friend?*

Question Topic #2: Role in Help-seeking

1. What was your role in seeking help for your friend?
2. Is there anything you would have done differently in seeking help?
 - d. *What advice would you give about help-seeking to someone in a similar circumstance?*
3. What (if anything) was important to your friend finding help?

Question Topic #3: Role in Recovery

1. What was your role in your friend's recovery process?
 - a. *What went well as you supported your friend through the recovery process?*
 - b. *Did your role change as your friend gradually recovered?*
2. Is there anything you would have done differently to aid in the recovery process?
 - a. *What advice would you give about the recovery process to someone in a similar circumstance?*
3. What (if anything) was important to your friend recovering?

Question Topic #4: Challenges/Struggles

1. What did you find most challenging in your role as a friend of someone who self-harms?
2. What did you struggle with most during your experiences with a friend who self-harms?
3. What part of your life was most affected?

Question Topic #5: Support Needs

1. During that time, what were your support needs?
 - a. *What sort of support would you have most benefitted from?*
 - b. *If any, what sort of emotional support did you want from others? What sort of tangible support? What sort of informational support?*
2. During that time, what information did you need?
 - a. *Looking back, what information/knowledge would have been most helpful to you?*
3. During that time, what type of involvement did you want from programs or services?

Conclusion

1. Is there anything we haven't covered, that you think was a key part of your experience?
2. What advice would you give to someone in a similar circumstance?

13.0 Appendix E

Consent Form

Project Title: Recovery from Deliberate Self-Harm: Perspectives from Those who have Survived, and from Those who have Helped

Primary Investigator: Bethany L. Gelinas, M.A.
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Invitation to Participate:

You are invited to participate in a study on the experiences of individuals who have recovered from deliberate self-harm (DSH) behaviours, and the experiences of their key social support people. This study involves participating in an interview to discuss your experiences with DSH, as well as completing a few brief questionnaires.

Purpose of the Study:

The purpose of this study is to investigate and document the various roles and experiences of individuals who a) have recovered from self-harm, and b) have supported someone in their recovery from self-harm. Furthermore, this study seeks to evaluate the utility and acceptability of the current 'mental health first aid guidelines' for responding to self-harm.

Voluntary Participation:

Participation in this study is entirely voluntary, so it is up to you to decide whether or not

to take part in this study. Before you make a decision, though, it is important for you to understand what the research involves. This consent form will tell you about the study, the purpose of the research, what will happen during the study, and the possible risks, and benefits. If you do decide to take part in this study, you will be asked to sign this consent form. Even after signing the informed consent form, you can choose to drop-out at any time, decline to answer any questions (verbal or questionnaire), as well as request that the information collected not be used. Withdrawal of data is only possible up to the points of dissemination (approximately 6 months from the project's end date). Not participating in the current research study will have no negative repercussions. Furthermore, your responses to questionnaires will not negatively impact your present or future use of any services.

Who is Conducting the Study:

The Primary Investigator is Bethany L. Gelinis, M.A., a doctoral student in Clinical Psychology at the University of Regina. Dr. Kristi Wright, R.D. Psych., is supervising the project. This project is part of a Ph.D. dissertation required for partial fulfillment of the University of Regina's Ph.D. program.

Specific Procedures:

Before you agree to participate, we would like to provide you with information about the procedures involved in the study so that you can make an informed decision.

Interview:

Following consent, you will be asked to complete an in-person semi-structured interview. This interview will be approximately 60 to 90 minutes in length, and will generally address your experiences with DSH, including: your role (either as a recovered individual, or a support person), experiences with help-seeking, experiences with the recovery process, and your support needs at the time. These interviews are meant to get an in-depth look at your personal experiences with this particular phenomenon, and as such, some questions may be personal in nature. All interviews will be audio-recorded and then transcribed by the primary investigator.

Assessment:

Following consent, you will also be asked to complete a few brief paper-and-pencil questionnaires. These questionnaires will take approximately 15 to 20 minutes to complete. The questionnaires include demographic questions, self-harm history questions, and rating scales for various responses/reactions to self-harm.

Appraisal of findings:

After study completion, you will be asked to read through a summary of the study's findings, in order to ensure that it accurately reflects your experience. You will then be given the opportunity to suggest changes or clarifications. Please note that this appraisal step is optional.

Potential Benefits:

Participation in this study has the benefit of providing you with the opportunity to provide valuable and constructive feedback in regards to your experiences with self-harm. Your participation will also assist future researchers in better structuring and implementing programs and interventions for individuals who self-harm and their social support people.

Potential Risks and Discomforts:

There are no anticipated risks associated with your participation in this research project; however, it is possible that you may experience some emotional discomfort when discussing your experiences in the interview. However, it is completely up to you to decide what to share during the interview.

Confidentiality:

Any information gained from taking part in this study is confidential and will only be shared with members of the research team involved in the study. All information collected for this study will be kept in a locked cabinet, in a locked office in the University of Regina. Furthermore, electronic information will be stored in password-protected files, and all identifying participant information will be excluded from the computer database. Any details that could potentially reveal your identity will be excluded from discussions, study reports, and presentations. All information will be held for a minimum of 5 years.

Contact Information: If you have any questions, feedback or comments about the research study or the results of the research study, please feel free to contact the primary investigator, Bethany L. Gelinabe at (306) 337-3339 (e-mail: gelinabe@uregina.ca) or the supervisor of the research project Dr. Kristi D. Wright (e-mail: kristi.wright@uregina.ca). A summary of study results will be available once all data have been collected and analyzed. This will likely take 2 years. If you have any further questions regarding research findings, or would like a copy of the results summary once complete, please feel free to contact us.

This project was approved by the Research Ethics Boards at the University of Regina. If participants have any questions or concerns about their rights or treatment as participants, they may contact the Chair of the Research Ethics Board at the University of Regina (585-4775; e-mail: research.ethics@uregina.ca).

Participant Endorsement:

I _____ have read and understood the terms of the study as described above. I agree to participate in the study as described above and the

aforementioned audio recording of the interview. I am aware that my participation in the research project (interview and questionnaires) is voluntary and that I can withdraw at any time. Furthermore, I understand that the information that I provide will be kept confidential and it will not be possible to identify me in any evaluation research reports that will be generated. If I have questions, I know whom to contact. A copy of this form will be provided to me for my own records.

Participant's Signature _____

Researcher Signature _____

Date _____

14.0 Appendix F

Debriefing Form

Project Title: Recovery from Deliberate Self-Harm: Perspectives from Those who have Survived, and from Those who have Helped

Thank you for taking the time to participate in this study on the experiences of individuals who have recovered from self-harm behaviours, and the experiences of their key social support people.

Past research has indicated that social support, particularly via friends and family members, is one of the most crucial components to self-harm recovery. Although parents and friends are vital to self-harm help-seeking and recovery, little is known about the experience of parents and friends in supporting someone through these processes. What little is known indicates that parents and friends struggle with DSH, as they feel uninformed, unsupported, and often overwhelmed.

In response to research indicating that key social support people are struggling with how to respond to a loved one's self-harm, the current research is aimed at improving our understanding of the lived experiences of individuals who have recovered from self-harm, as well as parents and friends who have supported someone who has recovered. This study is being conducted in order to improve services and supports for parents and friends of self-harming individuals, with the goal of improving their experiences and hastening recovery. This study may contribute to the future development and implementation of supports and services for parents and friends of self-harming individuals.

Again, sincere thanks for your participation. If you are interested in the results of the study please contact Bethany Gelinabe (gelinabe@uregina.ca), who will arrange for an aggregate summary of the information to be sent once the study is complete. Questions are welcomed, and any concerns that you may have are important and should be addressed.

15.0 Appendix G

PRINCIPAL INVESTIGATOR
Bethany L. Gelinas

DEPARTMENT
Psychology

REB# 2014-045

SUPERVISOR
Dr. Kristi Wright

FUNDER(S)
CIHR Regional Partnership Program

TITLE
Recovery from deliberate self-harm: Perspectives from those who have survived, and from those who have helped

APPROVAL OF	APPROVED ON	CURRENT EXPIRY DATE
In-class presentation script	March 17, 2014	March 17, 2015
Recruitment poster – parents		
Recruitment poster – recovered individual		
Appendix B - Consent Form		
Recovered Individual Screener Questionnaire		
Friend Screener Questionnaire		
Parent Screener Questionnaire		
Demographic Information – Recovered Individual		
Demographic Information – Friend		
Demographic Information – Parent		
Interview Guide – Recovered Individuals		
Interview Guide – Parents		
Interview Guide – Friends		
Debriefing Form		
Deliberate Self-Harm Inventory – adapted		
Attitudes Toward Non-Suicidal Self-Injury Questionnaire – Adapted		
Appendix E – List of Services		

Full Board Meeting
Delegated Review

CERTIFICATION

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: <http://www.uregina.ca/research/REB/main.shtml>



Dr. Larena Hoeber, Chair
University of Regina - Research Ethics Board